This document is the implementation strategy for CarePartners and addresses the community health needs identified through a collaborative Community Health Needs Assessment (CHNA) process conducted with local and regional partners in western North Carolina. This document outlines plans for CarePartners to support specific community benefit efforts as part of a larger community-wide plan.

OUR COMMUNITY AND KEY PARTNERS

CarePartners Community

CarePartners is a regional nonprofit healthcare organization in western North Carolina providing post-acute services in Home Health, Adult Day, PACE, Inpatient and Outpatient Rehabilitation, Orthotics and Prosthetics, along with Hospice and Palliative care. With approximately 1,300 employees and 400 volunteers, CarePartners is dedicated to helping people live fully through life’s journey. CarePartners primary location is in Asheville, and the focus of this implementation strategy will be on the health issues identified for Buncombe County. CarePartners is an affiliate of Mission Health and cares for patients from all over the WNC region. The hospital’s designated service area for the CHNA is Buncombe County.
Community Health Needs Assessment

**Process and Product**
The CarePartners CHNA was conducted in partnership with the Buncombe County Health Department, WNC Healthy Impact, and Mission Hospital. This written report describes:

- The community served by the hospital
- Community demographics
- Existing health resources in the community available to respond to needs
- How data was collected in the assessment process
- The priority health needs of the community
- Health needs and issues of uninsured, low-income, and minority groups
- The process for identifying and prioritizing community needs and services to meet the needs
- The process for consulting with persons representing the community's interests
- Information gaps that limit the hospital facility's ability to assess the community's health needs

**Sharing of Results**
Detailed findings of our assessment are posted on the CarePartners website, http://www.carepartners.org/about_community.html, the Mission Health website http://www.mission-health.org/community-health-needs-assessment.php and the Buncombe County Health Department website. The CHNA was reviewed by the CarePartners Board in August and approved on August 31st, 2016.

**Regional Partnership**
Our hospital's collaborative community health improvement effort is supported by a larger partnership with other hospital facilities and health department across a sixteen-county region in western North Carolina this collaboration is called WNC Healthy Impact. More information about this innovative regional collaboration, county-wide community health assessments, and overall regional findings are made widely available to the public at www.WNCHealthyImpact.com.
**Priority Health Needs & How They Were Established**

**Prioritization Process**

As part of the collaborative health assessment process in our community, specific health needs were prioritized based on the data that was collected, community input and various factors related to the feasibility of addressing the need. Details on this process are available in our CHNA, which is publicly available on CarePartners’ website, [http://www.carepartners.org/about_community.html](http://www.carepartners.org/about_community.html), and the Mission Health website: [http://www.mission-health.org/community-health-needs-assessment.php](http://www.mission-health.org/community-health-needs-assessment.php).

**Priority Health Needs for Our Community**

**Buncombe County**

In Buncombe County the following health issues were prioritized for collective community-wide action:

1. **Obesity & Chronic Disease Prevention** – “With 50 percent of adults and 33 percent of children either overweight or obese, it is essential to continue to make the healthy choice the easy choice. Diabetes mortality rates have worsened for the past eight years. There is a huge health disparity seen in diabetes mortality in NC. There is a great deal of momentum around active transportation, access to affordable healthy foods, and new partnerships with clinical partners to build links between clinical care and community supports. In addition, there is a great deal of work happening to improve diabetes care and linkages with community partners.”

2. **Mental Health and Substance Abuse Prevention** – “The hospital continues to see spikes in heroin-related visits and overdoses, neonatal abstinence syndrome continues to grow, and over half the homeless population has a substance use disorder or mental health illness. The new Comprehensive Care Center will provide improved access to services for those experiencing mental health and substance abuse concerns.”

3. **Infant Mortality** – “Infant mortality has increased in Buncombe County, with a striking disparity between African American infants and white infants (African American infants are much more likely to die during their first year of life than white infants in the county). Further, infant mortality is a key proxy measure of wellbeing, not just for infants and children in the community, but also for women’s health, poverty, and health equity, as mentioned the Buncombe County 2015 – 2018 CHA.”

