Northern Regional Hospital

Community Health Needs Assessment (CHNA)

Mount Airy, North Carolina

Adopted by Board Resolution September 2022

NORTHERN
REGIONAL HOSPITAL®

Dear Community Member:

At Northern Regional Hospital (NRH), we have spent 65 years providing high-quality compassionate healthcare to the greater Mount Airy community. The “2022 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how NRH will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

NRH will conduct this effort at least once every three years. The report produced three years ago is also available for your review and comment. As you review this plan, please see if, in your opinion, we have identified the primary needs of the community and if you think our intended response will lead to needed improvements.

While we do not have adequate resources to solve all the problems identified, it is our goal to work together as a community to help each other live healthier lives. Some needed improvements will require personal actions by individuals with support from organizations like NRH and many others. We view this as a plan for how we, along with other area organizations and agencies, can collaborate to bring the best each has to offer to support change and to address the most pressing identified needs.

I invite your response to this report. As you read, please think about how to help us improve health and medical services in our area. We all live in, work in, and enjoy this wonderful community, and together we can make our community healthier for every one of us.

Thank You,

Chris A. Lumsden, FACHE
President & CEO

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EXECUTIVE SUMMARY

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Northern Regional Hospital ("NRH" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community and develop an implementation plan to outline and organize how to meet those needs.

Data was gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Experts was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority.

The Significant Health Needs for Surry County are:

1. Accessibility/Affordability
2. Obesity/Overweight
3. Mental Health/Suicide
4. Cancer
5. Heart Disease

The Hospital has developed implementation strategies for three of the five needs (Accessibility/Affordability, Obesity/Overweight, and Mental Health/ Suicide) including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

APPROACH

APPROACH

A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. ***While Northern Regional Hospital is not a not-for-profit hospital, this study is designed to comply with standards required of a not-for profit hospital and helps assure NRH identifies and responds to the primary health needs of its residents.***

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury.

Project Objectives

NRH undertook this effort to:

- Complete a CHNA report, compliant with Treasury – IRS
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment[1]

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c)(3) of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided those who did not have means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- An Emergency Room open to all, regardless of ability to pay
- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital

privileges Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility must conduct a CHNA at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through the assessment.
- The assessment may be based on current information collected by a public health agency or

[1] Information comes from https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

non-profit organization, and may be conducted together with one or more other organizations, including related organizations.

- The assessment process must consider input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources).
- Each hospital facility is required to make the assessment widely available and downloadable from the hospital website.
- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.

Community Health Needs Assessment Subsequent to Initial Assessment

The Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. The specific requirement is:

The 2022 proposed regulations provided that a hospital must both solicit and take into account input received from all the following sources in identifying and prioritizing significant health needs and in identifying resources potentially available to address those health needs.

1. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health described in Section 338J of the Public Health Services Act, with knowledge, information, or expertise relevant to the health needs of the community.
2. Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of these populations.
3. Written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy

Representatives of the various diverse constituencies outlined by regulation to be active participants in this process were actively solicited to obtain their written opinion. Opinions obtained formed the introductory step in this Assessment.

To conduct a CHNA, a hospital facility must complete the following steps:

1. Define the community it serves.
2. Assess the health needs of that community.
3. In assessing the community's health needs, solicit, and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.
4. Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility.
5. Make the CHNA report widely available to the public.

In addition to soliciting input from the three required sources, a hospital facility may solicit and take into account input received from a broad range of persons located in or serving its community. This includes, but is not limited to:

- Health care consumers and consumer advocates
- Nonprofit and community-based organizations
- Academic experts
- Local government officials
- Local school districts
- Health care providers and community health centers
- Health insurance and managed care organizations,
- Private businesses, and
- Labor and workforce representatives.

Although a hospital facility is not required to solicit input from additional persons, it must take into account input received from any person in the form of written comments on the most recently conducted CHNA or most recently adopted implementation strategy.

A hospital facility is considered to have conducted a CHNA on the date it has completed all of these steps, including making the CHNA report widely available to the public.

additionally, a CHNA developed after the initial Assessment must consider written commentary received regarding the prior Assessment and Implementation Strategy efforts. We followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

> *"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the form of written comments."*

NRH takes a comprehensive approach to the solicitation of written comments. As previously cited, we solicitated input from the required three minimum sources. We asked all participating in the written

comment solicitation process to self-identify themselves into any of the following representative classifications, which is detailed in an Appendix to this report. Written comment participants self-identified into the following classifications:

(1) Public Health – Persons with special knowledge of or expertise in public health

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility

(3) Priority Populations – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

(4) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

(5) Broad Interest of the Community – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations

Other (please specify)

Attempted to reach Patrick County, Carroll County, and Surry County Health Department for feedback and received no response.

NRH also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.

Most data used in the analysis is available from public Internet sources. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating with us in this study are displayed in the CHNA report appendix.

Data sources include:

Website or Data Source	Data Element	Date Accessed	Data Date
https://americashealthrankings.org	Conclusions from Demographic Analysis Compared to National Averages	August 10, 2022	2021
https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2021qdr-final-es.pdf	Appendix B: National Healthcare Quality and Disparities Report	September 1, 2022	2022
www.cdc.gov	Leading cause of death information in Surry and "peer counties"	August 4, 2022	2017
https://www.census.gov	Used to compare demographics	August 8, 2022	2021
https://www.countyhealthrankings.org/app/north-carolina/2022/measure/factors/5/data	Preventable hospital stays	August 15, 2022	2019
National Risk Index | FEMA.gov	To identify Social Vulnerability Index Value	August 1, 2022	2021
https://www.usnews.com/news/healthiest-communities/data-explorer	Assessment of the dozens of social factors assessed in the Healthiest Communities	August 1, 2022	2021
https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3	Overview of Community Health Needs Assessment and Requirements	September 1, 2022	2022

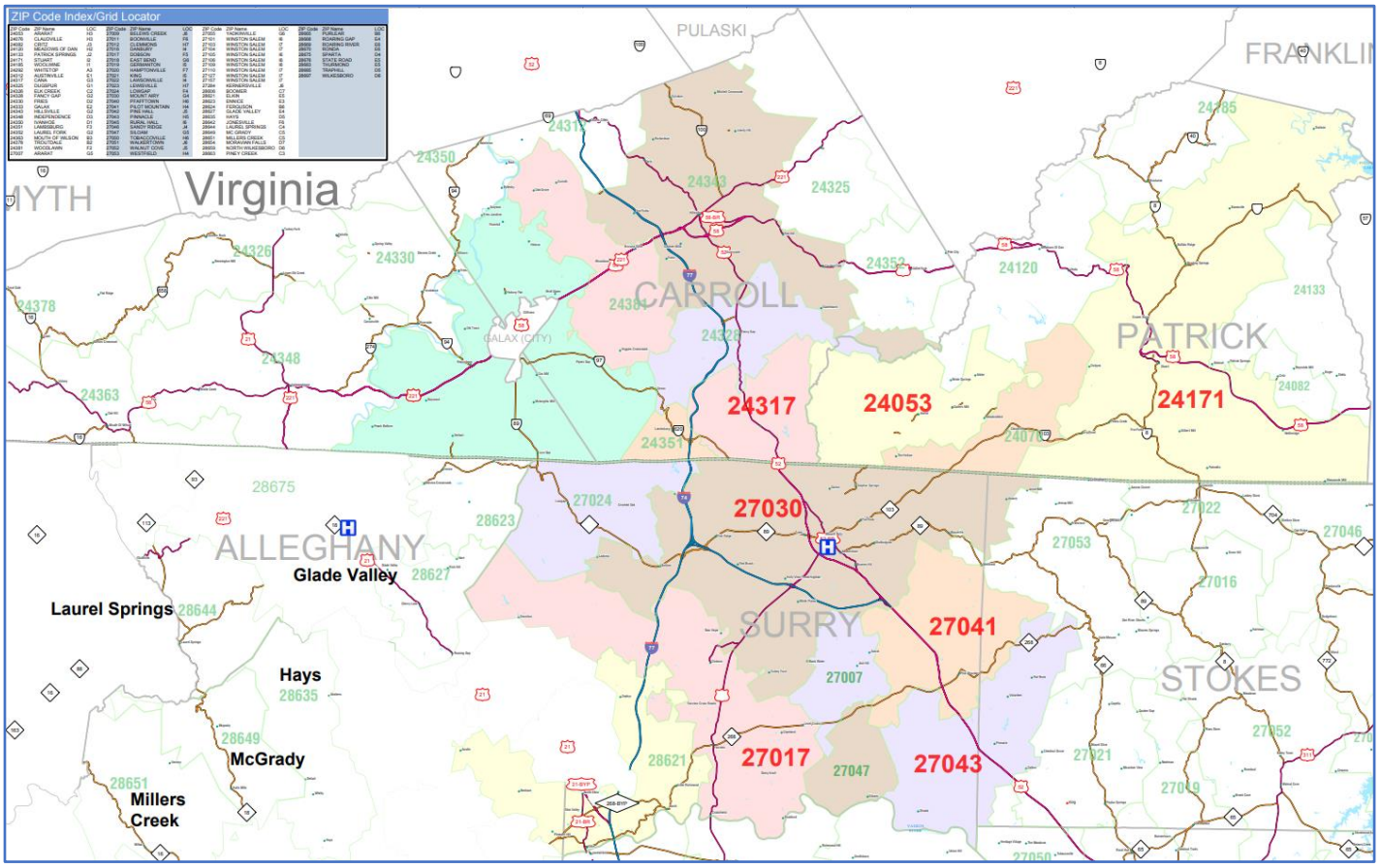
Federal regulations surrounding CHNA require local input from representatives of demographic sectors. For this reason, NRH developed a standard process of gathering community input. In addition to gathering data from the above sources:

