The Moses H. Cone Memorial Hospital

Community Health Needs Assessment 2013

In Partnership With

The Guilford County Health Department

&

The Center for Social, Community and Health Research and Evaluation

The Moses H. Cone Memorial 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 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 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. As a professor, researcher and evaluator, 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. The CSCHRE employs a cadre of full-time staff, 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 take place 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 currently co-leading the Guilford County Healthy Carolinians partnership with Dr. Smith. The health department team was instrumental in conducting town hall–style meetings and collecting health priority data as perceived by the community members at large.

Community Served by Moses Cone Hospital

The information on the communities served by Moses Cone 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.

Moses Cone Hospital provides care for patients requiring heart and vascular care, urgent and level II trauma care, and rehabilitation. The hospital also provides care for patients who suffer from brain and degenerative diseases and spinal conditions through its Neuroscience Center. Moses Cone Hospital provides care to residents of Davidson, Forsyth, Randolph and Rockingham counties but

primarily services residents of Guilford County. Guilford County, once an industrial-based 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 to 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.

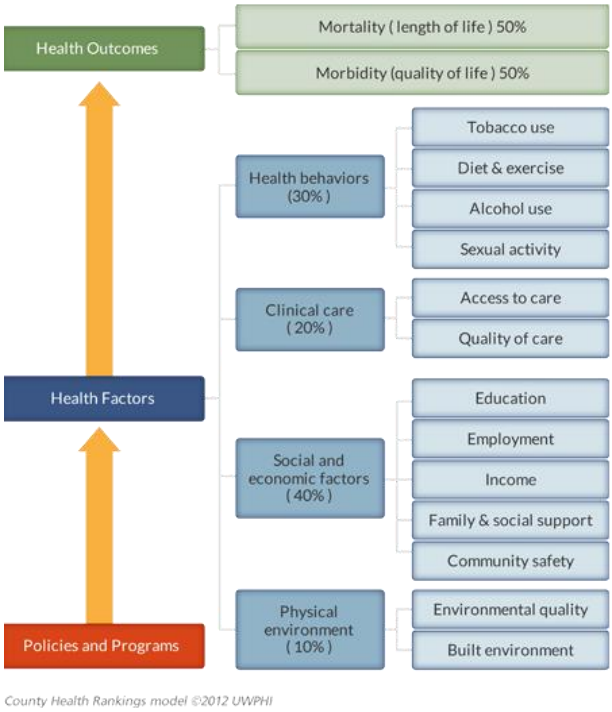
The Patient Protection and Affordable Care Act also provides a list of required and optional hospital level measures identified by the US Department of Health and Human Services. The health department synthesized data on these indicators, which are regularly tracked by Cone Health and High Point Regional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

Figure 1. County Health Rankings Model



The *County Health Rankings* use 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.

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 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 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 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.