4. **Intimate Partner Violence** – “Five homicides in 2013 were a result of intimate partner violence (IPV), and we have seen a drastic increase in IPV calls to the hotline. With a new Comprehensive Domestic Violence Plan and the opening of the Family Justice Center, Buncombe County has many collaborative efforts underway to address this challenging issue.”
HOW THIS IMPLEMENTATION STRATEGY WAS DEVELOPED

Engagement in a Community-Wide Plan

As a next step following the development of a CHNA, which includes prioritization of health needs, CarePartners collaborated with local public health experts and other key community stakeholders to develop a written description of the activities that hospital facilities, public health agencies, and other local organizations plan to undertake collectively to address specific health needs in our community. This collaborative action planning process resulted in the development of an electronic community health improvement plan (e-CHIP) for each county in our hospital facility’s defined community, which include Buncombe County.

The electronic Community Health Improvement Plan (e-CHIP) for Buncombe County can be found at https://www.buncombecounty.org/governing/depts/health/Chip.aspx

IMPLEMENTATION STRATEGY DETAILS

Priority Health Issue #1: Obesity and Chronic Disease Prevention

**Description of Community Need**

Obesity and related chronic disease are critical issues in Buncombe County, chronic diseases interrelated to weight include cardiovascular disease, diabetes, stroke, hypertension, cancer, and others. In Buncombe County 62.6 percent of adults have a BMI greater than 25. Healthy weight is complicated by many factors, including food insecurity and lack of access to affordable, healthy food, poverty, and barriers to physical activity. Rural areas are also less likely to have resources to support residents in addressing weight issues, including experts like dietitians or weight management experts, as well as exercise facilities and infrastructure. Chronic diseases that impact residents in Buncombe County make it harder to maintain or achieve a healthy weight by limiting individuals’ ability to exercise, and increasing medical costs which further stretch limited dollars that may otherwise be used to buy food or access transportation.

**Desired Community Result**

Buncombe County Results: (from the Buncombe County e-CHIP)
1. All in Buncombe County have access to nutritious food and are inspired to make choices and utilize skills that support a healthy life.
2. Everyone has access to safe and accessible transportation and recreation.
3. Everyone is able to prevent diabetes or better self-manage their diabetes.

**Partner Agencies and Roles**
Buncombe County agencies partnering to address this issue include: Appalachian Sustainable Agriculture Project; Asheville Buncombe Institute of Parity Achievement, Asheville Housing Authority, Asheville Buncombe Food Policy Council, Bountiful Cities, Buncombe County Health & Human Services – Community Service Navigators, WIC, and School Health and Migrant Education Program, Children First/Communities in Schools of Buncombe County, Cooperative Extension, FEAST Asheville, Gardens that Give WNC, MANA FoodBank, Mission Health, UNCA Asheville – NC Center for Health and Wellness, YMCA of WNC and the YWCA of Asheville.

**Related Hospital Strategy**

<table>
<thead>
<tr>
<th>Priority Health Issue #1: Obesity and Chronic Disease Prevention</th>
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</thead>
<tbody>
<tr>
<td><strong>Hospital Strategy – 1: Provide health education opportunities and health services that help individuals manage/prevent chronic diseases and maintain a healthy weight.</strong></td>
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<thead>
<tr>
<th>Description of Activities</th>
<th>Anticipated Impact</th>
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<tbody>
<tr>
<td>As a post-acute care provider, CarePartners primarily serves individuals who are recovering from an acute episode related to a chronic condition. Our clinical expertise is in preventing chronic diseases from getting worse and preventing the development of a secondary or tertiary condition. The following programs are part of CarePartners:</td>
<td>The Mindful Living Education Series is produced annually and is designed to educate seniors, families, and community members about aging in place and managing any chronic conditions. This is a long standing program that we are hoping to expand and develop more opportunities for education and outreach. Goals include:</td>
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<tr>
<td>• Mindful Living Education Series</td>
<td>• Early and appropriate access to community and clinical resources</td>
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<tr>
<td>• Year-round educational classes on SMART Goals and chronic disease therapy</td>
<td>• Increased utilization of in-home services that aid aging in place</td>
</tr>
<tr>
<td>• Outpatient Clinic offers balance screenings and rehabilitation therapy.</td>
<td>• Reduced risk of falls in older adults</td>
</tr>
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</table>