- We deployed a CHNA "Round 1" survey to our four Expert Agencies to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 1 Local Agency. Survey responses started August 1, 2022 and ended with the last response on August 12, 2022.
- Information analysis augmented by local opinions showed how our service area relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
    - Low-income groups are prevalent in the community
    - Surry County has a growing number of older adults with comorbidities
    - Accessibility and transportation are issues given the rural nature of the area

In the NRH process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the prior CHNA. We developed a summary of all needs identified by any of the analyzed data sets. The responding Local Agency ranked the needs based on what they felt were significant at this time based on the prior survey results. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving much support.

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital



NRH defines its service area as Surry County in North Carolina, which includes the following ZIP codes:

27007- Ararat (NC)	27017- Dobson	27024- Lowgap	27030- Mount Airy
27047- Siloam	27043- Pinnacle	28621- Elkin	24333- Galax
27343- Hillsville	24328- Fancy Gap	24171- Stuart	24076- Claudville
24317- Cana	24351- Lambsburg	27049- Toast	27317- Level Cross
27041- Pilot Mountain	24381- Woodlawn	24053- Ararat (VA)	

In 2021, the Hospital received 88.86% of its patients from this area.

Demographics of the Community[2]

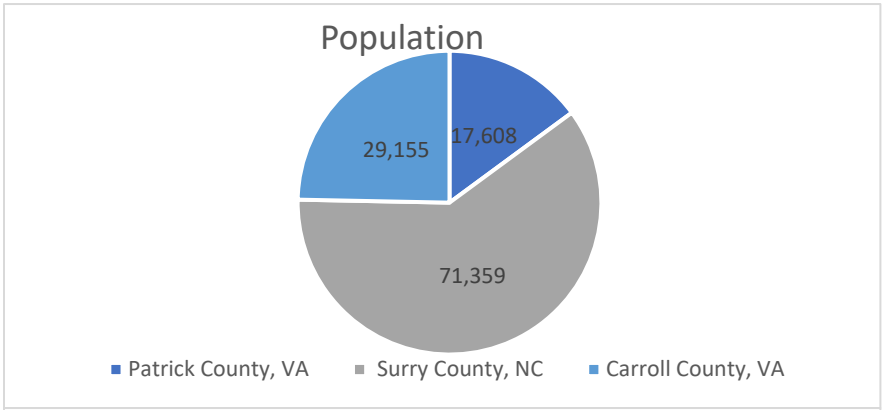
	North Carolina	Surry County, NC	Patrick County, VA	Carroll County, VA
2020 Population	10,439,388	71,359	17,608	29,155
Increase/Decrease	1.10%	-0.30%	0%	-0.40%
White, Non Hispanic %	61.90%	82.30%	89.50%	93.30%
Hispanic %	10.20%	11.80%	3.40%	4.30%
Median Age	38.9	44	50.4	48.3
Median Household Income	$56,642	$44,979	$46,941	$44,518
Unemployement Rate 2020	12.7	11.2	8.7	10.8
% Population > 65	17%	21%	27.10%	25.70%

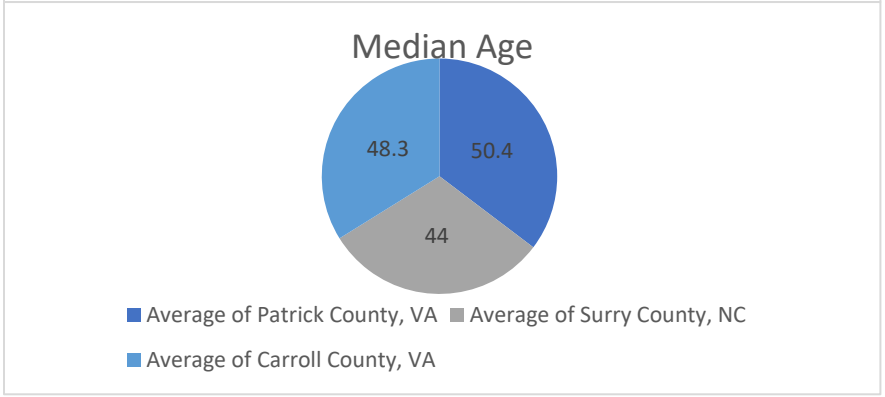
Population	North Carolina	Surry County, North Carolina	Patrick County, Virginia	Carroll County, Virginia
Population Estimates, July 1 2021, (V2021)	**10,551,162**	**71,152**	**17,602**	**29,048**
PEOPLE				
Population				
Population Estimates, July 1 2021, (V2021)	**10,551,162**	**71,152**	**17,602**	**29,048**
Population estimates base, April 1, 2020, (V2021)	10,439,388	71,359	17,608	29,155
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)	1.1%	-0.3%	0.0%	-0.4%
Population, Census, April 1, 2020	10,439,388	71,359	17,608	29,155
Population, Census, April 1, 2010	9,535,483	73,673	18,490	30,042
Age and Sex				
Persons under 5 years, percent	5.6%	5.3%	3.7%	4.2%
Persons under 18 years, percent	21.8%	21.2%	17.5%	17.7%
Persons 65 years and over, percent	17.0%	21.0%	27.1%	25.7%
Female persons, percent	51.1%	51.0%	49.8%	49.9%
Race and Hispanic Origin				
White alone, percent	70.1%	92.6%	92.4%	96.8%
Black or African American alone, percent (a)	22.3%	4.3%	5.3%	1.0%
American Indian and Alaska Native alone, percent (a)	1.6%	0.7%	0.7%	0.4%
Asian alone, percent (a)	3.4%	0.8%	0.4%	0.3%
Native Hawaiian and Other Pacific Islander alone, percent (a)	0.1%	0.1%	0.1%	Z
Two or More Races, percent	2.5%	1.5%	1.2%	1.5%
Hispanic or Latino, percent (b)	10.2%	11.8%	3.4%	4.3%
White alone, not Hispanic or Latino, percent	61.9%	82.3%	89.5%	93.3%
Health				
With a disability, under age 65 years, percent, 2016-2020	9.3%	14.7%	11.5%	13.6%
Persons without health insurance, under age 65 years, percent	13.4%	16.7%	11.7%	12.2%
Education				
High school graduate or higher, percent of persons age 25 years+, 2016-2020	88.5%	79.9%	82.3%	80.9%
Bachelor's degree or higher, percent of persons age 25 years+, 2016-2020	32.0%	17.9%	14.9%	14.8%

