Behavioral Health Hospital

Community Health Needs Assessment 2013

In Partnership With

The Guilford County Health Department

&

The Center for Social, Community and Health Research and Evaluation

CONE HEALTH
Behavioral Health Hospital

Behavioral Health Hospital
Community Health Needs Assessment Report and Implementation Plan

Table of Contents

Collaborating Partners Involved with the Assessment

Every four years the Guilford County Department of Public Health, along with community partners, conducts a community health assessment. Under the Affordable Care Act, each hospital system is now required to conduct a community health needs assessment every three years. This year the Guilford County health department, Cone Health and High Point Regional Health are collaborating to fulfill both health assessment requirements. With guidance from University of North Carolina at Greensboro's Center for Social, Community and Health Research and Evaluation (CSCHRE), collaborating partners utilized a participatory approach to document the health status of residents and the availability of resources in Guilford County, North Carolina. The purpose of the joint assessment effort was to collect data on health needs and assets within the county, priority health issues and potential recommendations for the development of action plans that address community health concerns.

A steering committee has been developed and is comprised of representatives from Cone Health, High Point Regional Health, the health department and the CSCHRE. The steering committee engaged community members and representatives from other entities residing in Guilford County in the assessment process to fulfill state and national reporting requirements for the health department and hospital systems. The project collected supplementary data to gain a deeper understanding of the community needs and assets and to maximize the utility of the work. In doing this, each system will also have a template for future reporting needs.

In collaboration with the health department, area hospital systems and foundations were identified as important partners impacting the local service area in Guilford County. Within Cone Health, The Moses H. Cone Memorial Hospital, Women's Hospital, Wesley Long Hospital and Cone Health Behavioral Health Hospital were identified as key partners. High Point Regional Health was another key partner in Guilford County. Cone Health Foundation was identified as an important funding partner for the greater Greensboro service area in particular. The Mental Health Association in Greensboro, the Center for New North Carolinians, St. Mary's Catholic Church, and Triad Adult and Pediatric Medicine played an important role in organizing and/or hosting health consumer focus groups.

The CSCHRE and the health department contributed substantially to the joint assessment effort. The mission of the CSCHRE is to "stimulate the development and facilitation of social and community-based public health research, evaluation, and practice in the context of institutional and community collaborations," (UNCG CSCHRE, 2013). The center specializes in initiating and maintaining community partnerships, database building and data collection, instrument and tool development, qualitative methods, research design and methodology development, evaluation, grant writing, and intervention design and development. The health department's mission is to "protect, promote and enhance the health and well-being of all people and the environment in Guilford County," (GCDPH, 2013) Department staff members have extensive experience working with both primary and secondary data and in conducting community health assessments in Guilford County.

Qualifications of Those Assisting with the Assessment

Dr. Joseph Telfair, CSCHRE Director, led the center's contributions to the community health needs assessment. Dr. Telfair is an interdisciplinary, community-based and community-oriented researcher

with many years of public health and social work research and practice experience. Dr. Telfair has extensive experience in directing team projects involving but not limited to social epidemiology, community-based and rural health, program evaluation, cultural and linguistic competency, public health genetics, elimination of health disparities, and policy issues concerning women, adolescents and children with chronic conditions. Holly Sienkiewicz is a coordinator and research scientist at the CSCHRE. Her area of expertise includes immigrant and refugee health, qualitative research methodologies and community-based participatory research and evaluation. Additionally, the CSCHRE employs a cadre of graduate research assistants and consultants qualified and experienced in cultural, ethical and social issues specific to health and wellness, health equity, health disparities and program assessment affecting geographically, economically and ethnically/racially diverse and/or vulnerable populations. During the last 25 years CSCHRE members have produced more than 45 technical reports and 67 peer-reviewed papers, books and book chapters addressing issues pertaining to public health and the health of marginalized and vulnerable populations. Research and evaluation initiatives occur at the local, state, national and global levels.

Guilford County's health department is the nation's second oldest full-time health department. It provides a spectrum of population-based and personal health programs and services to help individuals monitor their health and supports a healthy environment for everyone. Dr. Mark Smith, epidemiologist and head of the health department's Health Surveillance and Analysis Unit, has extensive experience leading countywide health assessments in Guilford County. From 1995 to 1997 Dr. Smith led a four-county health needs assessment as associate director of the Center for Community Research at the Wake Forest University School of Medicine, Department of Public Health Sciences. Between 1999 and 2011 he helped to lead community health assessments as co-chair of the Guilford County Healthy Carolinians, and from 2002 to 2007, he served as epidemiologist for Public Health Regional Surveillance Team Five. Dr. Smith additionally provided technical assistance to other counties in conducting community health assessments. Currently Dr. Smith leads the assessment effort on behalf of the health department with Laura Mrosla, a community health educator with the health department since 1999. During that time, Mrosla has helped plan and implement four community health assessments. She earned a master's degree in public health with a concentration in maternal and child health and a master's degree in social work from the University of North Carolina at Chapel Hill.

Community Served by Behavioral Health Hospital

The information on the communities served by Behavioral Health Hospital is based on information provided by the organization that is publicly available. The existing services are reflective of the needs in Guilford County for persons accessing mental health care. Behavioral Health Hospital serves patients in need of grief counseling, group therapy, substance abuse and addiction counseling, life skills education, medication management and intensive outpatient services. It also serves children and adolescent patients, particularly attention-deficit hyperactivity disorder (ADHD), bipolar management, depression, anxiety and oppositional defiant disorder. Though clients are primarily from Guilford County, persons from outside the county who cannot receive mental health services in their area also obtain services at Behavioral Health Hospital.

Guilford County was once an industrial-based center and has seen a large decline in the manufacturing of textiles, apparel and furniture. Currently, Guilford County Public Schools is the county's largest employer of Guilford County residents, followed by Cone Health and the City of

Greensboro. Individuals and families in Guilford County are still dealing with the impact of the economic recession. In 2011, the Guilford County annual unemployment rate was 6.7 percent, slightly up from 6.2 percent in 2008. The median household income in Guilford County for 2007–2011 was estimated at $46,288, lower than the $47,308 estimated from 2006 to 2008. Between 2007 and 2011, it was estimated that 16.1 percent of individuals were living in poverty.

Data Collection Methods

The 2012–2013 joint community health and community health needs assessments fulfill reporting requirements for the health department, Cone Health and High Point Regional Health and extend outside of Guilford County to the neighboring counties of Alamance, Randolph, Davidson, Forsyth and Rockingham. Both quantitative and qualitative data were collected and assessed at the county and subcounty geographic levels of census tract and ZIP code. Assessing health needs involved collection and assessment of a wide range of data on measures of health and health-related factors including morbidity and mortality, health behaviors, clinical care, social and economic factors, and environmental factors. In addition to secondary data sources, primary data were collected through focus groups and surveys conducted through community meetings and online.

Secondary Data

Data used for the assessment included both primary and secondary data collected from a variety of sources. The Health Surveillance and Analysis Unit collects and maintains a variety of secondary health data on county citizens and regularly makes these data available to keep community members, health providers, policy makers and community organizations up to date on health trends. The Health Surveillance and Analysis Unit provided such data—including leading causes of death and indicators related to communicable disease, chronic degenerative disease, maternal and infant health, and injury mortality—for the community health assessment process. Additional secondary data for mortality, birth outcomes, communicable disease and health risk factors were obtained from the NC State Center for Health Statistics.