CarePartners hosts 12 separate support groups to the community, creating a vital network for individuals who are looking to maintain a healthy lifestyle.

Outpatient therapists provide support and rehab for individuals in seven locations across Buncombe County. They provide screenings...
for older adults to reduce falls. Falls prevention includes community events and one-on-one evaluations.
- Increased access to appropriate therapy
- Increased health education and access to resources

**Hospital Strategy – 2: Through partner agencies promote increased physical activity in our community.**

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<tr>
<td>CarePartners PACE will partner with YMCA to offer low cost exercise classes to individuals with Parkinson’s or any other movement disorders. In addition other movement programs will be offered to the community at various CarePartners’ locations.</td>
<td>CarePartners will work with local teachers and experts to offer adaptive movement classes at low to no cost. In partnering with the YMCA, CarePartners is expanding the classes to offer them to more individuals. While most exercise efforts focus on preventing disease we plan to offer classes that work with individuals that have a limiting disease and would still benefit from activity (range of motion, balance, decreased falls risks, decreased rigidity). Classes for the public include Tai Chi for Arthritis and low impact therapeutic classes in the therapy pool. Programs are just beginning to grow and CarePartners will develop metrics and collect data for these groups.</td>
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**Priority Health Issue #2: Mental Health and Substance Abuse**

**Description of Community Need**

Mental health and substance use disorders co-occur in approximately 7.9 million adults in the United States, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2014 data. Abuse and misuse of substances, both illegal drugs and prescription or over-the-counter medications, is an increasing challenge in western North Carolina. Tobacco use in western North Carolina is 22.8 percent, nearly 3 percent higher than the state average and 6 percent higher than the national average. Lack of treatment facilities and programs was
identified as a major barrier to addressing this issue. In Buncombe County, increases were noted in abuse of heroin and prescription opioids, and unintentional medication deaths. In addition, 27 percent of homeless adults in Buncombe County are living with a substance use disorder.

**Desired Community Result**

Buncombe County Results: *(from the Buncombe County e-CHIP)*

1. Access to behavioral healthcare and substance abuse treatment improves, in particular for vulnerable populations like the homeless.
2. A community-wide effort is initiated to decrease the rate and impact of neonatal withdrawal syndrome (NWS), and improve outcomes for mothers and their babies affected by substance abuse disorders.
3. Overdose and deaths from unintentional drug poisonings decrease.
4. Social determinants of health are addressed to support residents and reduce the impact of poverty on substance use and abuse.

**Partner Agencies and Roles**

Buncombe County agencies partnering to address this issue include: Buncombe County Health and Human Services, Community Service Navigators Nurse Family Partnership program, Community Care of Western North Carolina, Crossroads Treatment Center, Mt. Zion Community Development, Inc., October Road, RHA Behavioral Health Services (Neil Dobbins Center and Mary Benson House), Vaya Health, Women’s Recovery Center, Western North Carolina Community Health Services, and YWCA MotherLove program and other health care providers.