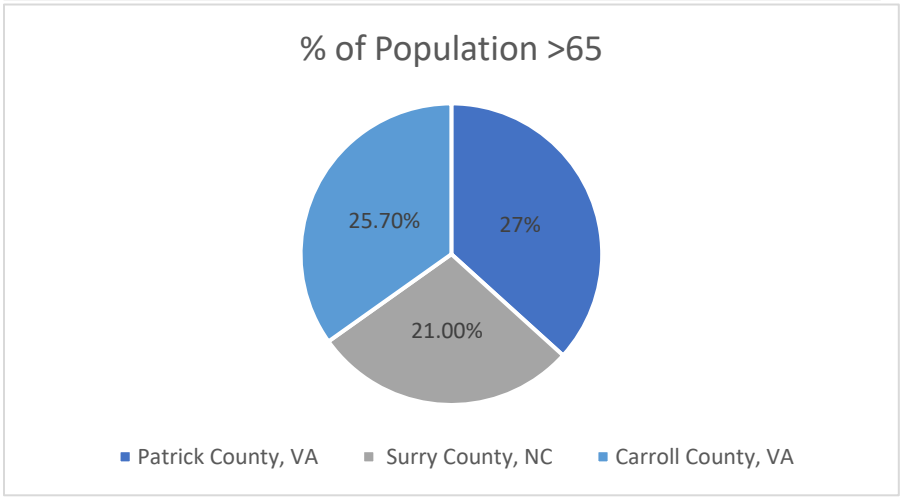
[2] Information comes from https://www.census.gov

Income & Poverty				
Median household income (in 2020 dollars), 2016-2020	$56,642	$44,979	$46,941	$44,518
Per capita income in past 12 months (in 2020 dollars), 2016-2020	$31,993	$26,074	$27,939	$24,476
Persons in poverty, percent	⚠ 12.9%	⚠ 15.4%	⚠ 14.2%	⚠ 13.2%

Demographic Charts[3]







[3] Information comes from http://www.census.gov

Comparison of Counties in our Service Area[4]

County	Surry County, NC	Patrick County, VA	Carroll County, VA
Peer Group	Urban, Up-and-Coming	Rural, High-Performing	Rural, Up-and-Coming
Population Health			
Population with no Insurance rate	17%	12%	12%
Primary doctor availability	1.29/1000	0.32/1000	0.86/1000
Flu Vaccine Rate	48%	47%	46%
Smoking Rate	23%	22%	23%
Cancer Rate	504.4/100,000	344.6/100,000	343.3/100,000
Heart Disease Rate	6.80%	6.50%	6.30%
Adults in Poor or Fair Health	22.70%	22.40%	21.00%
Adults with Frequent Mental Distress	16.40%	17.20%	17%
Nutrition			
Obesity Rate	36%	33.30%	33.90%
Diabetes Rate	11%	10.50%	10.30%

[4] Information comes from https://www.USnews.com

Leading Causes of Death[5]

Condition	NC Rank	Surry County Rank	Patrick County Rank	Carroll County Rank
Heart Disease	2	2	2	2
Cancer	1	1	1	1
Lung	3	4	5	5
Stroke	4	6	4	4
Accidents	5	5	3	3
Alzheimer's	6	3	6	6
Diabetes	7	7	7	7
Kidney	8	8	8	8
Flu-Pneumonia	9	9	10	10
Motor Vehicle	10	-	-	-
Sepsis	-	10	9	9

[5] Information comes from https://www.cdc.gov

Priority Populations

Information about Priority Populations in the service area of the Hospital is difficult to encounter if it exists. Our approach is to understand the general trends of issues impacting Priority Populations and to interact with our Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

We begin by analyzing the National Healthcare Quality and Disparities Reports (QDR)[6], which are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the healthcare system along three main axes: **access to healthcare**, **quality of healthcare**, and **priorities of the National Quality Strategy** (NQS). The complete report is provided in Appendix B.

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the report trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[16]

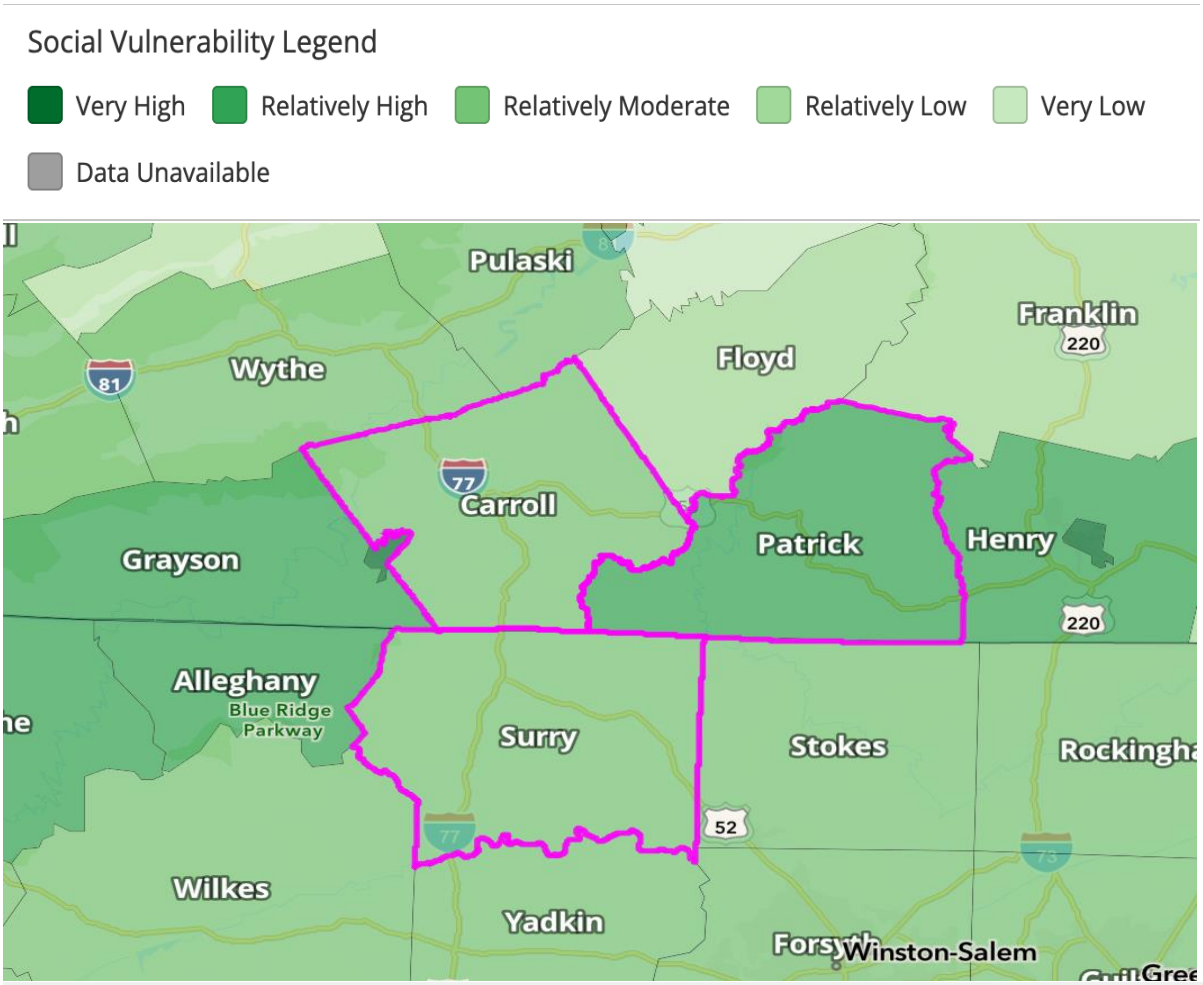
- Low-income groups and geriatrics are prevalent in the community
- Surry County has a high incidence of chronic diseases that need priority
- Psychiatry and substance abuse is a problem for which few care opportunities exist

[6] Information comes from 2021 National Healthcare Quality and Disparities Report: Executive Summary (ahrq.gov)

Social Vulnerability[7]

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks.

- Our service area falls into the relatively moderate and relatively high vulnerability.
- Surry County and Carroll County are relatively moderate, and Patrick County is relatively high.



Rank	Community	State	Rating	Score		
1	Patrick County	VA	Relatively High	45.13	0	100
2	Surry County	NC	Relatively Moderate	42.96	0	100
3	Carroll County	VA	Relatively Moderate	42.29	0	100

[7] Information comes from https://FEMA.gov

Summary of Survey Results on Prior CHNA

Attempted to reach Patrick County, Carroll County, and Surry County Health Department for feedback and received no response.

