

Cone Health Women's Hospital

Community Health Needs Assessment 2013

In Partnership With
The Guilford County Health Department
&
The Center for Social, Community and
Health Research and Evaluation

**Women’s Hospital
Community Health Needs Assessment Report and Implementation Plan**

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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. The 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, 2012). 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 the 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 Mroska, a community health educator with the health department since 1999. During that time, Mroska 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 Women's Hospital

The information on the communities served by Women's Hospital was gathered based on publicly accessible notification of services provided by the organization. The existing services are reflective of the needs in the county for persons accessing health care. Based on data reported specifically in the results, it is evident that gaps in services speak to the capacity of existing services rather than any altogether missing components.

Women's Hospital provides specialized care to women of all ages and infants who have special needs through the Level II and Level III Neonatal Intensive Care Unit. Women's Hospital provides care to residents of Davidson, Forsyth, Randolph and Rockingham Counties but primarily services residents of Guilford County. Guilford County, once an industrial center, has seen large declines in the manufacturing of textiles, apparel and furniture. Currently, Guilford County Public Schools is the 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 2006–2008. Between 2007 and 2011, it was estimated that 16.1 percent of individuals are 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 synthesized 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 (DRGs) with the greatest number of hospitalizations were also collected.

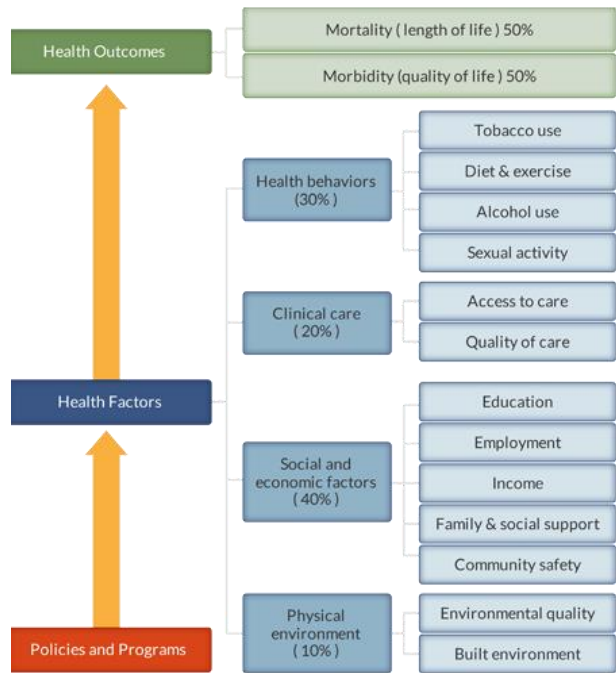
County Health Rankings

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



County Health Rankings model ©2012 UWPHI

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 the focus group discussions at corresponding hospitals. This allowed for each focus group topic guide to be tailored based on the suggestions and feedback of the key informant for each respective hospital. Key informants helped frame the 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 then 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 CSHRE 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 CSHRE 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 representing 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.

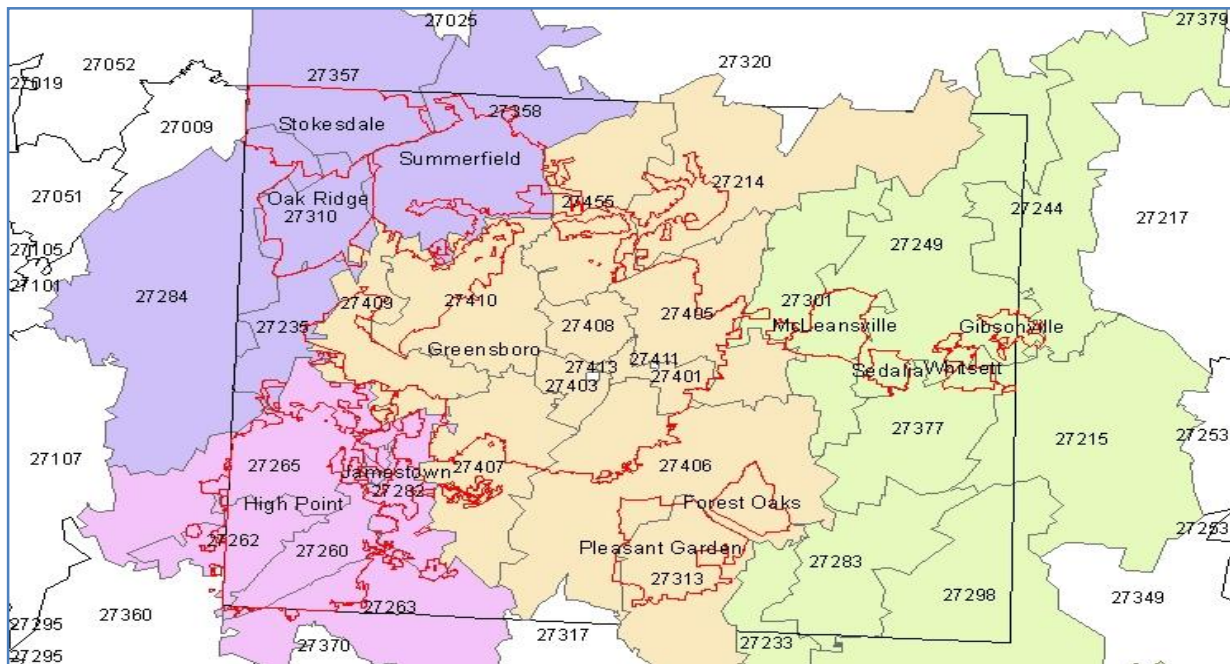
Three focus groups addressed special health care topics, including mental health and women's health issues. One group was held at Behavioral Health Hospital administrative offices with staff social workers, administrative staff and congregational nurses, in addition to providers from the Mental Health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



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 the 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, the 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, and 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 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 from persons 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 Women's Hospital

Various health and health care issues exist for women in Guilford County. These issues are primarily informed by the environmental realities of access challenges. Focus group participants discussed challenges with breastfeeding, attending programs with children, and breast and cervical programs. Next, statistics are provided on teen pregnancy rates, preterm and low birth weight infants, and infant mortality. Lastly, immigrant and refugee women's health issues are discussed.