The Patient Protection and Affordable Care Act also provides a list of required and optional hospital-level measures identified by the US Department of Health and Human Services. The health department produced data on these indicators, which are regularly tracked by Cone Health and High Point Regional Health. Additional measures were also collected, such as diagnosis-related groups with the greatest number of hospitalizations.

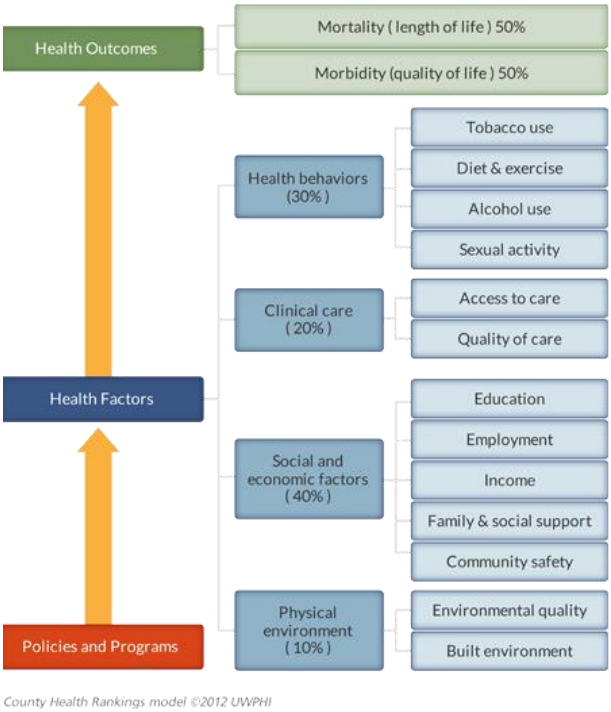
County Health Rankings

Each year, the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation collaborate to publish the *County Health Rankings* for all counties in the United States. The *County Health Rankings* helps us understand what influences our community's health and the health of its residents. These rankings recognize that our health outcomes, such as how long we live and how healthy we feel, are influenced by our own health behaviors, our access to and experience with clinical care, social and economic factors, and the physical environment in which we live, work and play. Local, state and federal policies and programs can also influence health outcomes through impact on health factors.

The *County Health Rankings* uses a model of health that represents health outcomes—morbidity and mortality—as functions of several health factors:

- The first health factor, health behaviors, consists of indicators of tobacco use, diet and exercise, alcohol use, and sexual activity. Health behaviors comprise 30 percent of variation in health outcomes.
- The second health factor, clinical care, includes indicators for access to care and quality of care. Clinical care makes up 20 percent of variation in health outcomes.
- The third health factor, social and economic factors, includes measures of education, employment, income, family and social support, and community safety. Social and economic factors make up 40 percent of variation in health outcomes.
- The last health factor, physical environment, includes measures of environmental quality and the built environment, including air quality, access to exercise facilities and access to healthy food. Physical environment makes up 10 percent of variability in health outcomes.

Figure 1. *County Health Rankings* Model



The *County Health Rankings* and its research-based model of community health provide an instructive way to frame an understanding of community health needs and method for organizing the assessment of health data.

Focus Groups

Qualitative data collection for the community health assessment occurred sequentially. Key informant interviews with executives at each hospital took place before focus group discussions at corresponding hospitals. This allowed each focus group topic guide to be tailored to the suggestions and feedback of the key informant for each respective hospital. Key informants helped frame focus group topic guides, which were specifically related to the knowledge and opinions of the key informants. As with the key informant interviews, several topics were general and asked of all focus groups, and there were also specific topics discussed that were unique to each site.

Members of the CSCHRE facilitated both the key informant interviews and the focus group discussions. Interview participants were provided with a consent form at the beginning of the interview (a consent form was emailed in advance to phone interview participants). Staff from the CSCHRE pointed out the main components of the consent form, allowed the participant time to read the form and asked if he or she had any questions before starting the interview. The signature requirement was waived. A copy of the consent form was left with all participants.

Focus group participants were also provided with a consent form at the beginning of the discussion. Staff from the CSCHRE pointed out the main components of the consent form, allowed

participants time to read the form and asked if they had any questions before beginning the discussion. The signature requirement was waived. A copy of the consent form was left with all participants. Focus group discussions were recorded. A CSCHRE staff member in the room took notes. Recordings of all focus group discussions were transcribed verbatim.

Key informant interviews were reviewed and broad categories created that encompassed the nature of each response. This was done for all participants (in which focus groups were being conducted at their institution) across all questions. Similar categories were collapsed where necessary. The frequency of each category determined the nature of the questions asked in all focus groups and those that would be institution specific. The response categories were assigned a number in chronological order of responses. The numbers for each category were recorded in a table denoting response patterns across institutions representing the key informants and across the entire interview conducted with a specific key informant. The summary columns showed all responses, with the most frequent listed first and the least frequent listed last. While frequency counts in qualitative accounts are not the norm, this strategy helped determine focus group topics and the order in which they were discussed.

The research team developed a priori codes for the focus groups and analyzed the transcripts by reading and rereading the content. One researcher coded each transcript and a fellow researcher verified those codes. Discrepancies in coding were discussed and revised until an agreement was reached. Finalized codes were reviewed for frequency and context for each transcript. Transcripts were then compared to one another to identify common themes. Research team members continued to compare and discuss findings with one another to ensure intercoder reliability. Findings from the transcripts were triangulated with quantitative data components analyzed for the larger community health assessment project.

Characteristics of focus group participants. Focus groups primarily took place in settings familiar to participants. Moses Cone Hospital providers addressed general health care issues in focus groups at Cone Health administrative offices. Similarly, High Point Regional Health held focus groups with staff and local service providers working for nonprofit organizations. In the same setting, low-income clients also participated in their own focus group. An additional focus group with low-income/Medicaid clients took place at Triad Adult and Pediatric Medicine. Another focus group was held with service providers associated with Cone Health Foundation.