In the Round 1 survey, Nancy Dixon at Surry Medical Ministries provided feedback on the 2017 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2017 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	0	0	0
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	1	0	1
3) Priority Populations	0	0	0
4) Representative/Member of Chronic Disease Group or Organization	0	0	0
5) Represents the Broad Interest of the Community	0	0	0
Other			
Answered Question			1
Skipped Question			0

Priorities from the last assessment where the Hospital intended to seek improvement:

- Accessibility/Affordability
- Mental Health/Suicide
- Obesity/Overweight
- Substance Abuse
- Cancer
- Heart Disease

NRH received the following responses to the question: **"Should the hospital continue to consider the needs identified as most important in the 2017 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Accessibility/Affordability	1	0	0
Mental Health/Suicide	1	0	0
Obesity/Overweight	1	0	0
Substance Abuse	1	0	0
Compliance Behavior		1	0
Cancer	1	0	0

NRH received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2017 CHNA?"**

	Yes	No	No Opinion
Accessibility/Affordability	1	0	0
Mental Health/Suicide	1	0	0
Obesity/Overweight	1	0	0
Substance Abuse	1	0	0
Compliance Behavior	0	1	0
Cancer	1	0	0

Conclusions from Demographic Analysis Compared to National Averages[8]

The following areas were identified from a comparison of the county to national averages. **Adverse** and **Beneficial** metrics impact more than 30% of the population and statistically significantly differ from the national average include:

- BMI: Morbid/Obese = NC is 1.7% above national average. Virginia is 0.3% above national, 31.9%
- Daily Exercise = NC is 1.4% below national average. Virginia is 0.3% below national, 23%
- Adolescent Soda Intake = NC is 1% above national average. Virginia is 1.6% above national, 15.1%
- Tobacco Use: Cigarettes = NC is 0.9% above national. Virginia is 1.9% BELOW national, 15.5%
- Attempts to Quit Smoking in last year = NC is 1.4% below national. Virginia is 3.1% ABOVE national, 54.7%
- Routine Cholesterol Screening = NC is 1.2% ABOVE national. Virginia is 3% ABOVE national, 88.9%
- Mammography Use = NC is 2% ABOVE national. Virginia is 1% ABOVE national, 77.9%
- Cervical Cancer Screening = NC is 4% ABOVE national. Virginia is 2% ABOVE national, 78%
- Colonoscopy Use = NC is 1.3% ABOVE national. Virginia is 1.4% ABOVE national, 74.3%
- Routine OB/Gyn Visit = NC is 3.2% ABOVE national. Virginia is 0.3% ABOVE national, 72.6%
- Suicide = NC is 1.36% BELOW national. Virginia is 1.2% BELOW national, 15.5%
- Avoided care because of cost = NC is 1.7% above national, Virginia is o.6% above national, 9.8%
- Flu Vaccine = NC 2.8% ABOVE national. Virginia is 3.7% ABOVE national, 47%
- Unemployment = NC is 0.1% above national. Virginia is 0.5% BELOW national, 4.6%
- Uninsured = NC is 2.1% above national. Virginia is 1.3% BELOW national, 9.2%
- Fruit and Vegetable consumption = NC is 0.2% ABOVE national. Virginia is 0.8% ABOVE national, 8%

[8] Information comes from https://www.americashealthrankings.org

Community Benefit

"Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.

"Community benefit operations" means:

- *activities associated with community health needs assessments, administration, and*
- *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following:

- A CHNA conducted or accessed by the organization.
- Documentation that demonstrated community need or a request from a public health agency or community group was the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to healthcare services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise, would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

Activities reported by the Hospital in its implementation efforts included:

- Bad Debt 2021 FY = $14 million
- Charity Care 2021 = $5 million

IMPLEMENTATION STRATEGY

Significant Health Needs

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by NRH The following list:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies NRH current efforts responding to the need including any written comments received regarding prior NRH implementation actions
- Establishes the Implementation Strategy programs and resources NRH will devote to attempt to achieve improvements
- Documents the Leading Indicators NRH will use to measure progress
- Presents the Lagging Indicators NRH believes the Leading Indicators will influence in a positive fashion, and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, Northern Regional Hospital is the major hospital in the service area. NRH is a 133-bed, acute care medical facility located in Mount Airy, North Carolina. The next closest facilities are outside the service area and include:

- Hugh Chatham Memorial Hospital in Elkin, NC, 27 miles (29 minutes)
- Twin County Regional Hospital in Galax, VA, 31 miles (41 minutes)
- Wythe County Community Hospital in Wytheville, VA, 42 miles (56 minutes)

All data items analyzed to determine significant needs are “Lagging Indicators,” measures presenting results after a period, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the NRH Implementation Strategy uses “Leading Indicators.” Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator.

1. **AFFORDABILITY/ACCESSIBILITY** – 2022 Significant Need; Local Expert concern; Surry County uninsured rate above NC average; NC is 13.4% and Surry County is 16.7%.

Public comments received on previously adopted implementation strategy:

- "Accessibility – opening of Urgent Care has increased access. However, this is very expensive care. The Fast Track implementation has been a good method in ED to help the flow... but has referred some out to primary care/urgent care
- Affordability – NRH has partnered with Surry Medical Ministries for access to diagnostics and some specialty care for qualifying patients. However, some "approved" specialty care practices still refuse patients unless considered life threatening. This is not good practice of healthcare as preventative is much more cost efficient."

NRH services, programs, and resources available to respond to this need include:

- Financial Assistance Policy available with sliding fee scale and self-pay discounts
- "Clear Balance" program offers no-interest payment plans, and NRH has a robust charity care policy and carefully monitors and maintains pricing and expenses to keeps costs low
- Financial counselors available on site to help people understand their bills and set up payment plans
- Navigators available on site to help people sign up for Medicare/Medicaid
- Provide free mammograms to un/under-insured women through grant program with Susan G Komen
- Provide scholarships for gym memberships through the Diabetic Center of Excellence to diabetic patients who qualify
- Free screenings provided at local health fairs including BMI, blood pressure, and finger-stick blood sugar, as well as discounted flu shots
- Offer discounted lab work and immunizations to employees of local employers
- Provide discounted student sports physicals through occupational health
  Specialties available on site: cardiology, family medicine, gastroenterology, general surgery, OB/GYN, orthopedics, pain management, pediatrics, primary care, urology, ophthalmology, podiatry, pediatric and family counseling, emergency medicine, anesthesiology, occupational health, rehabilitation, wound care, speech pathology, radiology, nutrition, medical weight loss, hospitalist, psychiatry, pathology, allergy, hospice, palliative care, and skilled nursing
- Telepsychiatry and tele neurology services available
- Digital mammography, PET/CT, MRI, nuclear medicine, stereotactic breast biopsy, lithotripsy, full-service lab, and two retail pharmacies are available on site
- Primary care and pediatric clinics available with extended hours on weekdays and Saturday coverage, as well as same-day appointments
- NRH is certified as a Primary Stroke Center
- Translation services are provided through a contracted service

Additionally, NRH plans to take the following steps to address this need:

- Bringing on new pulmonologist, full-time ENT, and audiologist, as well as neurology, neurosurgery, vascular surgery, internal medicine, sleep medicine, orthopedic surgeon, and pediatrician
- Adding providers to current primary care practices

Anticipated results from NRH Implementation Strategy:

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low-income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency	X	
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate NRH intended actions is to monitor change in the following Leading Indicator:

- Number of patients seen in Chronic Care Management and annual wellness visits
  - Chronic Care Management = 90
  - Annual Wellness Visits = 60% of total patients

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Preventable hospital stays = 4,924 (NC = 4,096, U.S. Best = 2,233)[9]

[9] Information comes from https://www.countyhealthrankings.org/app/north-carolina/2022/measure/factors/5/data

NRH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Surry Medical Ministries Clinic	Nancy Dixon	951 Rockford St. Mount Airy, NC 27030 336-789-5058
Clear Balance		www.myclearbalance.com http://www.northernhospital.com/patient-visitor-info/clearbalance
Susan G. Komen NC	Kimberly Burrows	https://www.komen.org/community/north-carolina/ 919-695-9756
Specialists On Call		http://specialistsoncall.com/
Surry County Health & Nutrition Center	Samantha Ange, Director	118 Hamby Rd, Dobson, NC 27017 (336) 401-8400 www.surry.com

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Other local providers		
Yadkin Valley Economic Development District, Inc. (YVEDDI) (transportation services)	Kathy Payne, Executive Director	336-367-7251 http://www.yveddi.com/yveddi-public-transportation/
Hugh Chatham Memorial Hospital	Paul Hammes, CEO	180 Parkwood Dr, Elkin, NC 28621 (336) 527-7000 www.hughchatham.org

2. **OBESITY/OVERWEIGHT** – 2022 Significant Need; BMI: Morbid/Obese NC is 1.7% above national average of 31.9%.