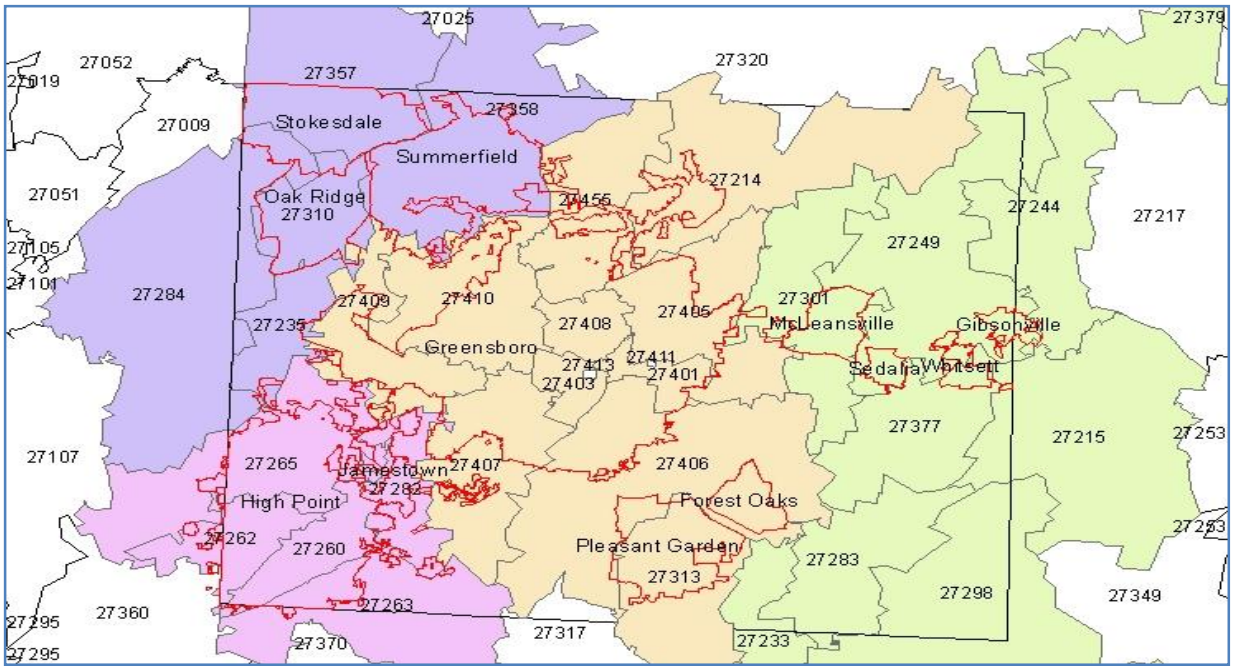
Three focus groups addressed special health care topics, including mental health and women's health issues. One group was held at Behavioral Health Hospital administrative offices with staff social workers, administrative staff and congregational nurses, in addition to providers from the Mental Health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

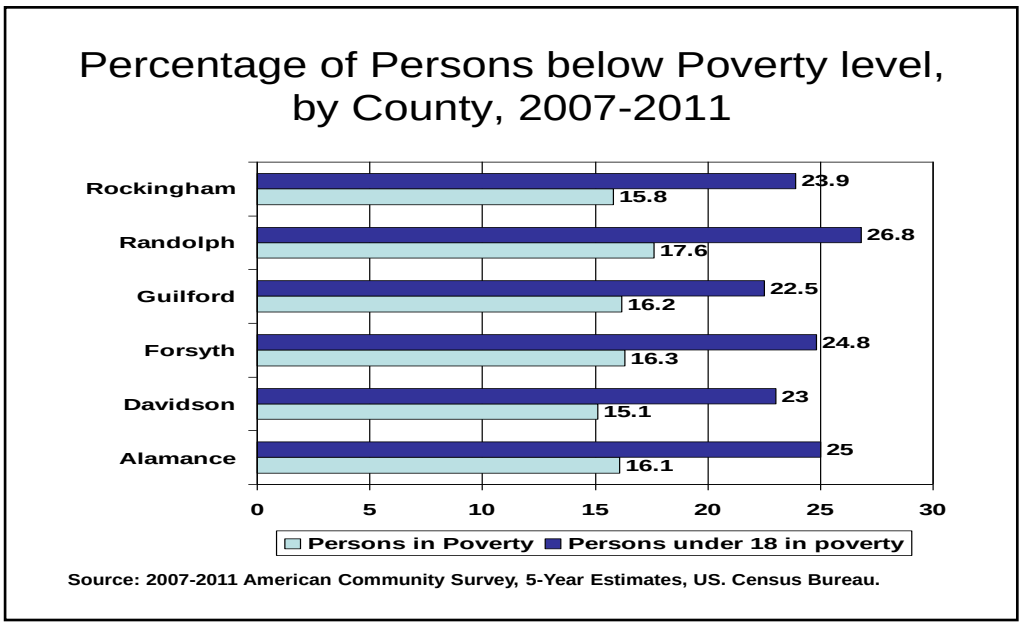
Data Results for Moses Cone Hospital

There are a number of overarching socioeconomic challenges in the county that contribute to poor health outcomes and many residents' inability to access health care.