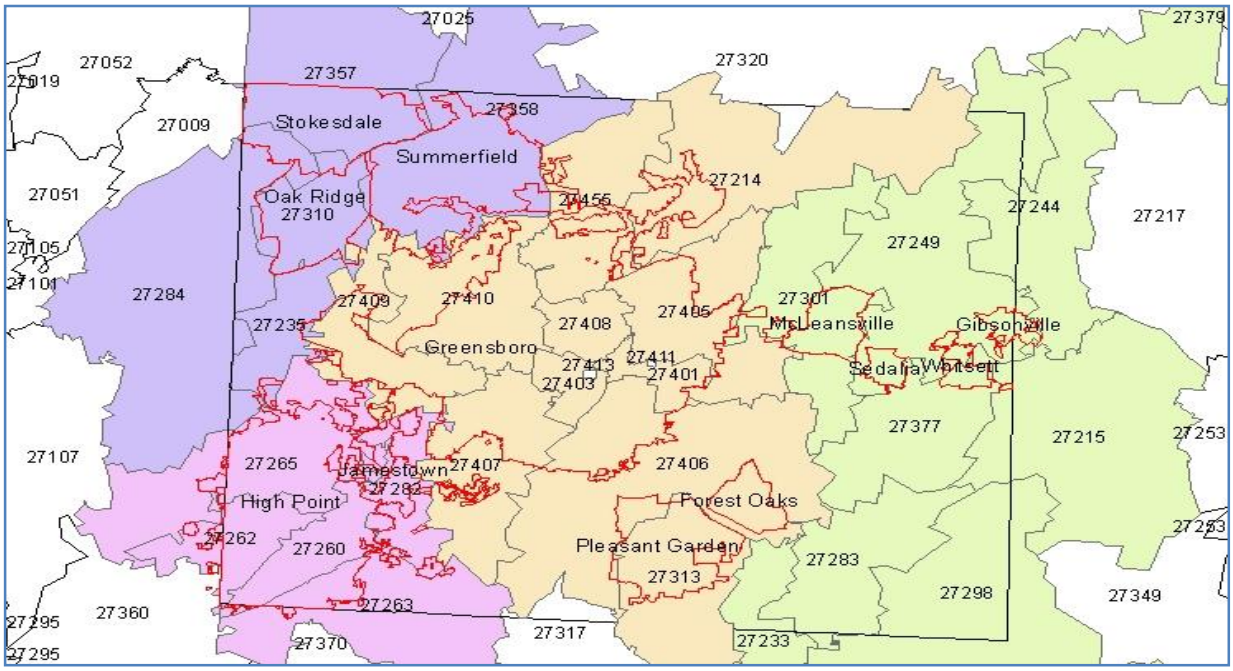
Three focus groups addressed special health care topics, including mental health and women's health issues. One group was held at Behavioral Health Hospital administrative offices with staff social workers, administrative staff and congregational nurses, in addition to providers from the Mental Health Association in Greensboro. The second group addressed mental health with clients from Mental Health Association in Greensboro. A number of providers, primarily physicians from Women's Hospital, also participated in a focus group held at Cone Health administrative offices.

Three focus groups were conducted with immigrants and refugees currently living in Guilford County: at Ashton Woods Community Center with French-speaking African refugees, at Glen Haven Community Center with Nepali-speaking Bhutanese refugees and at St. Mary's Catholic Church, where most of the Spanish-speaking focus group participants were also part of the congregation.

Guilford County Community Meetings

In order to gauge public opinion regarding the priority health issues facing Guilford County, a series of six meetings was scheduled during October and November 2012. Facilitators at these meetings shared recent county and subcounty, community-specific health data based on the indicators in the *County Health Rankings*. Attendees shared their views about health issues and health needs in their communities. All meetings were open to the public. Meetings were publicized through a press release to all print and electronic media as well as through the Guilford County and health department websites. Cone Health and High Point Regional Health also publicized these meetings.

Figure 2. ZIP Code Groupings for Guilford County Community



Guilford County was divided into six regions, representing a range of two to eight ZIP codes, to support participation from all areas and to help identify health issues specific to particular areas. Whenever possible, central meeting locations were chosen within the different geographic areas and publicized within those specific regions. To further encourage participation, a regional-specific announcement was developed and distributed to local contacts.

Almost 100 community members participated in the meetings. At each meeting, participants reviewed a presentation highlighting local data on 30 indicators from the *County Health Rankings* in comparison to state and national data. When available, these data were augmented with ZIP code–specific data synthesized by Master of Public Health students from Dr. Robert Aronson's Community Assessment class at UNCG's Department of Public Health Education. Participants then ranked the importance of each health indicator using a Likert scale questionnaire, choosing a response on a scale of 1 through 5, where 1 represents "little importance" and 5 represents "extremely important." Data collected from community meeting participants were used to identify priority health issues. Meeting participants also identified resources, assets and barriers to improvement for each health factor area as well as regional or countywide unmet needs.

Hospital Service Area Community Meetings

Hospital service areas of Cone Health and High Point Regional Health extend beyond Guilford County to include all or parts of Alamance, Rockingham, Forsyth, Davidson and Randolph counties. Meetings were publicized through press releases to local print and electronic media. Community meetings were held in the Archdale area of Randolph County and Reidsville in Rockingham County in early December 2012. These meetings shared recent county and community-specific health data with participants. Attendees shared their views about health issues and health needs in their communities and identified the most important issues in their communities. Forsyth County and Alamance County meetings were cancelled due to low attendance.

Guilford County Online Health Issue Prioritization Survey

To supplement community input from the Guilford County Community Meetings, the health department conducted an online survey regarding priority health issues facing residents of Guilford County. This allowed for additional community input from anyone who could not attend one of the scheduled community meetings. This survey presented data from the 2012 *County Health Rankings* and respondents ranked each health indicator on a Likert scale of 1 through 5, where 1 represents "little importance" and 5 represents "extremely important." The survey was available online between mid-January 2013 and March 1, 2013. During that time 51 persons completed the survey. Links to the survey were provided on the Guilford County website. The public was also informed of the survey and web link via a press release sent to all county media outlets.

Guilford County Community Health Assessment "Connecting the Dots" Meeting

In early March 2013, health department and community health assessment partners hosted a half-day "Connecting the Dots" meeting. This meeting had a dual purpose of informing community partners about the community health assessment and engaging these partners in identifying potential best practice strategies for improvement to address six potential outcome areas as outlined below. Participants at community meetings were invited and additional participants were identified and invited because of their particular interests, expertise and/or leadership regarding the session topic areas.

Participants attended two separate breakout sessions. Session 1 breakout topics included: healthy mothers and babies, sexually transmitted infections, and chronic disease/premature death. Session 2 breakout topics included: clinical care–primary and preventive care, social and economic factors, and environmental factors—access to healthy food. For each of the six breakout sessions, participants received content area data sheets that featured key data points for that given content area. Staff from the health department and the CSCHRE facilitated the breakout sessions with support from student volunteers. Participants reviewed and discussed a summary sheet that highlighted best practice interventions addressing the given topic area. Participants then ranked and expanded upon these potential strategies.

Hanlon Prioritization Meeting

In addition to the community assessment of health-related data, a panel of public health professionals, academic researchers and graduate students was assembled to prioritize data using the Hanlon prioritization method. The *Hanlon Method for Prioritizing Health Problems* was developed by J.J. Hanlon. The Hanlon Method is "a well-respected technique that objectively takes into consideration explicitly defined criteria and feasibility factors. The Hanlon Method is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values," (www.naccho.org). The Hanlon approach compares health indicators against specified criteria. Participants are asked to rank on a scale of 0 to 10 each health problem or issue on

the criteria of 1) size of problem, 2) magnitude of health problem and 3) effectiveness of potential interventions. The seriousness of the health problem is multiplied by two because it is weighted as being twice as important as the size of the problem. Based on the priority scores calculated, ranks are assigned to health problems. Below is an example of the form used for the Hanlon prioritization meeting.

