Community Health Needs Assessment Implementation Plan 2022-2024

WakeMed
WakeMed Health & Hospitals

In 2022, WakeMed participated in Wake County's 2022 Community Health Needs Assessment – the process is a collaborative effort between the residents of Wake County and its many community partners including the other health care systems operating in Wake County. Throughout the research and information- gathering process, three key opportunities were identified as critical to improving the health and well-being of our community:

- **Access to Healthcare**
- **Mental Health**
- **Affordable Housing and Homelessness**

As such, WakeMed has developed the following implementation plan to address the priorities outlined in the Wake County 2022 Community Health Needs Assessment. As part of WakeMed's mission to improve the health and well-being of our community by providing outstanding and compassionate care to all, we will weave health equity into our Implementation Plan by including initiatives that improve access to healthcare for people of color and other underserved and vulnerable populations. Our plan includes new ways of measuring outreach and quality outcomes using race, ethnicity and zip code indicators to ensure all populations have access to the care and treatment they need.

ACCESS TO HEALTHCARE

Ensuring all members of our growing community have access to the healthcare services they need is critical to maintaining the health of Wake County. WakeMed is focused on improving access to care and addressing healthcare disparities through continued growth and expansion, as well as the development of innovative models of care delivery.

PRIORITY	STRATEGY	ACTIVITY	ACCOUNTABILITY
Improve Access to Care	Evaluate system's state of access to identify gaps and opportunities to enhance access across the system.	• Perform ongoing assessment.	
	Increase access to primary and urgent care services throughout the community.	• Add new physician offices offering primary and urgent care in Fuquay-Varina, Wake Forest, Morrisville, Wendell and Raleigh, while also reaching beyond Wake County into Durham and Smithfield as many residents travel to Wake County for care. • Pediatric Primary Care will take on care management services for highest risk pediatric Medicaid beneficiaries. • Expand services to provide transitional care to recently hospitalized patients who often don't have a primary care provider.	• Track office locations, number of providers, patient volume and year-over-year increase in patient appointments.
	Expand and increase access to specialty care.	• Expand availability and introduce new specialty services not currently offered in Wake County, eliminating the need for patients to seek specialty care outside of the county, including cardiology, plastic and reconstructive surgery, vascular surgery and wound care, 3D mammography, nuclear medicine testing, Brain health, gastroenterology, urology and cancer care.	• Track the number of new services added, number of patients served. • Track quality metrics and outcomes.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASUREMENT
Improve Access to Care	Expand and increase access to specialty care.	• Establish Cardiometabolic Program for patients with diabetes and heart disease. • Continued development of Brain & Spine program to enhance services for patients with brain disease and/or neurological disorders. • Continue to participate in Project Access, refer patients via Project Access to specialty services-funded by Duke Endowment.	• Track "Time is Brain" door-to metrics • Track outcomes using The Joint Commission Thrombectomy and Primary Stroke Center metrics • Track referrals/volumes to the Back & Spine Center
	Improve affordable access for cancer care, screening, diagnosis, therapies.	• Establish a radiation oncology program to shorten wait times for access to radiation oncology services. • Continue to grow outpatient access to PET imaging diagnostic technology in Cary to support oncology and cardiology. • Develop Oncology specific referral program for Behavioral health. • Addition of WakeMed Cancer Care – Waverly Hematology and Oncology Practice (5 providers). • Addition of disease-based Medical Oncologist practice at Raleigh Medical Park location (4 total MDs). • 3 Dedicated Patient Navigators hired to help coordinate care across IP to OP and make sure no patient falls through the cracks. • Expand outpatient diagnostic capabilities with joint venture with Raleigh Radiology and continued growth of locations.	• Track patient volumes, including uninsured and underinsured • Track reduction in days of waiting for beginning cancer treatment plan of care. (Goal to provide access to all Oncology patients in 72 hours.) • Continue recruiting for Medical Oncologists to expand reach and maintain access goals.
	Expand access to inpatient acute care beds in Wake County.	• Complete addition of 16 acute beds and 6 critical care beds at WakeMed North Hospital. • Receive approval from the State to build 45 bed hospital in Garner. • Regularly evaluate bed counts, makeup and locations to determine whether the current compliment meets the needs of the community. • Focus efforts to shift surgery volume to outpatient where clinically appropriate to create additional inpatient capacity.	• Track bed count • Track inpatient volume and length of stay