Poverty

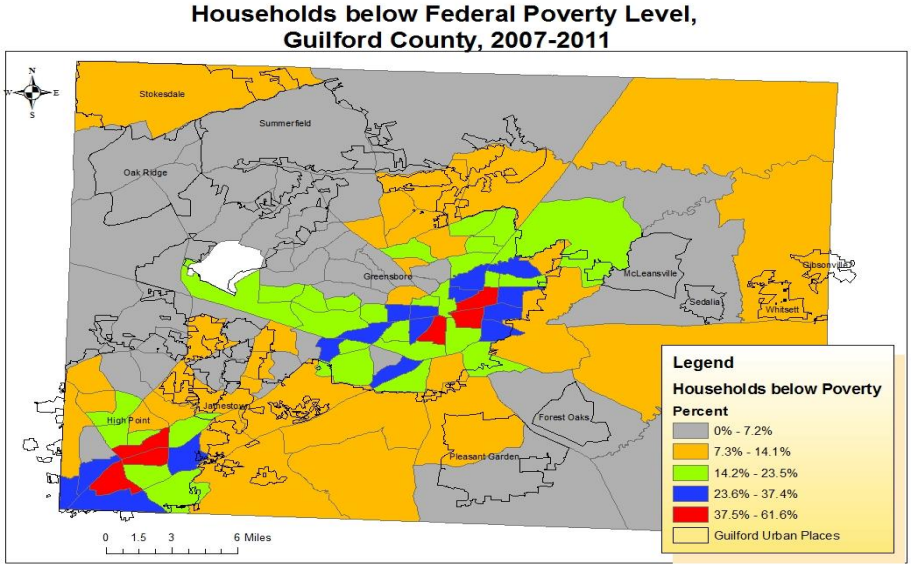
Randolph County had the highest rate of persons living below the poverty line (17.6 percent), followed by Forsyth (16.3 percent) and Guilford (16.2 percent). Randolph County also had the highest rate of child poverty (26.8 percent), followed by Alamance (25 percent) and Forsyth (24.8 percent).

Figure 3. Percentage of Persons Below Poverty Level by County, 2007-2011



Within counties in the community health needs assessment area, poverty is concentrated in urban core areas of Greensboro, High Point, Winston-Salem and Thomasville and to a lesser extent in Reidsville, Burlington and Asheboro. In Guilford County, six census tracts—three in Greensboro and three in High Point had greater than 37.5 percent and up to 63 percent of households below the poverty level. High poverty census tracts tend to have high percentages of minority racial and ethnic populations.

Figure 4. Households Below Poverty Level in Guilford County, 2007-2011



Source: American Community Survey Five-Year Estimates, 2007-2011; Map prepared by the Guilford County Department of Public Health

Table 2. Percent of Persons Below Poverty Level by Race and Ethnicity Guilford County, Forsyth County and North Carolina, 2007-2011

Residence	White	Black	Hispanic	Total
Guilford County	10.0%	24.5%	31.4%	16.2%
Forsyth County	10.6%	25.2%	36.5%	16.3%
North Carolina	11.8%	26.1%	26.1%	16.2%

Source: American Community Survey Five-Year Estimates, 2007-2011, US Census Bureau.

Statewide, African-Americans and Hispanics have poverty rates twice that of whites. In both Guilford County and North Carolina as a whole, high school graduates are half as likely to be in poverty as those without a high school diploma. Adults over the age of 25 with less than a high school education are 7.5 times more likely to be in poverty than college graduates.

Table 3. Percent in Poverty by Educational Status Guilford County, Forsyth County and North Carolina, 2007-2011

Residence	Less Than High School	High School Graduate	Some College	College Graduate and more
Guilford County	28.6%	14.4%	10.9%	3.8%
Forsyth County	28.9%	14.3%	9.8%	3.8%
North Carolina	28.3%	13.9%	10.0%	3.6%

Source: American Community Survey Five-Year Estimates, 2007-2011, US Census Bureau.