Table 1. Hanlon Method for Prioritizing Health Problems

Health Problem/Indicator	A Size	B Seriousness	C Effectiveness of Intervention	D Priority Score (A+2B)C	Rank
Morbidity and Mortality					
Chronic disease (includes heart disease, cancer, diabetes, asthma)					
Sexually transmitted diseases (includes HIV, syphilis, gonorrhea and chlamydia)					
Poor birth outcomes (includes infant mortality, low and very low birth weight, and premature birth)					
Health Behaviors					
Obesity, nutrition and physical inactivity					
Tobacco use					
Teen pregnancy					
Clinical Care					
Access to clinical care, including physical and mental health (includes insurance coverage, number of providers, transportation, care coordination/navigation, health education)					
Social and Economic Determinants of Health					
Poverty and unemployment					
Violent crime					
Educational attainment (increase percent completing high school, increase percent completing college and higher)					
Physical Environment					
Limited access to healthy food (includes problems of food deserts, food insecurity)					

Community Input

Input from the community, which is inclusive of providers, patients and community members at large, was used in a number of ways in the data collection and analysis process. Community-wide forums were advertised in the newspaper and on the local news, and attendance was open to the public. The health department presented secondary data and county health rankings at these meetings. Participants were then asked to prioritize the health issues and note any additional factors they felt impacted them or their communities using the Health Issue Prioritization Survey. The

Hospital Service Area Community Meetings were held in the same format but solicited participation only within that hospital's service area. The community meetings began in October 2012 and lasted through the end of January 2013.

Beginning around the same time as the community meetings, focus groups were conducted with administrative personnel, medical doctors, nurses, case managers, and health care consumers and patients. Focus groups took place at service provision sites and participants were strategically sampled and solicited for responses regarding a number of health and service delivery issues. Respondents were prompted about issues that arise during service provision, including frequently occurring health issues, hindrances to service provision and needs, and presently effective service strategies that should continue to be supported.

Providers were asked about access to care issues experienced by their patients as well as any services that they were unable to provide due to various funding and logistical constraints. Further, they were asked about the existing and needed resources in their service sector as well as their current and desired partnerships toward improved service provision. Specialized providers in women's health and mental health service sectors were asked to address issues specifically related to their service provision. Health care consumers or patients included low-income persons, immigrants and refugees, and persons receiving mental health services. Patients were asked to provide information about access to care issues and resources as well as issues specific to their needs.

Data Collection Limitations

Data collection efforts stemming from the community health and community health needs assessment process have several quantitative and qualitative study limitations. While limitations exist, they are due to the multiple sources of data collection used throughout the assessment period. Quantitative data limitations stem primarily from some of the challenges associated with the collection and use of secondary data. Many of the larger behavioral health surveys are conducted via telephone surveys using random-digit dialing. One limitation of a telephone survey is the lack of coverage of persons who live in households without a listed landline telephone number. Households without this type of connection are more likely to be younger, racial and ethnic minorities with a lower income. Therefore, many of the results of the health behaviors measured are likely to understate the true level of risk in the total population. Additionally, many of these surveys are based on self-reported data. It is expected that respondents tend to underreport health risk behaviors—especially those that are illegal or socially unacceptable. Lastly, the Youth Risk Behavior Survey is a school-based survey distributed to youths at school. This survey, therefore, is not representative of all persons in this age group and does not account for youths who may have dropped out of school or are homeschooled. Youths not attending school are more likely to engage in health risk behaviors. Additionally, local parental permission procedures are not consistent across school-based survey sites.

There were several limitations with the survey distributed at community meetings as well. While community meetings were held across diverse geographic locations across the county, not all meetings were well attended and thus not always representative of residents living in that area. The health department implemented an online version of the prioritization survey to address some of the limitations resulting from community meetings with low attendance.

Qualitative limitations also exist. Approximately half of the focus group sample was recommended and recruited by key stakeholders at each hospital site and the Cone Health Foundation (i.e.,

presidents and vice presidents). This sample included physicians, hospital staff and representatives of organizations working directly with community members. Though these participants were informed that their responses were strictly confidential, we cannot rule out the possibility that participants may have felt restricted in the responses that they provided. Health care consumer samples consisted of primary care patients and behavioral health clients who were in the networks of key stakeholders. Therefore, while important, their experiences may not apply universally to all primary care patients or behavioral health clients. Generalizations of participants' responses are further limited by the inability to account for the experiences of residents who cannot access care.

Immigrant and refugee populations were recruited through service providers and local churches. Therefore, our study may be limited to immigrants and refugees who attend church and/or have access to health care or social services. Among immigrant and refugee populations, participants were limited to Spanish-speaking immigrants, Nepali-speaking Bhutanese and French-speaking Africans. Large immigrant and refugee populations from East and North Africa, Vietnam and Burma reside within Guilford County but were not included in this study. Lastly, immigrant and refugee participants' responses were primarily interpreted and not directly heard. Therefore, immigrant and refugee responses were expressed through the lens of an interpreter.

Data Results for Behavioral Health Hospital

The following information was obtained from secondary data sources and focus groups conducted with mental health providers representative of staff from Behavioral Health Hospital and Mental Health Association in Greensboro (MHAG), as well as clients or persons in need of care who primarily obtain services from the Mental Health Association.

Of all the counties surveyed, residents in Guilford County reported being most satisfied with their lives. Respondents in Guilford and Forsyth Counties reported being the most satisfied with their lives. There was very little difference in life satisfaction by race in North Carolina and CHNA counties, with the exception of Davidson County. Respondents of other races in Davidson County were 10% less satisfied with their lives than their white counterparts. Across all geographic areas, those respondents who made $50,000 or more per year were more likely to report being satisfied or very satisfied with their lives than respondents who made less than $50,000 per year.

Table 2. Percent Satisfied or Very Satisfied with Their Life by County, 2010

Residence	Overall	White	Other Races	Less than $50,000	$50,000 or more
North Carolina	94.8	95.1	94.1	91.9	98.0
Alamance	91.6	89.9	95.6	92.7	100
Davidson	89.9	91.8	80.3	89.0	99.0
Forsyth	94.9	95.4	93.0	92.4	95.6
Guilford	96.4	96.0	97.0	93.7	97.7
Randolph	92.4	92.1	94.0	91.1	96.9
Rockingham	NA				

Source: Behavioral Risk Factor Surveillance System (BRFSS), NC State Center for Health Statistics

However, mental health continues to be a significant issue for many residents of Guilford County where approximately 9.5 percent of those surveyed reported that their mental health was not good anywhere from 8–29 days of the past 30 days and an additional 3.6 percent whose mental health was not good 30 of the past 30 days.

Table 3. Number of Poor Mental Health Days in the Past 30 Days by County, 2010

Residence	Overall		White		Other Races		Less than $50,000		$50,000 or more	
	8-29 days	30 days	8-29 days	30 days	8-29 days	30 days	8-29 days	30 days	8-29 days	30 days
North Carolina	8.1%	5.9%	8.1%	6.1%	8.1%	6.9%	9.5%	9.0%	5.8%	2.9%
Alamance	8.5%	7.9%	11.5%	11.0%	2.1%	1%	9.2%	8.7%	0.9%	2.3%
Davidson	9.4%	10.4%	9.0%	12.4%	12.0%	1.1%	12.2%	12.5%	3.2%	3.7%
Forsyth	5.0%	6.1%	5.1%	5.4%	5.2%	8.2%	4.3%	8.2%	5.6%	3.5%
Guilford	9.5%	3.6%	8.4%	4.3%	11.8%	2.4%	12.9%	6.2%	7.9%	1.4%
Randolph	10.8%	8.0%	12.1%	9.1%	4.3%	2.4%	12.5%	8.6%	10.5%	0.5%
Rockingham	NA									

Source: Behavioral Risk Factor Surveillance System (BRFSS), NC State Center for Health Statistics

Though the majority of those surveyed reported obtaining the social support that they need, there are significant differences between white respondents and respondents with an income of $50,000 or more obtaining social support at greater rates.