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASUREMENT
Improve Access to Care	Expand access to emergency care in Wake County.	• Increase bed capacity and enhance access to emergency departments (pending Raleigh Campus bed addition and renovations at North Hospital). • Construction on Wendell Falls Healthplex. Estimated opening date January 2024. • Pursue Level 1 Certification of Geriatric Accreditation at WakeMed Cary Hospital. Emergency Department • Provider in Triage program. • "Know Where to Go" patient education program. • Pilot telehealth options with Hospitalists for patients in emergency departments waiting for bed placement improving continuity of care. • Continue to expand Urgent Care options as an alternative to emergency departments when appropriate.	• Track total patient encounters to identify year-over-year increase. • Monitor throughput metrics to track improvement and efficiency. • Monitor Provider in Triage metrics and outcomes
	Expand access to inpatient rehabilitation care.	• Build a 52-bed inpatient Rehabilitation Hospital in Apex in partnership with Duke Health Lifepoint Rehabilitation and Kindred Healthcare. • Provide additional inpatient rehab services in the southwestern portion of Wake County and the immediate region. • Groundbreaking slated for early 2023.	• Track volumes and patient outcomes • Monitor Patient and Family Experience survey data • Track discharges from Cary Hospital • Monitor readmission rates
	Improve access to affordable surgical services throughout the region	• Open freestanding, low-cost Ambulatory Surgery Centers (ASC) in Cary and North markets. Estimated opening date January 2023 for Cary, early 2024 for North.	• Track volumes and outcomes
	Improve access and experience for unique populations (geriatric, maternal/infant, etc.).	• Establish more in-home care services for geriatric patients. • Improve access and patient experience for neonatal intensive care. • Use evidence-based interventions to improve maternal infant morbidity and mortality. • Join the Premier Perinatal Improvement Collaborative (PPIC) performance improvement collaborative. • Expand Milk Bank drop off sites to increase supply of human milk for fragile neonates.	• Establish dashboard to track screenings and outcomes metrics (falls reduction, delirium triage score completed, functional screen completed, etc.) • Track services and volumes for Independent Living and Assisted Living Communities. • Track patient satisfaction scores and patient outcomes. • Track donor milk volume.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASUREMENT
Improve Access to Care	Expand access to care for uninsured/underinsured and vulnerable populations.	• Establish the Center for Community Health as a resource for coordinated, holistic care to some of the Raleigh area's most vulnerable residents. • As an extension of CCH, expand outreach and education to the homeless population through HEART. • Expand Medical Residency Program to support care for uninsured working with FHQC. • Expand Community Case Management. • Skilled Nursing Facility Guarantee program to sponsor homeless/uninsured patients needing rehabilitation care. • Support community-based safety net providers – with volunteers, and financial contributions. • Establish Care Support Programs Collaborative to streamline access to care for vulnerable populations in the community. • HIM Outreach Initiative to help uninsured patients establish primary care home and address social determinants of health. • Analyze quality data across the system stratified by race, ethnicity and zip code.	• Track utilization and outcomes at Center for Community Health. • Track utilization of Community Case Management. • Track reduction in health care costs. • Track number of patients who receive help with food insecurity and get connected to Project Access for specialty medical care and Med Assist. • Track number of WakeMed volunteers assisting safety net providers. • Track financial contributions to safety net provider partners. • Track number of referrals made to primary care medical home for transitional health patients. • Monitor data to ensure consistent outcomes for all populations.
	Use technology to enhance access to care through innovative offerings.	• WakeMed Virtual Urgent Care access to high-quality urgent care services 7 days a week. • WakeMed App • WELL Health technology platform enabling two-way conversations between providers and patients. • Continue to utilize NC Cares 360 platform for referrals. • Implement Clarity an AI assisted screening technology to predict risk of suicide. • Tele Heart Care program to support patients following surgery helping to reduce medication use and complications. Reduces need for patients having to come to the hospital for follow up visits. • MyChart Care Companion offers interactive personalized plans of care for total joint patients, OB patients, and others.	• Track number of WakeMed Virtual Urgent Care visits by year. • Track utilization and downloads of All Access App • Track MyChart usage • Track WELL Health metrics • Track Tele Heart Care patient outcomes and readmissions. • Track utilization and outcomes.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASUREMENT
Improve Access to Care	Bring healthcare screenings and services into the community for greater access.	• Utilize mobile wellness vehicle to expand reach into the community and address healthcare disparities. • Provide cholesterol/blood pressure screenings, vascular screenings, flu and COVID-19 vaccines, health fairs and health education classes throughout the community. • Work with community partners to identify areas of need. • Offer worksite wellness programs and provide clinical services at local companies to improve access to care and connect employees with primary care providers, referral for other services, etc. • ENERGIZE! Program to address childhood obesity and promote healthy lifestyle.	• Track screening volume, vaccines administered, participation rates/attendance and clinical outcomes (where applicable). • Track referrals to primary care and specialists
	Address social determinants of health (SDOH).	• Chief Medical Officer to lead population health initiatives in the system and develop population health strategy. • Your Whole Health Program to screen for social drivers of health across all access points in the system. • Launch EPIC's Compass Rose whole person care coordination technology platform.	• Track percentage of encounters with up-to-date screening for social drivers of health in specific clinics/departments • Track number of patients connected to social resources through NCCARE360
	Ensure access is inclusive and eliminate barriers to access.	• Engage Patient & Family Advisory Council to receive feedback on specific programs initiatives. • Enhance Diversity, Equity & Inclusion efforts across the system, and implement D&I Council Diversity Scorecard program. • Provide Diversity & Inclusion training for employees and providers. • Establishing health equity scholars experts to guide teams internally at WakeMed.	• Track programs and initiatives established through Patient & Family Advisory Council. • Track the number of employees participating in DEI initiatives throughout the year, including training/education programs. • Track the number of Employee and Patient policies that have been reviewed and/or edited to ensure equity and inclusion.
	Provide Value Based Care.	• Working with our two Accountable Care Organizations, continue to reduce overall cost of care through care coordination, care management of those managing disease and high-risk factors – furthering key Population Health efforts. • Care Transformation Teams will address how to transform clinical care across the system to further ensure quality, efficiency and cost reductions.	• Track closures of care gaps • Care Transformation Team results