Healthy Pregnancy Program Challenges

Among mothers there is a continued need to encourage breastfeeding or give breast milk to their babies. While Women's Hospital promotes breastfeeding, many women felt that they did not receive the support they needed to breastfeed after hospital discharge. It was also stated that many of the peri-pregnancy classes offered were not child friendly. Hospitals and community organizations should provide child-friendly meeting places to increase mothers' participation in health classes, community meetings and health care in general. 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. The YWCA has a teen program that supports pregnant and parenting teens that can be modeled and expanded to provide more support for vulnerable mothers. Participants also mentioned that breast and cervical cancer programs should be promoted for those without health insurance or those who are underinsured. Community members feel that heart disease among women also needs more attention and that Women's Hospital could possibly play a bigger role in preventing heart disease among women.

Teen Pregnancy

Teen pregnancy rates were highest in Randolph County and lowest in Guilford County. A significant racial disparity is seen statewide, with rates for blacks twice as high as for whites. The highest teen pregnancy rates were for Hispanic females; the highest Hispanic rates were in Davidson County.

The greatest racial disparities between white and black women exist in Guilford and Forsyth Counties.

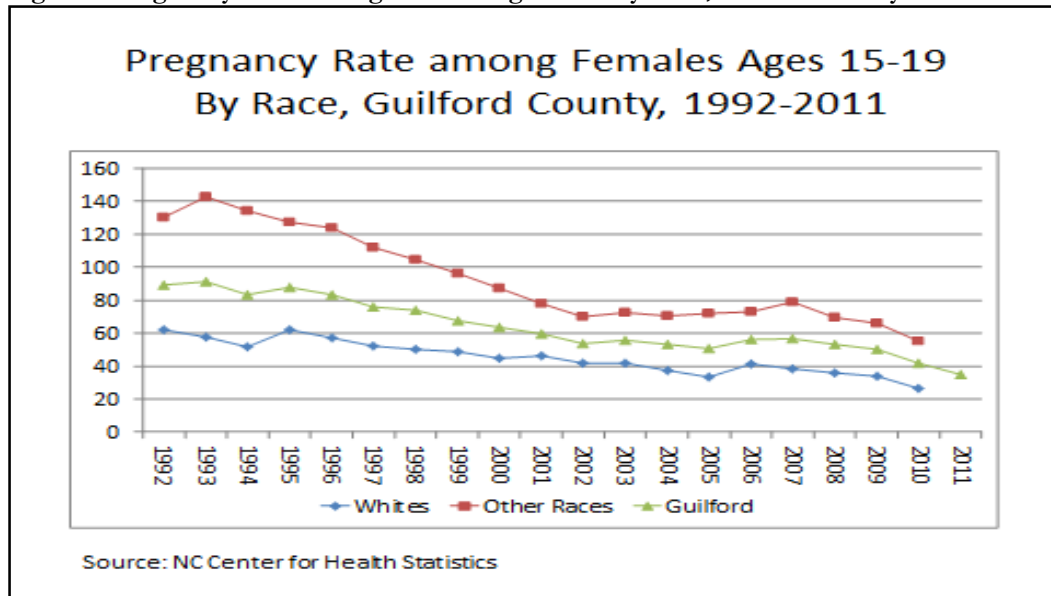
Table 2. NC Resident Pregnancy Rates per 1,000 Females Ages 15-19 by Race and Ethnicity, 2007-2011

| County | Total Rate | White Non-Hispanic | Black Non-Hispanic | Other Non-Hispanic | Hispanic |
|----------------|------------|--------------------|--------------------|--------------------|----------|
| North Carolina | 43.8 | 30.8 | 61.6 | 39.4 | 71.1 |
| Alamance | 38.6 | 30.2 | 49.9 | 8.5 | 66.7 |
| Davidson | 44.5 | 36.9 | 47.3 | 68.0 | 102.4 |
| Forsyth | 43.9 | 21.5 | 60.5 | 32.1 | 81.7 |
| Guilford | 35.6 | 15.8 | 54.4 | 26.6 | 57.8 |
| Randolph | 54.7 | 47.3 | 78.5 | 35.7 | 85.2 |
| Rockingham | 38.8 | 38.3 | 34.6 | 30.3 | 52.4 |

Source: NC County Health Databook, NC State Center for Health Statistics.