Table 4. Percent Who Always or Usually Get the Social and Emotional Support They Need by County, 2010

Residence	Overall	White	Other Races	Less than $50,000	$50,000 or more
North Carolina	80.9	84.9	70.1	74.0	90.9
Alamance	80.8	82.4	76.4	76.2	92.6
Davidson	81.4	82.6	74.8	76.3	95.5
Forsyth	82.6	92.3	57.9	73.3	93.8
Guilford	84.4	89.8	74.0	73.0	92.7
Randolph	76.0	77.2	68.9	73.8	88.1
Rockingham	NA				

Source: Behavioral Risk Factor Surveillance System (BRFSS), NC State Center for Health Statistics

Poor mental health can at times result in suicide, as evidenced by the rates noted in Table 5. Once adjusted for age, mortality from suicide accounts for almost 10 percent per 100,000 in Guilford County. The rates are three times higher for whites with more than 13 percent of reported suicides compared to African-Americans at more than 3 percent. Overall, the suicide rates in the county are lower than that of the state.

Table 5. Mortality from Suicide, 2007-2011

Residence	Overall		Whites		African-American		Other	
	Number	Age-Adjusted Rate per 100,000	Number	Age-Adjusted Rate per 100,000	Number	Age-Adjusted Rate per 100,000	Number	Age-Adjusted Rate per 100,000
North Carolina	5,751	12.1	4,986	15.0	489	4.8	123	7.7
Guilford County	240	9.7	204	13.6	29	3.6	3	N/A

Source: State of North Carolina. Department of Health and Human Services. Division of Public Health. State Center for Health Statistics. Public Use Data Tapes of North Carolina Detailed Mortality.

Disparities in mental health are also evident among youth. While lower than the state average, 17 percent of middle school and 23 percent of high school students reported feeling sad or hopeless almost every day for two weeks or more in a row, which prevented them from doing typical

activities. These finds are reflective of the concerns expressed during the focus group interviews described below.

Table 6. Reported Feeling So Sad or Hopeless Almost Every Day for 2 Weeks or More in a Row That They Stopped Doing Some Usual Activities, 2011

Residence	Middle School Students		High School Students	
	Number	Percent	Number	Percent
North Carolina	1,645	24.0%	2,229	28.3%
Guilford County	463	17.2%	547	23.3%

Source: 2011-2012 Guilford County Youth Risk Behavior Survey, Guilford Education Alliance.

Youth reported various behaviors directly linked to issues in mental health, such as tobacco and alcohol use. Approximately 2 percent of middle school and 11 percent of high school students reported smoking cigarettes on more than one day in the past 30 days in Guilford County. For middle school students this rate was substantially lower than that of the state (7.6 percent), by about one-third. Guilford County high school students also reported lower rates of cigarette use compared to the state rate of almost 18 percent.

Table 7. Current Cigarette Use: Smoked Cigarettes on 1+ days in the past 30 Days, 2011

Residence	Middle School Students		High School Students	
	Number	Percent	Number	Percent
North Carolina	1,922	7.6%	2,217	17.7%
Guilford County	65	2.4%	264	11.4%

Source: 2011-2012 Guilford County Youth Risk Behavior Survey, Guilford Education Alliance.

High school students also report alcohol use at about 13 percent in the county compared to the more than 17 percent in the state.

Table 8. Binge Drinking in the Past Month: Had 5+ Drinks of Alcohol in a Row (Within a Couple of Hours) on 1+ of the Past 30 Days, 2011

Residence	High School Students	
	Number	Percent
North Carolina	2,207	17.6%
Guilford County	308	13.2%

Source: 2011-2012 Guilford County Youth Risk Behavior Survey, Guilford Education Alliance.

At times coping mechanisms are not sufficient, which is evident in the 6 percent of Guilford County middle school students who reported trying to kill themselves. More than 3 percent of high school students attempted suicide that resulted in an injury, poisoning or overdose and had to be treated by a doctor or nurse. While again the percentages are lower than the state average, the need for prevention is evident.

Table 9. Reported Suicide Attempts, 2011

	Ever Tried to Kill Themselves		Suicide Attempt During the Past 12 Months That Resulted in an Injury, Poisoning or Overdose That Had to Be Treated by a Doctor or Nurse	
Residence	**Middle School Students**		**High School Students**	
	Number	Percent	Number	Percent
North Carolina	1,905	9.5%	1,907	5.0%
Guilford County	171	6.4%	79	3.4%

Source: 2011-2012 Guilford County Youth Risk Behavior Survey, Guilford Education Alliance.

The discussed incidence of mental health issues demonstrates the need for services in Guilford County and reviews of existing programs and their effectiveness. Given the evident incidence of mental health issues and resulting service needs, it is critical to consider these factors in the context of the resources available to address mental health.

Mental health service provision issues in the county are difficult because there are a limited number of mental health providers. Mental health patients have to wait two or three months to see a psychiatrist; this wait can be even longer for children, adolescents and the uninsured. Due to the limited options for treatment of mental illness in Guilford County, mental health patients often have to seek treatment in emergency departments. As a consequence, emergency departments have become a location to hold patients needing mental treatment; thus, mental health patients have and continue to drain resources from emergency departments due to preventable readmissions and the overall amount of resources expended upon any one visit for their care. Community members and providers feel the need for a shift from government funding on stringent regulations to providing resources for mental health.

Providing and promoting free or affordable mental health service is critical, particularly for young people because it could mean preventing drastic occurrences such as school shootings. Generally mental health care means connecting with others so as to avoid isolation and loneliness. Oftentimes this connection was with other peers or individuals who have had a mental health diagnosis and not necessarily formal service providers. Those individuals typically had access to therapy but found that connections with peers made more of a difference in their lives because those peers were proactive and sought the person out whenever they would isolate themselves.

Access to Health Care

Inadequate access to health care was brought up in all focus group discussions. Specifically, the limited number of health care providers, health care costs and prescription medicine costs were cited.