Employment

From 2007 to 2011, Rockingham County had the highest unemployment rate, followed by Guilford and Davidson counties. Unemployment varies by race and ethnicity. Blacks in North Carolina are unemployed at rates almost twice that of whites.

Table 4. Employment Status in Civilian Labor Force Status, by County, 2007-2011

County	Unemployment in Labor Force
Alamance	8.6%
Davidson	10.0%
Forsyth	8.8%
Guilford	10.1%
Randolph	9.5%
Rockingham	11.3%

Source: American Community Survey, Five-Year Estimates, 2007-2011 US Census Bureau.

Table 5. Percent Unemployed by Race and Ethnicity, 2007-2011

Residence	White	Black	Asian	Hispanic
Guilford	9.3%	16.0%	10.8%	10.1%
Forsyth	7.9%	18.1%	7.1%	10.0%

North Carolina	9.9%	17.9%	8.0%	13.1%

Source: American Community Survey, Five-Year Estimates, 2007-2011 US Census Bureau.

Immigrant and Refugee Socioeconomic Status

There are many social and economic factors that are challenging for immigrant and refugee residents of Guilford County. The majority of challenges faced by new arrivals pertained specifically to economic challenges. Obtaining a job and earning an income were the top priorities for refugee residents. The economic climate in Guilford County has changed considerably within the past decade. The factories and textile mills where many earlier immigrant and refugee residents worked have largely moved overseas. Manual labor positions are not as readily available as they once were. The shifting nature of economic positions has greatly affected immigrant and refugee residents' ability to find employment.

Obtaining employment is further exacerbated by challenges relating to transportation, language barriers, nontransferable degrees and skill sets, and nascent health problems. Language barriers greatly affect one's ability to seek and obtain employment. Without basic English language skills, it is difficult to even search for a position on one's own. Furthermore, effective communication skills are a requisite for even the most basic positions. Language barriers also affect one's chance of staying employed. Refugee residents noted that they have difficulty keeping their current positions if employed due to communication challenges. It is also important to note that challenges finding work and financial difficulties contributed to a great deal of anxiety and stress. Chronic stress was reported amongst refugee residents in particular. This type of stress was not anticipated prior to resettlement.

Health challenges also contributed to economic and social well-being. Immigrant and refugee residents noted that Medicaid was quick to send them to collections. While many were paying on the debt incurred from medical care, not all were able to pay the full amount that was to be sent in each month. Participants experienced difficulty negotiating payment plans due to language barriers and challenges navigating the system. Several participants stated that they could afford to pay $25 per month but that $50 was too much for the budget that they were on. If they missed payments or were sent to collections, this negatively affected their credit.

The physically demanding nature of many of the jobs (i.e., chicken farms) contributed to and/or exacerbated nascent health problems as well. It was observed that many refugee residents would work for two months or so and then begin to get sick. Several mentioned that they took a few days off to recover but were then asked not to return because of the missed time. Refugee residents specifically expressed concerns about the employment conditions of those working on chicken farms. It is to be noted that refugee participants may live in Greensboro but often find work in Rockingham (near to the South Carolina border) or Dobson (an hour and a half drive each way). Those who are able to find jobs that fit with their school schedule will also try to attend classes in addition to work. This type of demanding schedule contributes to exhaustion as well.

Additionally, several refugee residents had received college degrees in their countries of origin. Unfortunately, their degrees were not transferable to the United States since universities in developing countries often do not meet US accreditation standards. One resident lamented that

their degrees were wasted because they could not practice the jobs (or similar jobs) that they once had. College degrees are highly valued, and immigrant and refugee residents were frustrated when their degrees did not hold any value in the United States. Skill sets, regardless of the obtainment of a degree, also did not always transfer to life in the United States. Strict licensing requirements do not allow for former entrepreneurs (i.e., restaurant owner) to easily begin anew in the same industry post-resettlement.