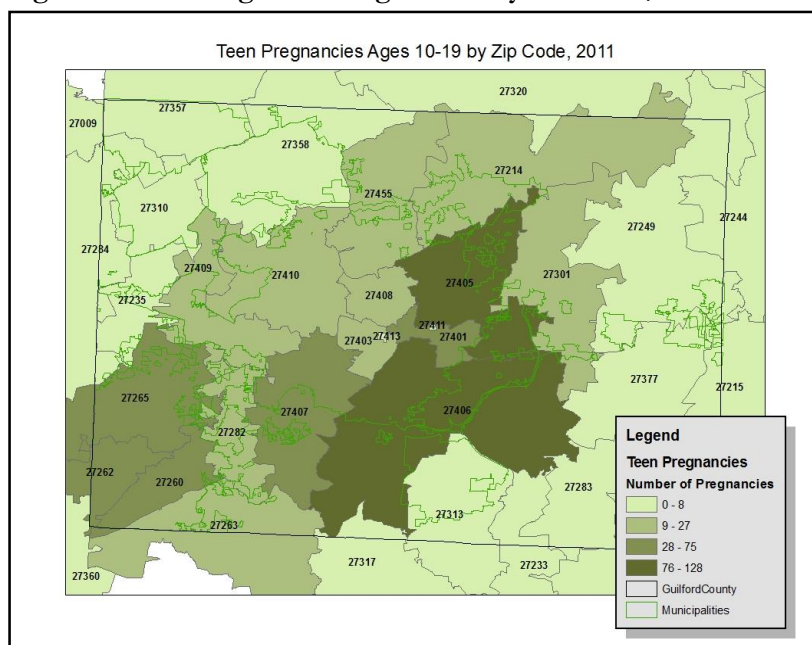
The significant racial disparity in teen pregnancy persists but has been reduced from levels seen in the 1990s. The teen pregnancy rate in Guilford County declined steadily during the past 20 years, from about 90 per 1,000 teens ages 15–19 (and 140 per 1,000 among African-Americans) in 1993 to less than 40 per 1,000 in 2011. It is evident that though pregnancy rates have decreased among women 15–19 over time, the rates continue to be the lowest for whites. Guilford County overall continues to be above the average rates of whites.

Figure 3. Pregnancy Rate Among Females Ages 15-19 by Race, Guilford County 1992-2011.



Teen pregnancies are fewest in ZIP codes in the northwest and southeast suburban and rural areas of Guilford County. The numbers of teen pregnancies are highest in ZIP codes in areas of the county with higher proportions of marginalized and lower-income residents.

Figure 4. Teen Pregnancies Ages 10-19 by ZIP code, 2011



Source: NC Center for Health Statistics; Map prepared by the Guilford County Department of Public Health

Preterm Birth and Low Birth Weight

Statewide, major racial disparities exist for both low birth weight and very low birth weight, with rates for low birth weight being about a third higher for black babies than white. The highest rate of low birth weight is in Forsyth County, followed by Davidson and Guilford. It should be noted that the highest rates among blacks are found in Forsyth and Davidson counties.

Table 3. NC Resident 2007-2011 Percent of Low Weight (Less than 2500 grams) Births by Race and Ethnicity, by County

| Residence | Total | White, Non-Hispanic | Black, Non-Hispanic | Other, Non-Hispanic | Hispanic |
|----------------|-------|---------------------|---------------------|---------------------|----------|
| North Carolina | 9.1 | 7.7 | 14.3 | 9.4 | 6.5 |
| Alamance | 9.4 | 8.3 | 14.9 | 14.2 | 6.8 |
| Davidson | 9.6 | 9.4 | 15.5 | 9.3 | 6.8 |
| Forsyth | 10.4 | 8.4 | 16.6 | 9.9 | 7.2 |
| Guilford | 9.6 | 7.5 | 12.8 | 10.1 | 6.9 |
| Randolph | 8.5 | 8.7 | 12.8 | 11.4 | 6.2 |
| Rockingham | 9.5 | 8.7 | 14.3 | 8.5 | 6.5 |

Source: NC County Health Data Book, 2013; NC State Center for Health Statistics

Trends are similar for very low birth weight such that the highest rates are found in Guilford and Forsyth counties, and black babies represent the highest rates.

Table 4. NC Resident 2007-2011 Percent Very Low Weight (Less than 1500 Grams) Births by Race and Ethnicity, by County

| Residence | Total | White, Non-Hispanic | Black, Non-Hispanic | Other, Non-Hispanic | Hispanic |
|----------------|-------|---------------------|---------------------|---------------------|----------|
| North Carolina | 1.8 | 1.3 | 3.3 | 1.5 | 1.2 |

| | | | | | |
|------------|-----|-----|-----|-----|-----|
| Alamance | 1.8 | 1.5 | 3.4 | 2.7 | 1.0 |
| Davidson | 1.5 | 1.4 | 3.4 | 0.9 | 1.0 |
| Forsyth | 2.2 | 1.4 | 4.2 | 1.1 | 1.6 |
| Guilford | 2.2 | 1.4 | 3.2 | 1.2 | 1.8 |
| Randolph | 1.5 | 1.4 | 2.7 | 1.7 | 1.3 |
| Rockingham | 1.9 | 1.7 | 3.1 | 1.7 | 1.0 |

Source: NC County Health Data Book, 2013; NC State Center for Health Statistics

Infant Mortality

Despite medical advances, infant mortality continues to be a noteworthy issue in women's health. A Spanish-speaking resident without a medical home felt that she lost her baby for unnecessary reasons. This participant lost her baby during pregnancy as a result of an infection. She had previously visited the emergency department multiple times and received treatment for inflammation of her abdomen, but she felt that she was not examined thoroughly. Eventually she was seen by a private physician, and the participant ultimately had to have a hysterectomy as a result of the infection.

Statewide, the black fetal mortality rate is more than twice as high as that of whites; the Hispanic rate is close to that of whites. The highest fetal mortality rates are in Guilford, Rockingham and Alamance counties.