Limited number of health care providers. There are a limited number of providers in Guilford County, particularly mental health providers. This shortage has resulted in a long wait for clients to ever get their first appointment and the co-pay is usually large (assuming a person even has insurance). Providers often encounter social work issues because the social work sector of the medical services is highly understaffed. The social work issues make the medical staff less efficient and less able to care for new patients or new challenges. Specifically, care cannot be provided when previous screenings are necessary but not affordable or accessible to the patients. There are resources available that provide access to care for low to no cost. However, there are a limited number of places that those in need can go to seek treatment with or without insurance outside the Mental Health Association in Greensboro. **Therefore, very specific issues cannot be addressed due to the limited number of resources.**

Health care costs. Patients are unable to afford the cost of health care and supplies. Many home foreclosures have stemmed from medical circumstances and health care costs. Many patients have to choose between health care costs and taking care of their families. **Therefore, many patients cannot seek treatment until they are in need of emergent care or have other resources**. Fear of health care costs causes patients to self-treat and delay care. Many patients suffer through illness

because they cannot afford acute or chronic treatment. Fear of health care costs also causes patients not to disclose all of their symptoms with the doctor for fear of higher doctor fees and co-pays. Additionally, many patients cannot obtain health care services due to high deductibles. Those who also have access to COBRA when employment is lost cannot afford to pay with no income.

Prescription medicine costs. Because the cost of prescription medicine is often too high for patients who need it, this often results in hospital readmissions for serious illness. Current medical assistant systems should be expanded to better cover the cost of prescription medicine. Some patients have expressed that they do not necessarily want prescription medications to solve their problems. **Patients would like to be examined holistically before medications are prescribed. Mental health patients particularly feel that mental health practitioners appear to be rushing to prescribe medicine without thorough examination.**

Health Prevention and Promotion

One way to at least partly address access to care needs is to consider the needs and assets in preventive care, which is often most cost efficient.

Preventative care. There is a health care shift from treatment to preventative care. However, preventative care is limited among marginalized populations, although the need continues to be great. Care in the community is necessitated by issues with transportation in Guilford County. Patients often deter care and miss scheduled appointments because they do not have transportation to their provider's office. Time restraints on providers affect their ability to stay current on best practices. As a result, providers do not have time to attend best practice workshops or research information on their own. Patients often have a long wait period for appointments, which are often during daytime work hours. This is an obstacle for patients who work during the day. Further, patients who do not have access to preventative care have no choice but to seek treatment in the emergency department (ED). Those who seek treatment in the ED often are unable to obtain additional help following their discharge. This results in recurring treatment in the ED or a lack of treatment altogether. **Lack of awareness and stigmatization has deterred patients and their families from seeking medical treatment, particularly in mental health. There is a need to educate the community as a whole on preventative care and mental illness. This is especially important as lesser stigma would allow for the identification and active seeking of support around mental health.**

Outpatient care. There is limited support for outpatient care as a result of decreased funding. When acute mental health issues turn out to be more severe, due to lack of care, these individuals end up in the ER. Public assistance with these issues is greatly limited and the need is growing. Mental health service issues cannot be solved by providers at the ground level but must start larger so that seeing a therapist is not considered a luxury or shameful. While mandates have been imposed upon the state, there is no existing financial support to uphold those mandates. This specifically includes the Critical Access to Behavioral Health program for which there is little support. Even for service sites that have behavioral health built in, such as Wesley Long Hospital, there is still a constant 24-hour overflow because the resources do not meet the demands. Patients end up waiting two to three weeks to get a psychiatric bed. This could save money on health care costs in the long run. Transitional care could provide the necessary support to prevent readmissions. There is a need for health care professionals to follow up with discharged patients to confirm whether discharged patients are keeping their outpatient appointments. Previously, doctors used to have to see patients

after visiting the ER. However, this requirement has changed and community members believe this should be reinstated.

Any and all services should also be considerate of the working hours kept by employed individuals and offer services accordingly so they may obtain much needed services. This is particularly true for those individuals who, if they do not receive services, are likely to struggle and/or lose their employment and any potential benefits received.

Special Populations and Foci

In addition to service provision there are several other components that must be considered in an effort to maximize mental health provision planning and implementation. In addition to existing resources, several special populations in need of services should also be taken into account in the scope of priority health challenges.

Community members identify budget cuts as priority health challenge. As a result of budget cuts, services are being cut for clients. This lessens the available resources in Guilford County. Prevention efforts should start to consider this new health challenge with a focus on the best use of funding to provide the most cost-effective care more widely.

Overall, **efforts need to be made to educate the public as well as the medical communities about mental health toward lessening the stigma surrounding it**. Alongside education, mental health screenings should be offered broadly, particularly in places of employment. Additionally, if supervisors at jobs recognize that an employee may be having a mental health issue, they should be able to accommodate this, particularly as some jobs offer insurance benefits but do not create the circumstances in which those benefits can be utilized. **This is especially important as many persons struggling with mental health issues eventually become unemployed due to lack of support and resources needed to deal with the issues effectively.**

Health educators and congregational nurses in particular should continue to be supported and funded as mental health service providers/screeners. **Though formal mental health provision through a therapist and psychiatrist is still necessary, community members note oftentimes not having the funds to seek out this assistance.** As such health educators and nurses serve as accessible providers which may prevent future admittance to the ER. This is especially true given that an estimated 60 percent of the persons receiving mental health services live 200 percent below the poverty line. As such, following the MHAG Benefit Bank model, free public assistance eligibility clinics can be held to ensure that those struggling with resources, particularly due to their mental health struggles, are able to get assistance if they qualify.

Immigrant health challenges. Language barriers among immigrant populations limit optimal health care. There are more than 154 different languages spoken in the Triad. Language and cultural barriers have also led to medical mistrust. This leads to deterrence of health care. Additionally, it is difficult to understand the health care needs of immigrant populations when there is a language barrier. Language barriers have also restricted immigrant populations, such as the Vietnamese, from flourishing economically and have led to consistent poverty.

Immigrant populations that are uninsured do not have access to any care and are likely to suffer dire economic consequences in the event of major illness. Since undocumented workers have no source of preventative care, their options when seeking care are limited to the use of emergency

departments and/or community clinics. The Affordable Care Act does not give undocumented immigrants access to health insurance. Furthermore, current resources require patients to enroll in government-sponsored health insurance, which undocumented patients fear will lead to deportation. The State of North Carolina will have to determine how to best handle undocumented immigrants who lack insurance coverage.

Health disparities. Health determinants were defined as access to income, education and help. Health determinants were considered to center on employment with a living wage and access to benefits. Unemployment and underemployment reduces access to health insurance and without insurance health care options are limited. Participants expressed the perception that it is not as important to access medical care when you are homeless and poor. There is a belief that physicians and health care providers are not aware of socioeconomic disparities and their influences on determinants of health. Additionally, patients with low incomes indicated that they wanted to be treated with respect by all members of the medical service sector, from persons processing payments to the medical doctors themselves.

Maternal and child health care. Hospitals and community organizations should provide meeting places that are child friendly to increase mothers' participation in health classes, community meetings and health care. Mothers may be burdened by lack of child care and may feel more comfortable bringing their children with them while they attend classes or obtain care. Subsidized services can be promoted for those who do not have insurance or are underinsured.

Depression and bipolar disorder are common among new mothers. As such, mental health services must be adequately addressed and funded so that with proper treatment those mothers are able to continue providing adequate care to their children. Furthermore, mental health issues among children are difficult to diagnose and treat. Providers may not be adequately trained to diagnose and treat mental health concerns; however, they are still expected to proceed with treatment. This is often with limited resources available to the child and his or her family.