Public comments received on previously adopted implementation strategy:

- "Not familiar with what the hospital has implemented
- I am aware that NRH has hired an additional nutritionist and dietician…"

NRH services, programs, and resources available to respond to this need include:

- Free screenings provided at local health fairs including BMI, blood pressure, and finger-stick blood sugar
- Scholarships provided for gym memberships through the Diabetic Center of Excellence for diabetic patients who qualify
- The Diabetic Center of Excellence offers A1C tracking, glucometers for enrollees, and education on nutrition, exercise, grocery shopping, meal planning, etc.
- NRH staff and physicians speak at schools, local organizations (e.g., Rotary), and on site about health and wellness
- Employee and family wellness program that includes lab tests, free gym membership, some free exercise classes, and participation in community leagues (e.g., volleyball)
- Corporate pricing for employees of local employers at gym
- Non-surgical medical weight loss program available that focuses on nutrition, exercise, counseling, and education
- Sponsor for almost all healthcare-related community events including local 5Ks, run/walks, bike races, etc.
- Published a diabetic cookbook in November 2016 specific to Surry County

Additionally, NRH plans to take the following steps to address this need:

- Diabetic Program
  - Training high school students to educate middle school students on stroke and heart attack awareness and how to make a healthy plan.
  - Developing a grocery store guided tour video for diabetics
- NRH sponsoring first obstacle course-style fitness challenge
- NRH also supports some community efforts such as Gates Pharmacy offering diabetic support classes
- NRH supports Surry County Health Department Diabetes Education Program

Some of our efforts were placed on hold due to the Covid 19 Pandemic.

Anticipated results from NRH Implementation Strategy:

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low-income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency	X	
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate NRH intended actions is to monitor change in the following Leading Indicator:

- Number of current members of Northern Wellness and Fitness Center = 3,994 (2022)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Adult obesity rate (BMI >30) = 33.6% [10]

NRH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Local schools		Surry County Schools Mount Airy City Schools Millennium Charter Academy
Local employers *Here is a list of just a few:*		
Altec	Megan Hicks	200 Altec Way Mount Airy, NC 27030 336-786-3659
Carport Central	Jeffrey Trenter	1018 Rockford St Mount Airy, NC 27030 336-325-7071

[10] Information comes from https://americashealthrankings.org

Insteel Industries	Peggy Sizemore	1373 Boggs Dr. Mt. Airy, NC 27030 336-786-2141
Leonard USA	Bill Wixon Angela Parrish	PO Box 1728 Mt. Airy, NC 27030 336-789-5018
OSG/ Southdata	Kenny Meredith	201 Technology Ln Mount Airy, NC 27030 336-783-5937
Shenandoah Furniture	Rocky Killon	109 Mountain View Rd Mount Airy, NC 27030 336-719-1567
Wayne Farms	Todd Ennis Travis Tilley	PO Box 383 Dobson, NC 27017 336-386-5832 336-386-5865
Fitness instructors for classes	Northern Wellness & Fitness Center	280 N Pointe Blvd, Mt Airy, NC 27030 336-783-0399
Surry County Health and Nutrition Center	Samantha Ange, Director	118 Hamby Rd, Dobson, NC 27017 (336) 401-8400 www.surry.com
American Diabetes Association		1300 Baxter Street, Suite 150, Charlotte, NC 28204 (704) 373-9111 https://www.diabeteseducator.org/
American Red Cross		844 Westlake Dr Mount Airy, NC 27030 336-786-4183 https://www.redcross.org
American Heart Association		336-542-4825 https://www.heart.org
Local organizations for community events	Hugh Chatham- Paul Hammes, CEO Mount Airy Chamber of Commerce	180 Parkwood Dr, Elkin, NC 28621 (336) 527-7000 www.hughchatham.org 200 N Main St Mount Airy, NC 27030 336-786-6116

3. MENTAL HEALTH/SUICIDE – 2022 Significant Need; NC 16.4% adults deal with frequent mental distress.

Public comments received on previously adopted implementation strategy:

In the past, NRH has not developed an implementation strategy to address this issue.

- **"**Especially after the first 2 years of COVID- the rise of mental health needs has become openly obvious. Not including substance abuse specific issues… which are also becoming increasingly prevalent.

- Currently - Surry County has NO: easy access to psychiatry, mental health counseling, multi-cultural/gender mental health counseling, no domestic violence assistance/shelter (current available resources are not sufficient to help persons in crisis needing placement)

- Mobile Crisis Team has been provided via Partners… this service has been available on and off, and 1 team covers an extremely large area – it can be very helpful or not at all."

NRH services, programs, and resources available to respond to this need include:

- Two safe rooms available on site for involuntary commitments
- Contracted psychiatrist and telepsychiatry services available for emergency psychiatric consultations
- Suicide risk assessments performed on all patients
- Adult and pediatric counselors/social workers on staff to connect patients with needed resources and referrals
- Start Here! Intervention Team: helps to connect people to support they need 24 hours/day.
    - Also helps to transport patients to detox and treatment facilities
- Mobile Crisis Team:24-hour response team for suicide treatment

Additionally, NRH plans to take the following step to address this need:

- Hire a psychiatrist at our organization
- Find inpatient psychiatric patients an outpatient place for help at discharge
- Work to develop a better Mobile Crisis Team

Anticipated results from NRH Implementation Strategy:

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low-income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency	X	
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate NRH intended actions is to monitor change in the following Leading Indicator:

- Number of Involuntary Commitments = 606

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Number of psychiatry referrals = 218

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Partners Behavioral Health Management		200 Elkin Business Park Dr, Elkin, NC 28621 (336) 835-1000 www.partnersbhm.org
Broughton Hospital		1000 S Sterling St, Morganton, NC 28655 (828) 433-2111 http://www.ncdhhs.gov/divisions/dsohf/broughton-hospital
Regional psychiatric facilities		

Daymark Recovery Services (Mobile Crisis Team)	Ritchie Puckett	940 W Lebanon St, Mount Airy, NC 27030 (336) 783-6919 http://www.daymarkrecovery.org/locations/surry-center 24-hour line: 866-275-9552
Mount Rogers Community Services Board Fernwood Counseling Center		6999 Carrollton Pike, Suite 1, Galax, VA 24333 https://www.mountrogers.org/
Old Vineyard Behavioral Health Services		3637 Old Vineyard Rd Winston Salem, NC 27104 336-794-3550 https://oldvineyardbhs.com/?utm_source=Google-Business-Yext&utm_medium=organic
PQA Healthcare Services		150 Franklin St Mount Airy, NC 27030 336-759-1751
Surry County Substance Abuse Recovery Start Here! Intervention Team	Mark Willis	336-401-8218 24-hour line: 336-899-1585 https://surrycountycares.org

4. **CANCER** – 2022 Significant Need; #1 leading cause of death; mammography screening below NC and US average; mammography screening 2% ABOVE national average; cervical cancer screening 4% ABOVE national average; colonoscopy screening 1.6% ABOVE national average

Public comments received on previously adopted implementation strategy:

In the past NRH has not implemented any new strategies to address this issue.

- "I am unfamiliar - I know of one oncology office that is part of Wake/Atrium that is in Mount Airy - I am unfamiliar of oncology services provided by NRH.. other than biopsies... which are performed at NRH but read by another service. Those have often taken an unfortunate amount of time to receive results – as of course, most needing this service are extremely anxious for the results."