MENTAL HEALTH

Like most health systems across the country, WakeMed has seen a steady increase in the demand for behavioral health services. As such, we have continued to invest significant time, energy and resources to increase the capacity and breadth of services needed to support patients suffering from behavioral health conditions. Many of these strategies rely on the strong partnerships we've built with community-based organizations and our peer healthcare organizations throughout Wake County.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASUREMENT
Mental Health	Enhance WakeMed Mental Health & Well-Being strategy.	• Chief Medical Director for Mental Health & Well-Being in place and developing comprehensive, system-wide Mental Health & Well-being program.	• Monitor and evaluate program performance.
	Enhance access to behavioral health inpatient services.	• Establish new 150-bed behavioral health hospital (anticipated to break ground in 2024). • Develop and implement Consultation Liaison Service to provide psychiatric consultative care to inpatients and observation patients.	• Track patient volumes and outcomes. • Track number of consults completed by the Consultation Liaison Service by campus.
	Bolster mental health crisis services in our emergency departments.	• Mental Health Crisis team of 40+ clinicians support WakeMed ED patients. Provide risk assessment and determine level of care needed, plus connecting patient with mental health resources in the community. • Develop Telepsychiatry Program and Behavioral Health Response Team at WakeMed North ED, expanding what is already working well in the Raleigh and Cary EDs. • Collaborate with Wake County EMS to support continued ED diversion programs.	• Track number of behavioral health consults completed by clinicians in all of WakeMed's EDs. • Track number of Telepsych consults at WakeMed North ED. • Track referrals received from EMS and directed to WakeMed primary care and urgent care.
	Develop innovative community partnerships to address behavioral health crisis.	• Network for Advancing Behavioral Health (NABH). • Connected Community - starting a healthy food pilot for patients at risk for diabetes. • Triangle Behavioral Inpatient Network. • Trauma Resilience and Recovery Program (partnership with MUSC & Duke Endowment). • Trauma Survivors Support Group • Continue to support Healing Transitions addiction programs.	• Track 30-day readmissions, avoidable bed days. • Track number of patients served by the NABH. • Track scheduled appointments within days of discharge. • Track referrals to social services from Connected Community.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASUREMENT
Mental Health	Offer support and education regarding behavioral health resources throughout our community.	• Offer up to 5,000 Calm App subscriptions to the community through faith-based organizations and community health partners. • Distribution of 988 Postcards/Magnets in the community, Postcards, ensuring patients/community members know how to access the new hotline. • Generate awareness and education through social media and participation in community events (World Mental Health Day, etc.)	• Track the number of Calm App subscriptions added as well as outcomes of individual and patient populations. • Track materials/postcards distributed in the community and made available to internal WM departments and NABH providers • World Mental Health Day event • Speaker's Bureau events, blogs, sponsorships, Walk for Hope
	Support patients with mental health and substance use disorders.	• Community Case Management program. • Support all 7 emergency departments with Naloxone rescue kits. • Deliver medical-supervised detox treatment for high-risk OB patients. • Continue WakeMed Pain Collaborative and subgroup Non-Pharmacologic Modalities Group. • Collaborate with Wake County EMS to support continued ED diversion programs.	• Track number of kits distributed in all 7 WakeMed ED's. • Monitor overdose readmits to ED. • Monitor community overdose data. • Monitor initial patient population outcomes for Alcohol Withdrawal CEB
	Address the growing mental health problems affecting our youth.	• Pediatric Primary Care Telehealth Program • Pediatric Weight Management program features embedded behavioral health services. • Enhance Pediatric primary care referrals to NABH Partners. • Establish the NABH Youth Taskforce to monitor trends and maximize partner resources for youth services.	• Track program performance and utilization. • Track number of WM Pediatric Primary Care referrals to NABH partners
	Reduce narcotic and opioid use throughout the WakeMed system.	• Opioid Stewardship initiative (focused on eliminating Dilaudid, decreasing dosing and number of pills prescribed, and use of alternative therapies). • WakeMed Pain Collaborative/Non-pharmacologic Modalities Work Group • WKCC focus on reducing opioid use. • Continue and add Enhanced Recovery After Surgery (ERAS) protocols for heart surgery, elective C-sections, total joint, and 8 other procedures.	• Continue to monitor downward trend in dilaudid prescriptions and use of alternative pain management. • Track ERAS Full Pathway Adherence in the 11 total populations.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASUREMENT
Mental Health	Enhancing mental health support and services for hospital workforce.	• Develop a multidisciplinary task force to oversee this work – led by Human Resources and Mental Health and Well-Being. • Plans to bolster Employee Assistance Program services and encourage proactive use of services to build resiliency. • Reviewing policies and procedures to ensure they support employee well-being. • Reviewing internal insurance networks to ensure easy access to mental health care for our employees and their beneficiaries. • Continue to implement Workplace Violence Prevention Program as events have a profound impact on employee wellbeing.	• Follow metrics from annual employee health & well-being opinion survey
	Enhanced Spiritual Care program efforts throughout our community.	• Expansion of Spiritual Care support resources throughout hospital campuses, Adult & Pediatric Bereavement Programs; "Life After Covid" virtual peer support group, Advanced Care Planning education, engaging faith community, etc. • Continue to provide staff support programs such as EVS Resiliency, Tea for the Soul, COVID Resiliency Rounds.	• Track utilization of various programs. • Track number of volunteers and hours of support in various programs. • Track the number of one-on-one grief sessions offered to grieving family members. • Track and evaluate patient/family survey feedback.
	Support patients with unique needs through ongoing support groups.	• Amputee Support Group; Mended Hearts; Life After COVID; Diabetes; Aneurysm and AVM; Bariatric Surgery; Breastfeeding; Brain Injury; Postpartum; Stroke; Spinal Cord; Trauma Survivors and Grief Support Groups and a variety of cancer support groups under development.	• Track participation/engagement and participant feedback.
	Enhance staff competency in supporting behavioral health patients.	• Incorporate comprehensive online and in-person training programs into new RN orientation – focusing on areas including: non-violent crisis intervention, trauma-informed care, managing aggression, etc. • Establish 24/7 Mental Health Response Nurse to address urgent needs. • Establish Behavioral Health Nurse Champion Program to ensure non-behavioral health areas are supported by leaders with additional BH training. • Increase the number of nurses certified in Psychiatric-Mental Health Nursing.	• Track participation in training, monitor evaluations • Track utilization of Mental Health Response Nurse calls and evaluate program effectiveness. • Track # of Behavioral Health Nurse Champions • Track # of nurses who earn specialty certification