Special populations. Generally, public awareness and education about resources and services are needed particularly among certain African-American communities, men and military veterans. There is a perception that these groups may feel that there is no social space for them to experience mental illness. This results in persistent mental health stigma and deters seeking care. In addition, immigrants were noted as needing particular assistance and discussions about seeking services around mental health.

Because the number of individuals with substance abuse and mental health issues in prisons is rather high, it seems critical to first address issues of substance abuse in general and find resources to deal with them so that mental health is not jeopardized. Services and prevention/educational materials should be tailored to different populations, such as women. The system of care approach, which involves the prison, law enforcement and health care systems, was recommended.

Guilford County Priority Health Issues

The process of prioritizing health issues for the community health needs assessment involved several steps. The first step included a community prioritization process. Participants at five community meetings in Guilford County, two meetings outside of Guilford County but within the

hospital partner service areas (Reidsville in Rockingham County and Archdale/Trinity in Randolph County) as well as participants in an online survey reviewed data on a set of indicators of Morbidity and Mortality, Health Behaviors, Clinical Care, Social and Economic Factors, and Environmental Factors. The prioritization form reproduced below was utilized for the community meetings to rank health issues.

Figure 3. 2012 Community Health Assessment Health Issue Prioritization

2012 Community Health Assessment
Health Issue Prioritization

Your input is needed in order to help identify health-related issues that are of greatest importance to the health of community residents. Priority health issues will be addressed through a community action planning process. For each of the following health issues please circle a number from 1-5, where 1 = little importance and 5 = extremely important.

Health Issues	Little Importance	Somewhat Important	Moderate Importance	Very Important	Extremely Important
Morbidity and Mortality					
1. Premature death	1	2	3	4	5
2. Chronic disease mortality	1	2	3	4	5
3. Poor or fair health	1	2	3	4	5
4. Poor physical health days	1	2	3	4	5
5. Poor mental health days	1	2	3	4	5
6. Low birth weight babies	1	2	3	4	5
Health Behaviors					
7. Adult smoking	1	2	3	4	5
8. Adult obesity	1	2	3	4	5
9. Physical inactivity	1	2	3	4	5
10. Excessive drinking	1	2	3	4	5
11. Sexually transmitted infections	1	2	3	4	5
12. Motor vehicle crash death rate	1	2	3	4	5
13. Teen birth rate	1	2	3	4	5
Clinical Care					
14. Uninsured	1	2	3	4	5
15. Primary care physicians	1	2	3	4	5
16. Preventive Hospital Stays	1	2	3	4	5
17. Diabetic Screening	1	2	3	4	5
18. Mammography Screening	1	2	3	4	5
Social and Economic Factors					
19. High school graduation	1	2	3	4	5
20. Completed some college	1	2	3	4	5
21. Unemployment	1	2	3	4	5
22. Children in poverty	1	2	3	4	5
23. Inadequate social support	1	2	3	4	5
24. Children in single-parent families	1	2	3	4	5
25. Violent crime rate	1	2	3	4	5
Physical Environment					
26. Air pollution particulate matter days	1	2	3	4	5
27. Air pollution ozone days	1	2	3	4	5
28. Access to recreational facilities	1	2	3	4	5
29. Limited access to healthy food	1	2	3	4	5

30. Fast food restaurants	1	2	3	4	5

The results of the community ranking are as follows (Overall N = 158):

Table 10. Community Ranking Results

Health-Related Issue	Average Score	Rank
Child poverty	4.61	1
Unemployment	4.52	2
Adult obesity	4.48	3
Lack of health insurance	4.42	4
Low access to healthy food	4.39	5
Chronic disease	4.36	6
Violent crime	4.29	7
Lack of physical activity	4.23	8
High school graduation	4.22	9
Sexually transmitted infections	4.18	10
Low birth weight	4.12	11
Primary care physicians	4.11	12
Teen births	4.1	13
Adult smoking	4.04	14
No social support	4.02	15
Fair or poor self-rated health	3.97	16
Premature mortality	3.95	17
Fast food restaurants	3.93	18
Diabetic screening	3.9	19
Air quality ozone days	3.89	20
Excessive drinking	3.88	21
Mammographic screening	3.87	22
Preventable hospital stays	3.79	23
Poor self-rated mental health days	3.77	24
Recreation	3.76	25
Single-parent households	3.75	26
Air quality particulate matter days	3.7	27
Poor self-rated physical health days	3.67	28
Completed some college	3.59	29
Motor vehicle mortality	3.59	30

To gain additional perspective on the health issues facing the community health needs assessment area, a panel of 11 public health professionals from the Guilford County health department and academic researchers and graduate students from UNCG met to prioritize health issues using the

Hanlon prioritization method. The issues that were included were based on issues that rose to the top from the community prioritization. The results of the Hanlon prioritization are as follows:

Table 11. Hanlon Prioritization Ranking

Hanlon Prioritization Ranking	
Health-Related Issue	**Priority Ranking**
Chronic Disease	1
Teen Pregnancy	2
Obesity, Nutrition and Physical Inactivity	3
Sexually Transmitted Infections	4
Tobacco Use	5
Access to Healthy Food	6
Poor Birth Outcomes	7
Access to Clinical Care	8
Violent Crime	9
Poverty and Unemployment	10

The leading issues that emerged from the community prioritization are shown in the table below.

Table 12. Community Prioritization Ranking—Top Ten Issues

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

Table 13. Synthesizing Community Rankings and Hanlon Rankings

Community Ranking (Top Ten Issues)	Hanlon Ranking (Top Ten Issues)	Priority Health Issues
Health Outcomes: Morbidity and Mortality		
(6) Chronic Disease	(1) Chronic Disease	**Chronic Disease** Includes Risk Factors: Obesity, Nutrition, Physical Activity and Tobacco Use
(10) Sexually Transmitted Infections	(4) Sexually Transmitted Infections	**Sexually Transmitted Infections**
	(7) Poor Birth Outcomes	**Healthy Pregnancy** Includes Risk Factors: Teen Pregnancy and Healthy Behaviors
Health Behaviors		
(3) Obesity	(3) Obesity, Nutrition and Physical	

(8) Physical Activity	Activity	
	(2) Teen Pregnancy	
	(5) Tobacco Use	
Clinical Care		
(4) Lack of Insurance	(8) Access to Clinical Care (includes physical and mental health and lack of insurance)	Access to Clinical Care
Social and Economic Factors		
(1) Poverty	(10) Poverty and Unemployment	Poverty and Unemployment
(2) Unemployment		
(7) Violent Crime	(9) Violent Crime	Violent Crime
(9) Education Attainment		
Environmental Factors		
(5) Access to Healthy Food	(6) Access to Healthy Food	Access to Healthy Food

Major Needs and Establishing Priorities

Cone Health Priorities

The community rankings are representative of the priority areas deserving attention as rated by Guilford County residents attending open meetings. At these community meetings health data was presented and community members were asked to prioritize community health issues. These findings were compared to the Hanlon rankings and a merged set of priority health issues was determined. Cone Health held a meeting with presidents and vice presidents of individual hospital sites located in Guilford County to discuss the prioritized health challenges. Of the top priority health issues in Guilford County (chronic disease, sexually transmitted infections, healthy pregnancy, access to clinical care, poverty and unemployment, violent crime, and access to healthy food), Cone Health decided it was feasible to focus on four primary health issues. These issues are:

1. access to clinical care for minority populations
2. mental health and substance abuse
3. healthy pregnancy
4. obesity

These top priorities were selected in accordance to community need, clinical impact and strategic fit. Community need was determined through health priorities identified through the overall Guilford County Community Health Assessment. All of the Cone Health priorities were identified as top priorities within Guilford County. Priorities were also determined with regard to clinical impact, particularly for minority populations. This includes increasing access to health services and the availability of health care providers willing to accept Medicaid and Medicare. This also includes support for services to promote health and disease prevention. Obesity was considered a precipitator of chronic disease; therefore, it was identified as an area of focus. Enhancing programs and services that focus on obesity is believed to reduce chronic disease among patients. Priorities were also selected based on strategic fit within the mission, values and goals of Cone Health. Two hospital sites within Cone Health will lead initiatives to address selected health priorities. Behavioral Health Hospital will lead collaborative efforts with mental health organizations within the Cone Health catchment area to enhance mental health services and programming for residents. Women's

Hospital will lead efforts to improve the number of healthy pregnancies through collaboration with community partners in addition to enhancing pregnancy-related programs and services.

Priority Needs Not Addressed and Reasons Why

Several priorities were identified by the overall Guilford County health assessment that were not selected as priorities for Cone Health. These priorities were sexually transmitted infections, poverty and unemployment, violent crime, and access to healthy food. Several community agencies within the Cone Health catchment area have services and programs directly targeting these priorities. Cone Health is aware of these ongoing efforts by community agencies. By focusing on the selected priorities above, Cone Health seeks to provide efforts to reduce the gaps in the current services and programs in the catchment area.

Sexually Transmitted Infections
The Cone Health Foundation, a supporting organization to Cone Health, provides grants and other support to reduce the burden of HIV/AIDS and other sexually transmitted diseases. The Guilford County Department of Public Health, Piedmont Health Services and Sickle Cell Agency, and the Triad Health Project strengthen these efforts. Combined, these agencies offer HIV and sexually transmitted diseases infection counseling, free and confidential testing and treatment for syphilis, gonorrhea and chlamydia, and HIV testing and referral services.

Poverty and Unemployment
Community agencies such as the Employment Security Commission, Guilford County JobLink Center and Vocational Rehabilitation Office work to reduce poverty and unemployment within the Cone Health catchment area. These organizations provide unemployment compensation, job resources and training, and access to employment opportunities.

Violent Crime
There are a number of community organizations dedicated to reducing crime within the Cone Health System catchment area. For example, the Juvenile Crime Prevention Council in Guilford County provides crime prevention efforts for juveniles at risk of becoming delinquent, community-based alternatives to training schools, and substance abuse prevention programs for youth. Additionally, programs such as the Criminal Justice Partnership and the Day Reporting and Restitution Center offer prevention programs to reduce recidivism, probation revocation and substance abuse among offenders.

Access to Healthy Food
Lastly, Guilford County Cooperative Extension, the Edible Schoolyard Project, Food Assistance, Inc., FoodCorps, Inc., and the Greensboro Urban Ministry are community agencies that focus on increasing food access and providing nutrition education to community members. These organizations work to increase access to healthy food within the catchment area.

Community Assets

The following is a list of available community assets for mental health and substance abuse issues.

Mental Health Association in Greensboro. The Mental Health Association in Greensboro was established in 1940 and is a community partner of United Way of Greater Greensboro. The association conducts programs that promote better mental health, provides support to those who suffer from mental illness and strives to reduce the stigma associated with mental illness through education and service.

Center for Behavioral Health and Wellness. The mission of the Center for Behavioral Health and Wellness is to "provide community-focused, evidence-based and culturally competent behavioral health services through the integration of best practice research, training and technical assistance. The community is served by providing community-based assessment and treatment services, including both mental health and substance abuse services for individuals and families across the lifespan," (NCA&T CBHW, 2011). The Center for Behavioral Health and Wellness also provides applied research and evaluation expertise in partnership with community-based agencies while offering training opportunities to community-based providers, building the capacity to deliver evidence-based services.

Sandhills Center. The Sandhills Center provides management and oversight of mental health, intellectual/developmental disabilities and substance abuse services in the nine-county catchment area. Upon its merger with the Guilford County Center, it maintains a local presence in Guilford County, providing service management and oversight functions to include care coordination and ensuring 24-hour access to services.

Table 14. List of Community Assets in Mental Health and Substance Abuse

Resource	Description
Mental Health Association in Greensboro	Wellness Academy classes (including writing, cooking and self-esteem courses)
A&T Center for Behavioral Health and Wellness	Community-based assessment and treatment services for mental illness and substance abuse
Cone Health Behavioral Health Hospital	Adolescent and adult outpatient and inpatient services
Sandhills Center	Psychiatric services
Partnership for Health Community Care	Offers access to TAPM, internal medicine, family practice and adult dental clinic with Orange Card
Planet Fitness	Affordable stress management through physical activity
Ginger Mitchel Firm	Referral service for persons needing medications
Guilford Transportation	Offers transportation for those with Medicaid
Benefit Bank	Food stamp assistance and taxation assistance
Interactive Resource Center	Day resource center for the homeless
Medicaid/DHSS	Providing assistance needed for those who are unable to work
Parks and Recreation	Provide much needed resources for physical activity which many mental health clients require
Women's Resource Center	Provides services to women needing assistance, particularly when in abusive living conditions; make referrals as needed
Congregational Nurses	Offer screenings and referrals for services based on the patient's needs
Private Therapists	Care providers clients are able to access privately through insurance or by paying out of pocket

Community members were largely unaware of resources available and how to navigate between them. There is a need for health care providers to be trained on issues such as substance abuse and mental health. Community members perceive that health care providers are unaware of mental health services and resources in the area.

Though other services exist, aiding participants with resources and services that assist with fulfilling daily life and family needs were strongly desired and/or appreciated. Employment services, food assistance, as well as several other resources were cited as services used by many mental health clients. The Interactive Resource Center and the Mental Health Association in Greensboro were especially noted as positive change agents in the community that provided much needed resources to individuals dealing with mental health issues. Specifically, the Mental Health Association in Greensboro offers a Benefit Bank and a free public assistance eligibility clinic that aids individuals unable to work or keep full-time jobs due to mental health issues. These associations in particular should be sought out as community partners when addressing mental health and substance abuse issues.

Community members in Guilford County experienced difficulty accessing health information and clinics among other health care resources. It is difficult for patients to access the services/resources they need, in part, due to uncoordinated efforts. One area of particular concern is eligibility requirements that deny resources to individuals once employment has been established. Requirements such as these can cause clients to stop seeking care in addition to leading to financial setbacks and hardship once employed. It is important to note that community resources do exist, but mental health clients are not always cognizant of available services. Coordinated service and resource efforts amongst community partners could assist with this challenge.

A general lack of funding for services and resources was cited throughout Guilford County. Due to limited resources, there is a need to prioritize the allocation of resources. Funding should be directed toward long-term health outcomes as opposed to short-term objectives.