Table 5. NC Resident 2007-2011 Fetal Death Rates per 1,000 Deliveries, by County

| Residence | Total Fetal Deaths | Total Fetal Death Rate | White Fetal Death Rate | African-American Fetal Death Rate | Hispanic Fetal Death Rate | Non-Hispanic Minority Fetal Death Rate |
|----------------|--------------------|------------------------|------------------------|-----------------------------------|---------------------------|--|
| North Carolina | 4,119 | 6.5 | 4.9 | 11.7 | 4.7 | 4.7 |
| Alamance | 61 | 6.4 | 5.2 | 10.0 | 5.4 | 13.2 |
| Davidson | 44 | 4.7 | 3.6 | 14.3 | 4.0 | 4.6 |
| Forsyth | 120 | 4.9 | 3.5 | 8.9 | 3.0 | 4.8 |
| Guilford | 218 | 7.0 | 4.7 | 10.9 | 4.5 | 3.6 |
| Randolph | 48 | 5.5 | 5.3 | 6.2 | 5.5 | 11.2 |
| Rockingham | 35 | 6.9 | 4.9 | 13.4 | 8.7 | 0 |

Source: NC County Health Data Book, 2013, NC State Center for Health Statistics.

Statewide the neonatal mortality rate (death less than 28 days after birth) is more than the post-neonatal mortality rate (28 days to 1 year, Table 7), as most infant deaths occur in the first month after birth. Neonatal mortality rates are highest in Guilford and Forsyth counties, but post-neonatal rates are highest in Davidson County.

Table 6. NC Resident 2007-2011 Neonatal (<28 Days) Death Rates per 1,000 Live Births, by County

| Residence | Total Neonatal Deaths | Total Neonatal Death Rate | White Neonatal Death Rate | African-American Neonatal Death Rate | Hispanic Neonatal Death Rate | Non-Hispanic Minority Neonatal Death Rate |
|----------------|-----------------------|---------------------------|---------------------------|--------------------------------------|------------------------------|---|
| North Carolina | 3,298 | 5.2 | 3.7 | 9.8 | 4.2 | 3.8 |
| Alamance | 42 | 4.4 | 4.3 | 6.9 | 2.3 | 8.9 |
| Davidson | 39 | 4.2 | 3.6 | 10.1 | 2.4 | 9.3 |
| Forsyth | 169 | 6.9 | 4.1 | 14.4 | 4.2 | 23.8 |
| Guilford | 218 | 7.1 | 4.2 | 11.1 | 6.7 | 2.0 |

| | | | | | | |
|------------|----|-----|-----|------|-----|------|
| Randolph | 43 | 5.0 | 5.2 | 8.3 | 3.9 | 0 |
| Rockingham | 33 | 6.6 | 5.5 | 11.5 | 3.5 | 16.9 |

Source: County Health Data Book, 2013, NC State Center for Health Statistics.

The racial disparities continue throughout the various maternal and child health indicators, including post-neonatal health, with whites persistently having the lowest rates of poor health outcomes.

Table 7. NC Resident 2007-2011 Post Neonatal (28 Days – 1 Year) Death Rates, by County

| Residence | Total Post-Neonatal Deaths | Total Post-Neonatal Death Rate | White Post-Neonatal Death Rate | African-American Post-Neonatal Death Rate | Hispanic Post-Neonatal Death Rate | Non-Hispanic Minority Post-Neonatal Death Rate |
|----------------|----------------------------|--------------------------------|--------------------------------|---|-----------------------------------|--|
| North Carolina | 1,601 | 2.6 | 2.0 | 4.5 | 1.6 | 2.4 |
| Alamance | 24 | 2.6 | 2.2 | 3.7 | 1.8 | 9.0 |
| Davidson | 34 | 3.7 | 3.3 | 5.6 | 4.8 | 0 |
| Forsyth | 79 | 3.3 | 2.7 | 5.9 | 1.7 | 0 |
| Guilford | 71 | 2.3 | 1.4 | 3.6 | 1.4 | 2.6 |
| Randolph | 18 | 2.1 | 2.3 | 4.2 | 1.1 | 0 |
| Rockingham | 14 | 2.8 | 1.8 | 8.4 | 0 | 0 |

Source: NC County Health Data Book, 2013; NC State Center for Health Statistics.

Infant mortality rates in North Carolina are at historically low levels. However, the racial disparities are especially evident here. Five-year infant mortality rates are highest in Forsyth, Guilford and Rockingham counties. African-American rates are highest in Forsyth and Rockingham counties. Hispanic rates tend to be comparable to that of whites.