Violent Crime

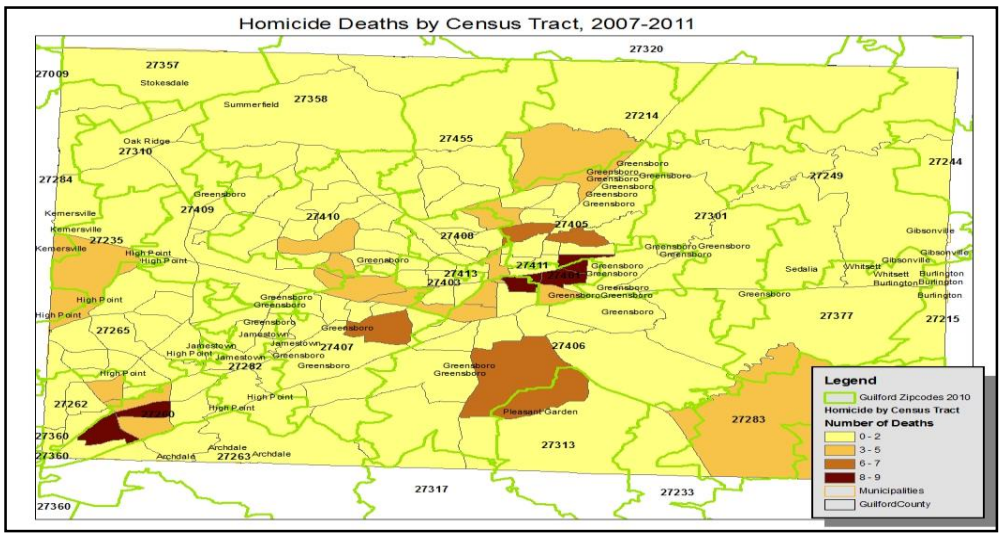
Table 6. Crime Rates per 100,000 by County 2010-2011

County	Year	Index Crime Rate	Violent Crime Rate	Property Crime Rate
Alamance	2010	4,435.3	429.8	4,005.5
	2011	4,451.7	433.7	4,018.1
Davidson	2010	2,819.6	231.2	2,588.4
	2011	2,921.9	213.0	2,708.9
Forsyth	2010	5,463.5	532.9	4,930.6
	2011	5,683.0	553.2	5,129.8
Guilford	2010	4,867.2	478.7	4,388.4
	2011	4,724.3	483.5	4,240.8
Randolph	2010	3,426.2	125.7	3,300.5
	2011	3,727.1	144.4	3,582.7
Rockingham	2010	4,045.6	318.9	3,726.7
	2011	3,908.7	218.6	3,609.1

Source: Crime in North Carolina, 2011, Annual Summary Report of 2011 Uniform Crime Reporting Data, NC Department of Justice, State Bureau of Investigation, July 2012. Note: Index Crime includes the total number of violent crimes (murder, rape, robbery and aggravated assault) and property crimes (burglary, larceny and motor vehicle theft).

The violent crime rate is considerably higher in more urbanized counties such as Forsyth and Guilford, followed by Alamance County.

Figure 5. Homicide Deaths by Census Tract, 2007-2011



The most violent form of crime, homicide, is a greater problem in Guilford County census tracts that are characterized by higher rates of poverty and minority populations.

Table 7. Mortality from Homicide and Injury Purposely Inflicted on Other Persons 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	2,949	6.3	1,064	3.4	1,458	13.8	135	8.0
Guilford County	170	7.0	57	4.4	100	11.9	4	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.

The age-adjusted homicide rate for Guilford County was slightly higher than the North Carolina rate overall. A significant disparity exists for African-Americans in Guilford County and North Carolina, with a rate four times as high as whites.

Table 8. 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.

The age-adjusted suicide rate for Guilford County was slightly lower than the North Carolina rate overall. A significant disparity exists for whites in Guilford County and North Carolina, with a rate three times higher than African-Americans.

Table 9. Injured in a Physical Fight, 2011

	Ever Been in a Physical Fight in which They Were Hurt and Had to Be Treated by a Doctor or Nurse		In a Physical Fight One or More Times in the Past 12 Months in Which They Were Injured and Had to Be Treated by a Doctor or Nurse	
Residence	**Middle School Students**		**High School Students**	
	Number	**Percent**	**Number**	**Percent**
North Carolina	135	5.0%	2,232	3.7%
Guilford County	92	3.4%	62	2.6%

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

A similar percentage of Guilford County middle and high school students reported being injured in a physical fight as compared to North Carolina middle and high school students.