**Related Hospital Strategy**

**Priority Health Issue #2: Mental Health and Substance Abuse**

<table>
<thead>
<tr>
<th>Hospital Strategy – 1: Support vulnerable individuals and families through free and low cost bereavement and mental health counselling.</th>
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<tbody>
<tr>
<td><strong>Description of Activities</strong></td>
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<tr>
<td>CarePartners offers bereavement services to all who are experiencing mental health issues as related to the death of a loved one. Ability to pay is not a consideration to receive support.</td>
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<tr>
<td>Bereavement services will continue to be provided in local schools to help students struggling with loss of a loved one or family member.</td>
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Priority Health Issue #3: Infant Mortality

Description of Community Need
Buncombe County identified infant mortality as a community health priority in large part due to the startling disparity in rates between African American and white babies – 5-year aggregated numbers show that African American babies die at twice the rate (10.1 deaths per 1,000) of white babies (6.2 deaths per 1,000) in Buncombe County. The rate of infant mortality can be attributed to some known common causes, like premature birth, low birth weight and congenital or chromosomal defects. Other factors that increase the risk of infant mortality include complications during pregnancy, such as chronic health conditions or infections the mother may have, placenta problems, weight issues, and smoking, alcohol, and substance abuse. Social determinants may also be indirectly linked to the risk of infant mortality, including poverty, unemployment and low education levels of the parents.

Desired Community Result
1. Women have access to the full spectrum of care to stay healthy before they get pregnant and during their pregnancy.
2. Community efforts support living wages and resilient communities to help families thrive.
3. Providers and community efforts address racial equity to reduce and eventually eliminate disparities in maternal and child health outcomes.
4. Infant mortality rates, and infant mortality disparity ratios decrease for babies born in Buncombe County.

Partner Agencies and Roles
Community agencies partnering to address this issue include: Asheville Police Department, Buncombe County District Attorney’s Office, Buncombe County Health and Human Services, Mission Health and Mission Hospital, Mountain Area Health Education Center, Pisgah Legal Services and YWCA of Asheville.

Priority Health Issue #3: Infant Mortality

| Hospital Strategy – 1: Grow and Strengthen the program for infants with neonatal withdrawal syndrome (NWS). |
| Description of Activities | Anticipated Impact |

healthy grief. Counselors will provide support and help guide individuals seeking assistance.
Continue to increase the intervention and treatment for vulnerable babies suffering from NWS and families who are returning home. For NWS babies who are returning home to face a wide array of developmental hurdles and issues, CarePartners provides clinical education to families and new parents. We will continue to train clinical staff and the pediatric home health team reaches approximately 40 families per month. CarePartners plans to:

- Increase the expertise for clinical staff
- Standardize the education for families and parents to take care of NWS babies
- Strengthen community connections and resources

Needs Not Addressed in This Plan

Though we recognize that each community health need identified by the community is important, for the reasons described below, our hospital facility will not have a specific role in the implementation of strategies to address the following issues:

**Intimate Partner Violence**

Intimate partner violence is not a clinical core competency of CarePartners and the hospital does not necessarily have the expertise or resources to address this need directly. As an affiliate of Mission Health, Mission Hospital has more resources and experts to address this community need.

**Substance Abuse**

Substance abuse is not a clinical core competency of CarePartners and the hospital does not necessarily have the expertise or resources to address this need directly. As an affiliate of Mission Health, Mission Hospital has more resources and experts to address this community need.
NEXT STEPS

As part of the community health improvement process, CarePartners will continue to work with community partners in the development, implementation, and monitoring of our collaborative electronic community health improvement plan (e-CHIP) that includes some of the hospital strategies outlined in this document. The e-CHIP will be reviewed by CarePartners Senior Leadership to assess progress on key community indicators and updates will be made publically available in a county-wide State of the County Health Report (SOTCH Report). The next community health needs assessment (CHNA) will be conducted in 2018. In addition, we will be creating an electronic scorecard to monitor the performance of key strategies included in this document.

APPROVAL

This report was prepared in December 2016, for the CarePartners Governing Board, and is approved as signed below by the Board Representative and Hospital President.

Larry Harris, Vice-Chair

Date

Tracy Buchanan, President & CEO

Date