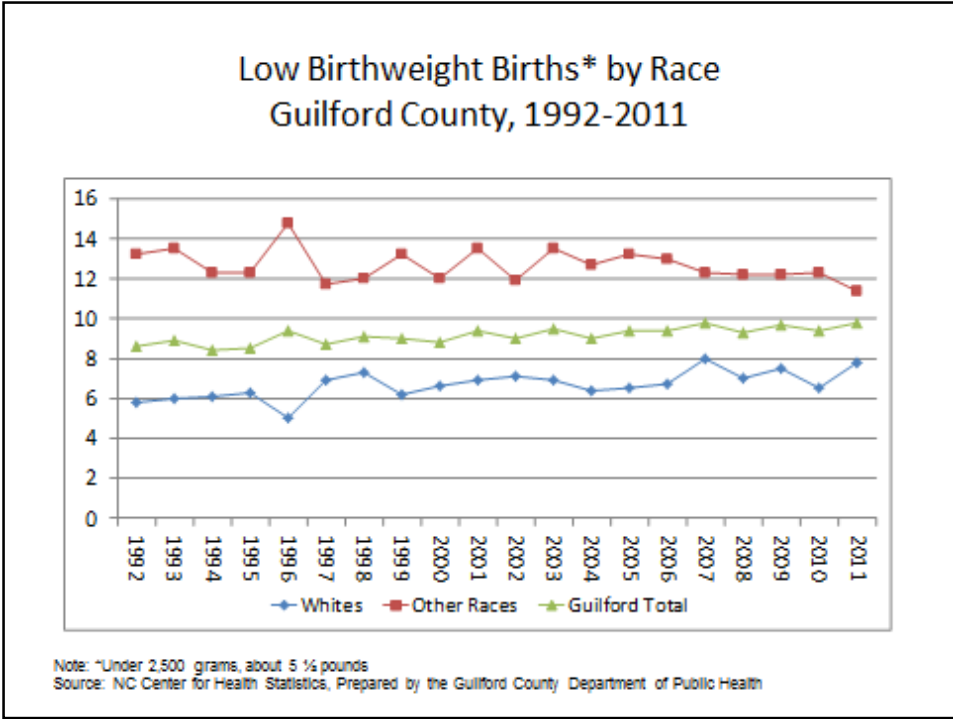
Table 8. NC Resident 2007-2011 Infant (<1 Year) Death Rates per 1,000 Live Births, by County

| Residence | Total Infant Deaths | Total Infant Death Rate | White Infant Death Rate | African-American Infant Death Rate | Hispanic Infant Death Rate | Non-Hispanic Minority Infant Death Rate |
|----------------|---------------------|-------------------------|-------------------------|------------------------------------|----------------------------|---|
| North Carolina | 4,899 | 7.9 | 5.7 | 14.3 | 5.8 | 6.2 |
| Alamance | 66 | 7.0 | 6.4 | 10.6 | 4.1 | 17.8 |
| Davidson | 73 | 7.9 | 6.9 | 15.6 | 7.2 | 9.3 |
| Forsyth | 248 | 10.2 | 6.8 | 20.2 | 5.9 | 3.2 |
| Guilford | 289 | 9.4 | 5.6 | 14.6 | 8.1 | 4.6 |
| Randolph | 61 | 7.0 | 7.4 | 12.4 | 5.0 | 0 |
| Rockingham | 47 | 9.3 | 7.3 | 19.8 | 3.5 | 16.9 |

Source: County Health Data Book, 2013, NC State Center for Health Statistics

Low birth weight is a principal predictor of infant mortality, higher hospital costs and subsequent health problems. The rate of low birth weight in Guilford County has increased slightly over a 20-year period.

Figure 5. Low Birth Weight Births* by Race, Guilford County, 1992-2011



A major racial disparity exists between whites and other races. The rate of low birth weight is highest in births to residents of census tracts in the southeastern and eastern area of Greensboro and central High Point.

Figure 6. Percent of Births Low Birth Weight, 2007-2011

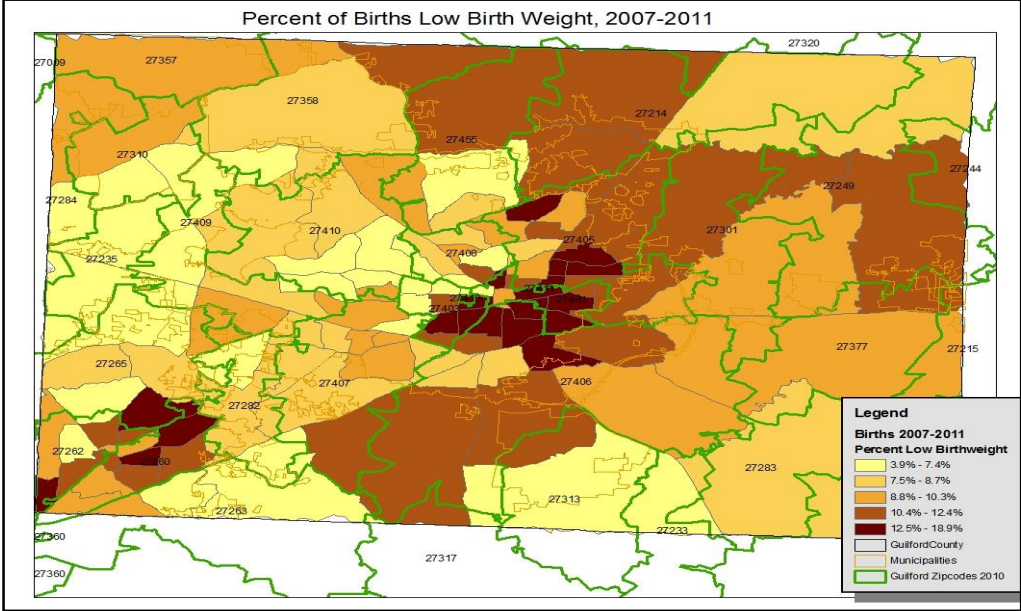
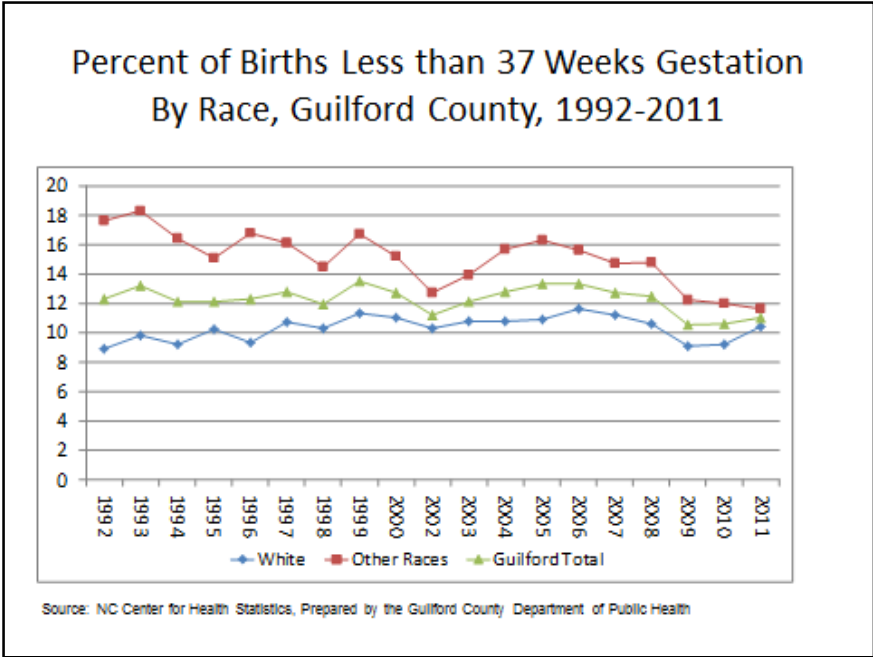