NRH does not intend to develop an implementation strategy for this Significant Need

Due to resource constraints and a relative lack of expertise to address this need, we are choosing not to develop an implementation strategy for this need currently. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

Federal classification of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need	
1. Resource Constraints	**X**
2. Relative lack of expertise or competency to effectively address the need	**X**
3. A relatively low priority assigned to the need	**X**
4. A lack of identified effective interventions to address the need	
5. Need is addressed by other facilities or organizations in the community	

NRH services, programs, and resources available to respond to this need include:

- Free mammograms provided to un/under-insured women through grant program with Susan G. Komen
- NRH offers free smoking cessation classes
- NRH staff and physicians speak at schools, local organizations (e.g., Rotary), and on site about health and wellness
- Digital mammography, PET/CT, MRI, nuclear medicine, and stereotactic breast biopsy available on site
- Discounted lab work (including PSAs) offered to employees of local employers
- Basic medical oncology services provided
- NRH promotes breast cancer awareness month each year
- Direct Access Screening Colonoscopies (phone pre-screening without physician office visit)

- Surry County Health Department Breast and Cervical Cancer Control Program (BCCCP)

Other local resources identified during the CHNA process that are believed available to respond to this:

Organization	Contact Name	Contact Information
Susan G. Komen NC	Kimberly Burrows	https://www.komen.org/community/north-carolina/ 919-695-9756
Hugh Chatham Memorial Hospital	Paul Hammes, CEO	180 Parkwood Dr, Elkin, NC 28621 (336) 527-7000 www.hughchatham.org
Piedmont Hematology Oncology Associates		1010 Bethesda Court, Winston-Salem, NC 27103 (336) 277-8800
Wake Forest Baptist Medical Center Oncology		(888) 716-WAKE www.wakehealth.edu/Comprehensive-Cancer-Center
Triad Radiology Associates		3010 Trenwest Dr, Winston-Salem, NC 27103 (336) 970-5300 www.triadradiology.com
Surry Cancer Awareness Team	Judy Smith	https://www.facebook.com/Surry-Cancer-Awareness-Team-244430668051/?fref=nf 336-789-2460

5. **Heart Disease:** NC heart disease rate is 6.8%. Heart disease is the second leading cause of death in the US as well as NC.

Public comments received on previously adopted implementation strategy:

Our local expert stated that we should add heart disease as a significant need.

NRH does not intend to develop an implementation strategy for this Significant Need

Due to resource constraints and a relative lack of expertise to address this need, we are choosing not to develop an implementation strategy for this need currently. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

Federal classification of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need	
1. Resource Constraints	**X**
2. Relative lack of expertise or competency to effectively address the need	**X**
3. A relatively low priority assigned to the need	
4. A lack of identified effective interventions to address the need	**X**
5. Need is addressed by other facilities or organizations in the community	

NRH services, programs, and resources available to respond to this need include:

- American Heart Association
- Smoking cessation classes
- NRH Cardiac Rehabilitation
- NRH supports Surry County Health Department Adult Health Clinic- heart disease and chronic illnesses

Other local resources identified during the CHNA process that are believed available to respond to this:

Organization	Contact Name	Contact Information
American Heart Association		336-542-4825 https://www.heart.org
Surry County Health & Nutrition Center	Samantha Ange, Director	118 Hamby Rd, Dobson, NC 27017 336-401-8400 www.surry.com

Other Needs Identified During CHNA Process

6. **EDUCATION**
7. **ALCOHOL/SUBSTANCE ABUSE**
8. **DIABETES**
9. **SOCIAL DETERMINANTS OF HEALTH**
10. **MATERNAL/INFANT MEASURES**
11. **PHYSICAL INACTIVITY**
12. **DENTAL**
13. **STROKE**
14. **ACCIDENTS**
15. **SMOKING**
16. **ALZHEIMER'S**
17. **CHRONIC LOWER BACK PAIN**
18. **LUNG DISEASE**
19. **FLU/PNEUMONIA**
20. **SOCIAL FACTORS**
21. **CHRONIC LOWER RESPIRATORY DISEASE**
22. **SEXUALLY TRANSMITTED INFECTION**
23. **LIFE EXPECTANCY**
24. **KIDNEY DISEASE**
25. **PALLIATIVE CARE**
26. **GERIATRIC CARE**
27. **PSYCHIATRY**

Overall Community Need Statement and Priority Ranking Score

1. Accessibility/Affordability
2. Obesity/Overweight
3. Mental Health/Suicide

Significant needs where hospital did not develop implementation strategy

4. Cancer
5. Heart Disease

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

1. Alcohol/Substance Abuse
2. Diabetes
3. Social Determinants of Health
4. Maternal/Infant Measures
5. Physical Inactivity
6. Dental
7. Stroke
8. Accidents
9. Smoking
10. Alzheimer's
11. Chronic Lower Back Pain
12. Lung Disease
13. Flu/Pneumonia
14. Chronic Lower Respiratory Disease
15. Sexually Transmitted Infection
16. Education
17. Life Expectancy
18. Kidney Disease
19. Palliative Care
20. Geriatric care
21. Psychiatry

APPENDIX

Appendix A – Written Commentary on Prior CHNA

Hospital solicited written comments about its 2017 CHNA. 1 Local Expert Agency responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.**

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy
1) Public Health Expertise
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital X
3) Priority Populations
4) Representative/Member of Chronic Disease Group or Organization
5) Represents the Broad Interest of the Community
Other

Congress defines "Priority Populations" to include:

- **Racial and ethnic minority groups**
- **Low-income groups**
- **Women**
- **Children**
- **Older Adults**
- **Residents of rural areas**
- **Individuals with special needs including those with disabilities, in need of chronic care, or in need of end- of-life care**
- **Lesbian Gay Bisexual Transsexual (LGBT)**
- **People with major comorbidity and complications**

2. **Do any of these populations exist in your community, and if so, do they have any unique needs that should be addressed? Yes**

In the 2017 CHNA, there were six health needs identified as "significant" or most important:

1. **Accessibility/Affordability**
2. **Mental Health/Suicide**
3. **Obesity/Overweight**
4. **Substance Abuse**

5. **Compliance Behavior – disagree – these are usually related to SDOH**
6. **Cancer**

3. **Should the hospital continue to consider the needs identified as most important in the 2013 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Accessibility/Affordability	X		
Mental Health/Suicide	X		
Obesity/Overweight	X		
Substance Abuse	X		
Compliance Behavior		X	
Cancer	X		

4. **Should the Hospital continue to allocate resources to help improve the needs identified in the 2013 CHNA?**

	Yes	No	No Opinion
Accessibility/Affordability	X		
Mental Health/Suicide	X		
Obesity/Overweight	X		
Substance Abuse	X		
Compliance Behavior		X	
Cancer	X		

5. **Are there any new or additional health needs the Hospital should address? Are there any new or additional implementation efforts the Hospital should take? Please describe.**

   "Heart disease, geriatrics, psychiatry"

6. **Please share comments or observations about keeping <u>Accessibility/Affordability</u> among the most significant needs for the Hospital to address.**

   *"Statistically speaking, to adequately serve this county/region, the local healthcare system must recognize the high percentage of persons living between 100% - 200% as well as up to 400% FPL, the uninsured rate, the rate of major medical policies, the rate of HH without a vehicle, the average HH income. The lack of any **AFFORDABLE** comprehensive healthcare provider and difficult process to receive any specialty healthcare. "*

7. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Accessibility/Affordability</u>.**

   "Accessibility – opening of Urgent Care has increased access. However, this is very expensive care. The Fast Track implementation has been a good method in ED to help the flow.. but has referred some out to primary care/urgent care
   Affordability – NRH has partnered with SMM for access to diagnostics and some specialty care for qualifying patients. However, some "approved" specialty care practices still refuse patients unless considered life threatening. This is not good practice of healthcare as preventative is much more cost efficient."

8. **Please share comments or observations about keeping Mental Health/Suicide among the most significant needs for the Hospital to address.**

   "Especially after the first 2 years of COVID- the rise of mental health needs has become openly obvious. Not including substance abuse specific issues… which are also becoming increasingly prevalent.

   Currently - Surry County has NO: easy access to psychiatry, mental health counseling, multi-cultural/gender mental health counseling, no domestic violence assistance/shelter (current available resources are not sufficient to help persons in crisis needing placement)

   Crisis Mobile Team has been provided via Partners… this service has been available on and off, and 1 team covers an extremely large area – it can be very helpful or not at all."

9. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Mental Health/Suicide</u>.**

   "I am not familiar with what the hospital has implemented to address this issue."

10. **Please share comments or observations about keeping Obesity/Overweight among the most significant needs for the Hospital to address.**

    "This issue goes hand in hand with the incidence of chronic disease… I have not seen a recent study, but rates have tended to be high, and I am not aware of any signification community-wide intervention to have abated the upward trend. Especially, specific interventions in communities of color."

11. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Obesity/Overweight</u>.**

"Not familiar with what the hospital has implemented

I am aware that NRH has hired an additional nutritionist and dietician. "

12. **Please share comments or observations about keeping <u>Substance Abuse</u> among the most significant needs for the Hospital to address.**

    "These rates are simply rising… collaborating with local entities to create a strong substance abuse intervention/treatment continuum would be significant… only treating/ handling the overdoses is simply not enough"

13. **Please share comments or observations about the implementation actions the Hospital has taken to address Substance Abuse.**

    "Not certain what hospital has implemented.

    The need for local detox beds is critical and not available at NRH. Only available by "accident" if a patient has been admitted for another reason… car accident, overdose, heart attack… then as the patient is inpatient, the patient is "not using" thus has a few clean days when being discharged. Addressing the patient's addiction at this time could be beneficial and transferring patient to a

transitional care or half-way house setting would be very helpful if collaboration with NRH staff was organized."

14. **Please share comments or observations about keeping <u>Compliance Behavior</u> among the most significant needs for the Hospital to address.**

"I am not certain what is meant by this topic..??? Is this patient compliance behavior? Or hospital compliance behavior?"

15. **Please share comments or observations about the implementation actions the Hospital has taken to address Compliance Behavior.**

"I am sorry, I am not familiar with this?"

16. **Please share comments or observations about keeping <u>Cancer</u> among the most significant needs for the Hospital to address.**

"Yes… Cancer, but the chronic diseases are also high priority: respiratory illnesses, endocrine, cardiology ….. add geriatrics… "

17. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Cancer</u>.**

"I am unfamiliar - I know of one oncology office that is part of Wake/Atrium that is located in MA - I am unfamiliar of oncology services provided by NRH.. other than biopsies…. which are performed at NRH but read by another service. Those have often taken an unfortunate amount of time to receive results – as of course, most needing this service are extremely anxious for the results."

18. **Finally, after thinking about our questions and the information we seek, is there anything else you think is important as we review and revise our thinking about significant health needs in the county?**

"To be viewed as health experts who are "on the side of the community" then that is part of a relationship that must be developed.
I would like to see the hospital collaborate more with the community. Have a presence.
Reach out to partner with other healthcare organizations/ education organizations for events, initiatives, etc. Plan grant projects together. Even if small… be seen as a collaborator. "Be Seen" in the homes of the residents' of your community via a partnership with another entity or swag from a 5K. Should see your logo on any effort that supports the health and wellness of your community.
Wake Forest (Atrium)/ Novant … you see their logo on parks, community clinics, community rec centers for youth, etc.

"Identify the needs…. AND build the relationship"

Appendix B – National Healthcare Quality and Disparities Report[11]

The National Healthcare Quality and Disparities Report (NHQDR) is sometimes described as a "document of record" that has summarized the status of health and healthcare delivery in the United States since 2003. To compile this report, the NHQDR team prioritizes reporting data and measures that are broadly representative of the performance of the nation's healthcare system over time.

Multiple data partners, including all states and agencies throughout the Department of Health and Human Services (HHS), contribute data to the report. Before the report is finalized and submitted by the Secretary of HHS to the U.S. Congress, the report undergoes multiple cycles of review by reviewers who include representatives from contributing agencies.

Summary of the Report

The 2021 NHQDR is organized in sections that provide an overview of the healthcare system and summarize access, quality, and disparity measures. The Quality and Disparity sections are further divided into domain-specific chapters that highlight key healthcare trends or gaps in care. The appendixes include a list of data sources, definitions and abbreviations, and measures used in summary maps.

Overview of Disease Burden and the Healthcare System

The NHQDR provides an overview of the context in which people receive healthcare services, including a summary of disease burden in the United States; number, distribution, and characteristics of hospitals and healthcare workers who deliver services, and distribution of healthcare expenditures. Findings include:

- The leading causes of death in the United States are heart disease, cancer, and unintentional injuries. However, unintentional injury is the leading cause of years of potential life lost (YPLL).
- Death rates from unintentional injury have been rising, while deaths from heart disease and cancer have declined.
- Rates of suicide, another important contributor to YPLL, have also been rising.
- While the number of full-time, year-round healthcare workers has almost doubled since 2000, healthcare worker shortages still exist in many states. In addition, lack of racial and ethnic diversity persists within the healthcare workforce, notably among psychologists, therapists, dentists, advanced practice nurses, physician assistants, emergency medical technicians, and registered nurses.

Access to Healthcare

Of nine core access measures, five were improving over time: two measures related to access to health insurance, two measures assessing timely access to care, and one measure assessing patients' access to services when they perceive a need. Only one measure worsened over time: it assessed access to specialty care services for children. Notably, despite an overall increase in access to health insurance, a measure of access to dental insurance has not changed. Although the overall trend in access to care has improved, significant disparities by race, ethnicity, household income, and location of residence persist for access to health insurance and access to dental insurance. Disparities by race, ethnicity, household income, location of residence, and insurance type also exist for having an ongoing source of care, receiving timely care, and receiving care when needed.

Quality of Care

- **Person-Centered Care**: More than half (14 of 26) of Person-Centered Care measures were improving. No measures were worsening. The three measures that improved most reflect more discussion about pain by home

[11] Information comes from 2021 National Healthcare Quality and Disparities Report: Executive Summary (ahrq.gov)

health care providers, more emotional and spiritual support from hospice providers, and better communication about medications prescribed during hospital stays.

- **Patient Safety**: More than 40% (11 of 26) of Patient Safety measures were improving. Only one measure worsened. The three measures that improved most reflect fewer adverse events in nursing homes (two measures) and fewer adverse drug events involving the blood thinner heparin in hospital settings. The only worsening measure reflects declining review of over the-counter medication by home health care providers.
- **Care Coordination**: More than half (5 of 9) of Care Coordination measures were improving, but one-third (3 of 9) were worsening. The three measures that improved the most reflected improved communication with patients at hospital discharge, timely initiation of home health care services, and fewer home health care patients needing hospital admission. The three measures that worsened relate to increased reliance on emergency departments for conditions that could normally be managed at home or in ambulatory settings (two measures) and less consideration of patients' preferences when planning hospital discharge.
- **Affordable Care**: When accounting for the overall population, all (2 of 2) Affordable Care measures remained stable. However, closer examination of these measures by insurance status showed that over time, people with public insurance experienced lower out-of-pocket spending and were better able to have a usual source of care. By contrast, trends for people with private insurance showed higher out-of-pocket spending, while their likelihood of having a usual source of care did not change.
- **Effective Treatment**: More than 40% (15 of 35) of Effective Treatment measures were improving, while approximately 11% (4 of 35) of measures worsened. The three measures that improved most reflected better care for people with colon cancer and HIV and less inappropriate prescribing of antibiotics for people with viral respiratory infections. The three measures that worsened most reflected worsening trends in the opioid and suicide epidemics.
- **Healthy Living**: Almost two-thirds (40 of 63) of Healthy Living measures were improving, while three measures worsened. Among the many improving trends, the three measures that improved most reflected increased vaccinations for adolescents and for people receiving home health care services and less use of physical restraints in long-stay nursing homes. The two measures that worsened most reflect decreased pneumococcal vaccinations for nursing home residents and a troubling rise in childhood obesity.

Disparities in Healthcare

- **Race and Ethnicity**: Table ES-1 shows the number of measures for which racial or ethnic minority groups have better, same, or worse care compared with White groups. Compared with White groups, the number of measures that were worse exceeded the number of measures that were better for all racial and ethnic minority groups except Asian groups. Some healthcare disparities, such as those related to HIV outcomes, were common to most racial and ethnic minority groups. Other healthcare disparities were more prominent for certain groups, reflecting specific contexts and issues experienced by that group.

  Each racial or ethnic minority group has experienced improving care for many measures, but significant disparities persist because White populations experienced similarly improving care. Since 2000, disparities have narrowed for only about 8% of measures for American Indian and Alaska Native populations, 2% of measures for Asian populations, 3% of measures for Black populations, 4% of measures for Hispanic populations, and 10% of measures of Native Hawaiian/Pacific Islander populations.