HOUSING & HOMELESSNESS

WakeMed is actively engaged in supporting our community's homeless population. Focusing on social determinants of health, we continue to explore innovative ways to improve access to care for patients in Wake County who are dealing with housing insecurity.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASUREMENT
Housing & Homelessness	Support homeless community members by connecting them with community resources.	• Continue HEART Program under the Center for Community Health program. • Actively engage in supporting the homeless population in our community with medical care focusing on social determinants of health.	• Track program performance and utilization.
	Provide respite services for patients with medical needs and housing insecurity.	• Behavioral Health & Medical Respite Program through Community Case Management and the Center for Community Health.	• Monitor utilization and readmissions.
	Partner with local non-profit organizations providing services to homeless community members.	• Develop a health clinic at Oak City Outreach Center. • Center for Community Health Community Outreach efforts in the community and at area homeless shelters via mobile program, new education topics each month. • Community Advisory Council will advise what topics and what services are needed in the community to match education programed and provided by CCH. • Provide financial and volunteer support where appropriate for those nonprofit organizations addressing medical, food and housing insecurities.	• Track volunteer hours and financial contributions. • Track utilization at Oak City Center health clinic. • Track the number of outreach events and education programs.
	Support efforts to preserve and add affordable housing.	• When appropriate, support agency and community efforts including those along the New Bern Avenue BRT Corridor.	• Monitor progress in the community made by agencies working in this space.