Figure 7. Percent of Births Less Than 37 Weeks Gestation by Race, Guilford County, 1992-2011



Premature births are a leading factor in low birth weight births (Figure 7) and infant mortality (Figure 8). Though disparity has been reduced in recent years, the problem of preterm births is greatest among racially marginalized persons. Infant mortality rates have tended to be higher in Guilford County than in the state as a whole but in 2011 almost reached state levels.

Figure 8. Infant Deaths Less Than One Year, Guilford County, 1991-2011

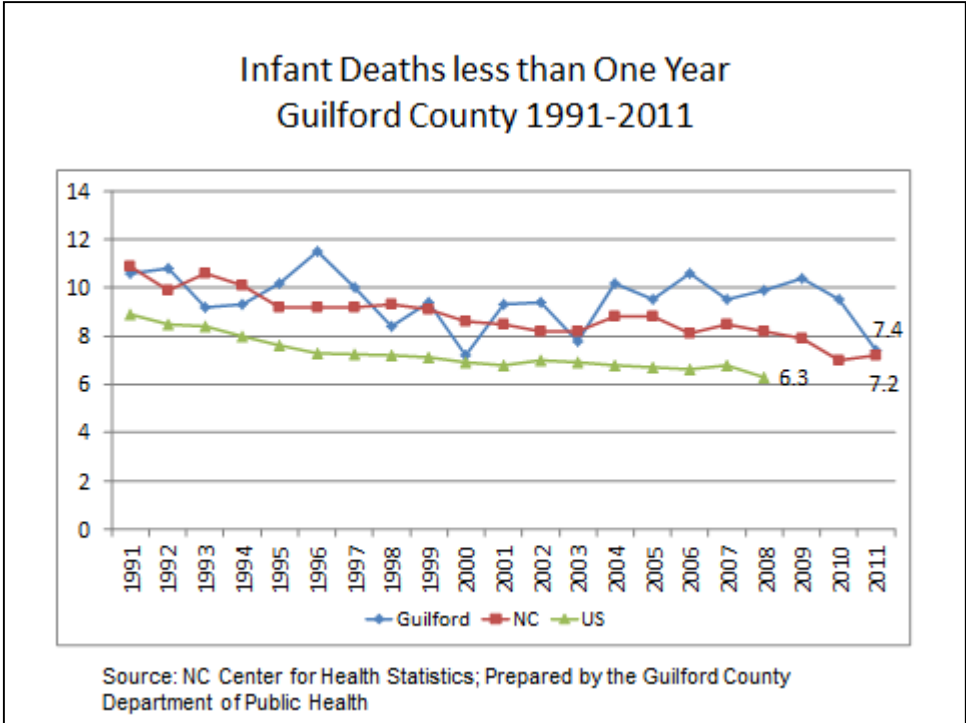
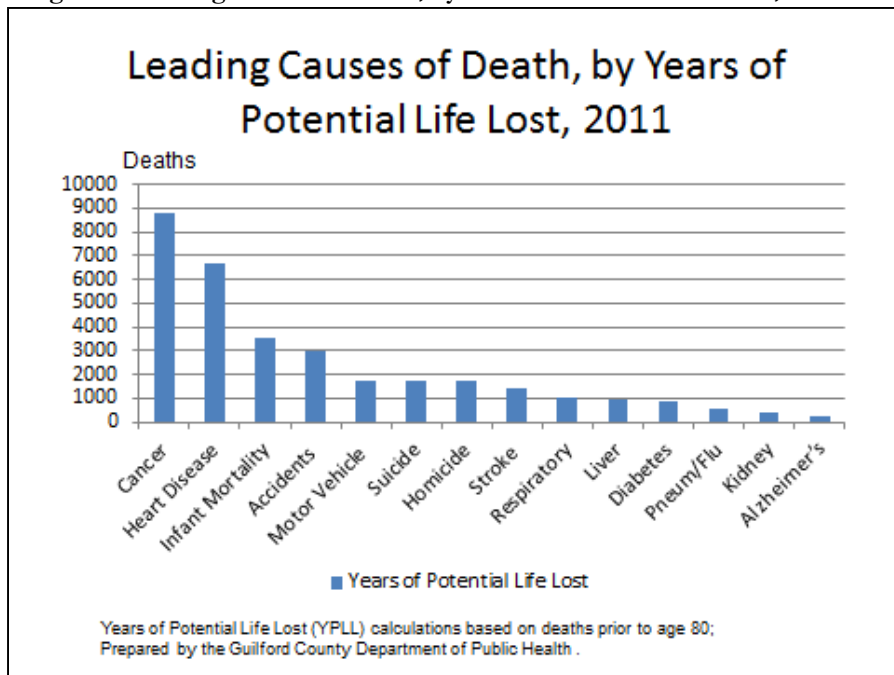