  Table ES-1. Number and percentage of quality measures for which selected racial or ethnic groups experienced better, same, or worse quality of care compared with White groups

Race or Ethnic Group	Better	Same	Worse
American Indian and Alaska Native	12 (11%)	53 (49%)	43 (40%)
Asian	50 (29%)	75 (43%)	48 (28%)
Black	21 (11%)	90 (46%)	84 (43%)
Hispanic	34 (20%)	76 (44%)	62 (36%)
Native Hawaiian/Pacific Islander	15 (19%)	43 (53%)	23 (28%)

- **Income**: People in poor and low-income households experienced worse care than people in high-income households on more than half of quality measures (67 of 117 and 65 of 116 measures, respectively). The disparate measures reflected lack of access to health insurance, lack of access to healthcare services, and lack of timely access to care. People in poor and low-income households experienced better care than high-income households on approximately 5% and 3% of measures, respectively. Since 2000, disparities have increased on approximately 5% of quality measures, including measures related to opioid-related conditions, and have decreased for only one measure.
- **Insurance Status**: Compared with people under age 65 with private insurance, people under age 65 with public insurance experienced worse care on nearly 40% (27 of 69) of quality measures and better care on 10% (7 of 69) of measures. People under age 65 with no health insurance experienced worse care on more than 60% (37 of 61) of measures and better care on about 7% (4 of 61) of measures.

  The largest disparities experienced by people under age 65 with public insurance reflect difficulty arranging a usual source of care, lower quality communication from providers, and lower quality care for breast cancer. The largest disparities experienced by people under age 65 with no insurance reflect difficulty arranging a usual source of care and lack of access to routine preventive services.

  Notably, people under age 65 with public insurance or no insurance had better outcomes for a measure of out-of-pocket spending than people under age 65 with private insurance.

  Over time, disparities among insurance groups have remained unchanged, except for one measure related to influenza vaccinations for people with diabetes. For that measure, the disparity narrowed between uninsured people and people with private insurance.
- **Residence Location**: Compared with people in large fringe metropolitan counties (i.e., the suburbs of large cities), people in urban cores, medium and small cities, and nonmetropolitan areas all experience worse care on more measures than better care. The types of healthcare disparities experienced by people in different locations suggests people in different locations have different underlying healthcare needs. For example, HIV and asthma stood out as conditions that disproportionately affected people in densely populated counties, whereas limited access to routine care services and increased risk of dying in a hospital stood out as prominent concerns for people in less densely populated counties.

  Overall, healthcare disparities among residence locations have not changed over time. An exception is a narrowing disparity between large fringe metro and large central metro areas in terms of hospital admissions for opioid-related conditions. However, this finding reflects a disappointing trend in which opioid-related hospitalization rates increased faster in suburban communities than in urban cores.

Key Findings and Trends

All measures reported in the 2021 NHQDR were collected in 2019 or earlier, before the rapid health system changes prompted by the COVID-19 pandemic. However, when viewed as a whole, the NHQDR still offers valuable information that can contribute to understanding how our nation's healthcare system has performed over time.

Readers should view the 2021 NHQDR as a definitive "snapshot" of where the nation stood as it entered the COVID-19 pandemic. The report can help answer questions about which aspects of our healthcare system exhibited the highest and lowest levels of quality and which were or were not improving before the COVID-19 pandemic.

Key lessons from the 2021 NHQDR include:

- **Several areas in which the nation has invested in quality improvement and patient safety have shown substantial improvements. For example:**
  - From 2000 to 2018, the HIV death rate decreased from 5.2 to 1.5 deaths per 100,000 population.
  - From 2000 to 2018, the rate of colon cancer deaths decreased 36%, from 20.8 to 13.4 deaths per 100,000 population.
  - From 2002 to 2018, the percentage of adults age 65 and over who received at least 1 of 33 potentially inappropriate prescription medications for older adults decreased from 19.3% to 10.2%.

- **The United States has seen significant gains in the number of people covered by health insurance and who have a usual source of healthcare. For example:**

  - From 2002 to 2018, the percentage of people under age 65 years who had any period of uninsurance decreased by 33%, and the percentage of people under age 65 who were uninsured all year decreased by 42%, with the largest change occurring after 2013. Concurrent with these trends, the percentage of Americans who have access to a usual source of care has improved.
- **Personal spending on health insurance and healthcare services decreased for people under age 65 with public insurance and increased for people with private insurance. For example:**
  - For people with public insurance, the percentage under age 65 whose family's health insurance premium and out-of-pocket medical expenditures were more than 10% of family income decreased from 17.7% to 12.7% (2002-2018).
  - For people with private insurance, the percentage under age 65 whose family's health insurance premium and out-of-pocket medical expenditures were more than 10% of family income rose from 12.3% to 19.3% (2002-2018).
- **Access to dental care and oral healthcare services remains low and has not substantially improved, particularly for people with low income or who live in rural areas. For example:**
  - The percentage of people under age 65 with any period of private dental insurance in the year showed no statistically significant change from 2006 to 2018, going from 54.0% to 58.9%.
  - The percentage of adults who received preventive dental care services in the calendar year showed no statistically significant change from 2002 to 2018, going from 33.6% to 35.4%.
  - Rates of emergency department (ED) visits for dental conditions remained persistently high from 2016 to 2018: 312.3 visits per 100,000 population in 2016 and 290.2 visits per 100,000 population in 2018.
  - Compared with people in the highest family income quartile, people in the lowest family income quartile were less likely to report having any private dental insurance during the year: 13.4% in the lowest income quartile vs. 81.1% in the highest income quartile.
  - Compared with people in who live in non-low-income ZIP Codes, people who live in low-income ZIP Codes had significantly higher rates of ED visits for dental conditions: 511 visits per 100,000 population in low-income areas vs. 213.4 visits per 100,000 population in non-low-income areas in 2018.
  - Compared with people in large fringe metropolitan counties (i.e., the suburbs), people who reside in micropolitan and noncore counties (i.e., small towns and rural areas) had significantly lower rates of dental insurance: 49.2% and 48.2% in micropolitan and noncore areas, respectively, vs. 66.6% in large fringe metropolitan counties in 2018.
  - Compared with large fringe metropolitan counties, nonmetropolitan counties had significantly higher rates of ED visits for dental conditions: 459.7 visits per 100,000 population in nonmetropolitan areas vs. 210.3 visits per

100,000 population in large fringe metropolitan counties in 2018.

- **The opioid and mental health crisis worsened in the years leading up to COVID-19. Limited access to substance abuse and mental health treatment may have contributed to this crisis. For example:**
  - Opioid-related ED visits and hospitalizations more than doubled between 2005 and 2018.
  - From 2015 to 2019, there were no statistically significant changes in the percentage of people ages 12 and over who needed treatment for illicit drug use and received such treatment at a specialty facility, going from 18.3% to 17.8%.
  - Suicide death rates rose 23%, going from 14.0 deaths to 17.2 deaths per 100,000 population between 2008 and 2018.
  - The percentage of adults with a major depressive episode who received depression treatment in 2008 to 2019 showed no statistically significant changes, going from 68.3% to 66.3%.
  - From 2008 to 2019, the percentage of children ages 12-17 with a major depressive episode who received depression treatment showed no statistically significant changes, going from 37.7% to 43.3%.

- **While Black, Hispanic, and American Indian and Alaska Native communities all experienced substantial improvements in healthcare quality, significant disparities in all domains of healthcare quality persist. Even when rates of improvement in quality exceeded those experienced by White Americans, they have not been enough to eliminate disparities. For example:**
  - Despite an overall decrease in HIV death rates, including in Black populations, significant disparity persists. From 2000 to 2018, HIV deaths in Black populations decreased from 23.3 deaths to 6.2 deaths per 100,000 population. Still, deaths in Black populations remain more than 6 times as high as HIV deaths in White populations (0.9 deaths per 100,000 population).
  - From 2001 to 2018, the incident rates of end stage renal disease due to diabetes decreased 48% from 526 to 273.1 events per million population in American Indian/Alaska Native communities and decreased 29% from 525.7 to 372.2 per million population in Black communities. Despite these gains, significant disparities persist among non-Hispanic American Indian and Alaska Native, Black, and White populations, with respective incident rates of 273.1, 372.2, and 152.2 events per million population in 2018.
  - Similarly, the incident rates of end stage renal disease due to diabetes decreased 29% from 410 to 292.7 events per million population from 2001 to 2018 in Hispanic communities. Despite these gains, incident rates in 2018 in Hispanic communities were still more than double the rates in non-Hispanic White communities (142.8 events per million population).

The relationships between race/ethnicity, socioeconomic status, gender, age, and geography and health are complex and not easily summarized in a single document. The full set of findings in the 2021 NHQDR provide additional nuance and insights concerning the complexity of quality and disparities in American healthcare. Thus, readers are encouraged to explore the NHQDR Data Query website, where they may access the full collection of data that were used to produce this report.