Figure 9. Leading Causes of Death, by Years of Potential Life Lost, 2011



Years of Potential Life Lost reveals that infant mortality is the third leading cause of premature mortality.

Table 9. 2007-2011 NC Live Births by County of Residence: Number with Interval from Last Delivery to Conception of Six Months or Less and Percent of All Births Excluding 1st Pregnancies

| Residence | Number | Percent of Births |
|----------------|--------|-------------------|
| North Carolina | 52,500 | 12.6 |
| Alamance | 895 | 13.8 |
| Davidson | 882 | 14.3 |
| Forsyth | 1,743 | 10.6 |
| Guilford | 2,846 | 13.4 |
| Randolph | 764 | 12.9 |
| Rockingham | 426 | 12.8 |

Source: NC County Health Databook, NC Center for Health Statistics

Immigrant and Refugee Women’s Health

Scheduling appointments with the Women’s Clinic located at the Guilford County health department can be challenging. If a Spanish-speaking interpreter is needed, appointments are scheduled sometimes months in advance. Women have been told to go to the emergency department (ED) because they will be seen quicker there; however, a visit to the ED is more costly for the patient and society as a whole. Residents also noted that they were able to get appointments quicker if they spoke English. Appointments are difficult to schedule for healthy children as well. When participants can get through, they are often told to call back next month. Participants also stated that they have repeatedly been hung up on when calling the health department to schedule a well-child checkup. Excessive wait times for appointments have the potential to negatively affect pregnant women or mothers and their children.

A participant was told about a program offering free mammograms at Women’s Hospital. After making an appointment and going to the conceivably free mammogram, she later received two bills for the visit. The participant felt like she had been misled and expressed that she is not likely to sign up for another “free” program.

Lastly, Spanish-speaking mothers in particular expressed the need for language-specific nutrition classes. Mothers stated that they give their kids whatever they want to eat because that was how they had been raised. They realize that their kids may not be eating healthy but do not necessarily know how to prepare healthy meals and snacks for them.

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 and 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. (See page 4 for more on the community data assessment process.)

Table 10. Guilford County Priority Health Issues

| | |
|------------------------------------|---------------------------------------|
| Morbidity and Mortality | |
| 1. | Premature death |
| 2. | Chronic disease mortality |
| 3. | Poor or fair health |
| 4. | Poor physical health days |
| 5. | Poor mental health days |
| 6. | Low birth weight babies |
| Health Behaviors | |
| 7. | Adult smoking |
| 8. | Adult obesity |
| 9. | Physical inactivity |
| 10. | Excessive drinking |
| 11. | Sexually transmitted infections |
| 12. | Motor vehicle crash death rate |
| 13. | Teen birth rate |
| Clinical Care | |
| 14. | Uninsured |
| 15. | Primary care physicians |
| 16. | Preventive hospital stays |
| 17. | Diabetic screening |
| 18. | Mammography screening |
| Social and Economic Factors | |
| 19. | High school graduation |
| 20. | Completed some college |
| 21. | Unemployment |
| 22. | Children in poverty |
| 23. | Inadequate social support |
| 24. | Children in single-parent families |
| 25. | Violent crime rate |
| Environmental Factors | |
| 26. | Air pollution particulate matter days |

| |
|---------------------------------------|
| 27. Air pollution ozone days |
| 28. Access to recreational facilities |
| 29. Limited access to healthy food |
| 30. Fast food restaurants |

The prioritization form reproduced here was utilized for the community meetings to rank health issues.

**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.

Table 11. 2012 Community Health Assessment Health Issue Prioritization

| 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 12. 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 |

Hanlon Prioritization

To gain additional perspective on the health issues facing the community health needs assessment area, an additional prioritization approach was utilized. On Friday, April 12, 2013, an expert 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 Hanlon method is a respected approach to health issue prioritization that takes into account the size or magnitude of a health issue, the severity of the health issue and the feasibility of addressing the issue.

The preceding table shows the form that was used by meeting participants. 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 13. 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 14. 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 15. Synthesizing Community Rankings and Hanlon Rankings

| Community Ranking (Top Ten Issues) | Hanlon Ranking (Top Ten Issues) | Priority Health Issues |
|--|--|---|
| <i>Health Outcomes: Morbidity and Mortality</i> | | |
| (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 |
| <i>Health Behaviors</i> | | |
| (3) Obesity | (3) Obesity, Nutrition and Physical Activity | |
| (8) Physical Activity | | |
| | | |
| | (2) Teen Pregnancy | |
| | (5) Tobacco Use | |
| <i>Clinical Care</i> | | |
| (4) Lack of Insurance | (8) Access to Clinical Care (includes physical and mental health and lack of insurance) | Access to Clinical Care |
| <i>Social and Economic Factors</i> | | |
| (1) Poverty | (10) Poverty and Unemployment | Poverty and Unemployment |
| (2) Unemployment | | |
| (7) Violent Crime | (9) Violent Crime | Violent Crime |
| (9) Education Attainment | | |
| <i>Environmental Factors</i> | | |
| (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. 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 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, organizations such as the Criminal Justice Partnership and the Day Reporting and Restitution Center

offers 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 that pertain to healthy pregnancy.

Guilford Coalition on Adolescent Pregnancy Prevention (GCAPP).

The Guilford Coalition on Adolescent Pregnancy Prevention (GCAPP) is “a local, countywide membership organization that focuses on the issues of adolescent pregnancy, pregnancy prevention and adolescent parenting. Members include educators, health care providers, human service providers, faith-based organization representatives, program administrators, policy makers, parents and adolescents from the community. The coalition exists to increase community awareness and involvement in the prevention of adolescent pregnancy by discovering practical solutions, building alliances and strengthening Guilford County’s social and economic future,” (GCAPP, 2013).

(<http://gcapponline.org/about-gcapp/>)

Guilford County Department of Public Health. Reproductive Health Services

Adolescent Pregnancy Prevention Programs. The health education team offers several programs to help teens make responsible choices and to help reduce teenage pregnancies. Various programs focus on abstinence, education, leadership, responsibility and support for teens, parents and the community. (<http://www.appcnc.org/data/map/guilford>)

Pregnancy Care Management. Pregnancy Care Management provides case management services to assist Medicaid-eligible pregnant women in finding services to meet their needs throughout pregnancy and at least two months after delivery. The program offers parenting and prepared childbirth classes, home visits during pregnancy and within one week of delivery, and referrals to needed resources. (<http://www.guilfordhealth.org/>)

Family Planning Services. Any resident of North Carolina may receive family planning services at public health clinics. Charges are based on income and family size. All services provided are strictly confidential regardless of the age of the patient. Parental involvement is encouraged with minors, but not required. Men are also encouraged to participate in the Family Planning Services program. Men can receive information on reproductive health issues that affect them in private one-on-one sessions. Free condoms are available in the clinic. A full range of family planning services are offered including birth control, physical examination, Pap smear; health education, short-term counseling, laboratory tests (through our in-house laboratory), pregnancy tests, counseling and referral for male/female sterilization, adult immunizations, HIV testing and counseling, sexually transmitted infection testing and counseling, initial and annual exams with screening for high blood pressure, diabetes and anemia, and vaginitis and urinary tract infection screening and treatment.

(<http://www.guilfordhealth.org/>)

Maternity Services. Any female resident of North Carolina may receive maternity services at Guilford County Department of Public Health. The facility accepts Medicaid and Presumptive Medicaid or charges a sliding scale fee (based on family size and income). Some residents may qualify for a special maternity care program (Adopt-a-Mom). Maternity/prenatal care services include physical examination, laboratory tests and prepared childbirth classes.

Guilford County Coalition on Infant Mortality. The Guilford County Coalition on Infant Mortality is a nonprofit organization housed within the Guilford County Department of Public Health. Its goal is to ensure that babies in Guilford County are born healthy and thrive beyond their first year of life. The coalition works to eliminate infant death and disability through community education and involvement. The Adopt-a-Mom Program coordinates prenatal care with private obstetricians and gynecologists (OB-GYNs) for pregnant women who do not qualify for Medicaid and do not have private insurance to cover the cost of prenatal care. (http://www.co.guilford.nc.us/publichealth/divisions/?page_id=63)

Newborn Home Visits. All parents of newborns in Guilford County may receive newborn home visits within three to five days of delivery by registered nurses free of charge. County health department nurses check on the baby's health, answer questions and offer support and education. Incentive items are given at each visit. Interpreters are provided for Hispanic clients. These visits are supported by a Smart Start grant. (<http://www.guilfordhealth.org/>)

The Regional Vasectomy Program. Men age 21 years and older who have concluded that surgical sterilization is the best choice for permanent birth control but are unable to afford the procedure still have an option. The Guilford County Department of Public Health offers interested men in North Carolina the opportunity to have permanent birth control through the Regional Vasectomy Program. Cost is based upon family size and income. The vasectomy program contracts with local board certified urologists in 11 cities in North Carolina where patients may go for a vasectomy. (<http://www.guilfordhealth.org/>)

Triad Baby Love Plus. A component of North Carolina's Healthy Start Baby Love Plus Network, Triad Baby Love Plus is a local program that strives to give local babies the best start possible in life by linking moms and babies with important health care and support services. Local program services include: intensive outreach to connect women of childbearing age and their infants with prenatal and family health services; coordination of care to promote healthy lifestyles for moms between pregnancies and well-child care for their children up to two years after delivery; depression screening and referral for moms; culturally sensitive care for mom and children; health education and training for local health and social service agencies, area hospitals and businesses, public health officials, church and civic volunteers, and community members; and leadership training and support for community partners. Triad Baby Love Plus is part of the national Healthy Start initiative and receives federal funding. (<http://www.piedmonthhealthservices.org/babylove.htm>).

YWCA Healthy Moms Program. Healthy Moms Healthy Babies is a program for moms age 20–30 and their children. The program seeks to help young women have healthy pregnancies and healthy children and maintain a healthy lifestyle between pregnancies. Programs include childbirth preparation classes, fitness classes, discussion groups and doula services. All programs are free for women who meet eligibility requirements.

(<http://www.ywca.org/site/apps/nlnet/content2.aspx?c=6nICIOOoG5IOE&b=8085965&ct=11872865¬oc=1>)