Table 10. Experienced Relationship Violence in the Past Year: Were Ever Hit, Slapped or Physically Hurt on Purpose by their Boyfriend or Girlfriend During the Past 12 Months, 2011

Residence	High School Students	
	Number	**Percent**
North Carolina	2,245	14.1%
Guilford County	215	9.1%

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

In the past year 9.1 percent of Guilford County high school students reported experiencing relationship violence compared to 14.1 percent of North Carolina high school students.

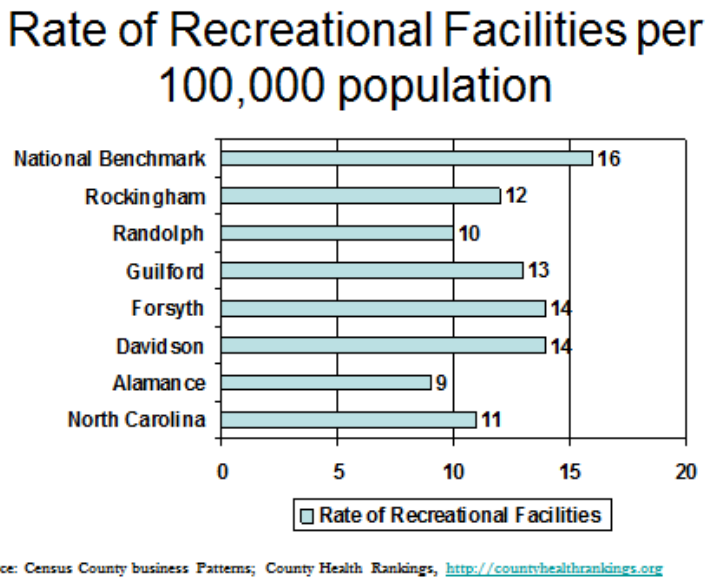
Table 11. Ever Been Sexually Assaulted: Ever Been Physically Forced to Have Sexual Intercourse When They Did Not Want To, 2011

Residence	High School Students	
	Number	**Percent**
North Carolina	2,238	9.5%
Guilford County	169	7.2%

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

7.2 percent of Guilford County high school students reported they have ever been sexually assaulted.

Figure 6. Access to Recreational Facilities



Source: Census County business Patterns; County Health Rankings, http://countyhealthrankings.org

This indicator measures the number of commercial exercise facilities such as gyms and exercise clubs. Davidson and Forsyth counties have the highest rates of recreational facilities and Alamance and Randolph have the lowest.

Access to Healthy Food

Table 12. Percentage of All Restaurants That Are Fast Food, by County, 2010

Residence	Fast Food Restaurant Percentage
North Carolina	49%
Alamance	52%
Davidson	42%
Forsyth	47%
Guilford	48%
Randolph	48%
Rockingham	47%
National Benchmark	27%

Source: Census County Business Patterns, 2010; County Health Rankings, http://countyhealthrankings.org

Approximately 50 percent of all restaurants in North Carolina are fast food restaurants. The percentage of restaurants ranges from 8 percent to 73 percent among community health needs assessment counties. Davidson County has the lowest percentage of fast food restaurants and Alamance County has the highest.

Patients need assistance with access to healthy and nutritious foods. It is cheaper to buy processed foods that will not expire, particularly in families with children. Malnutrition has been identified as an emerging issue because of hunger and limited access to healthy food within the county. Families struggled to afford any food once their bills were paid. Furthermore, only one stand accepts food stamps at the farmers market. However, it is not always at the market. Another challenge to consider is subsidized resources, such as Supplemental Nutrition Assistance Program (SNAP),

which do not differentiate individuals who may be diabetic. This means there are no special accommodations for their diet.

Table 13. Limited Access to Healthy Food, by County, 2012

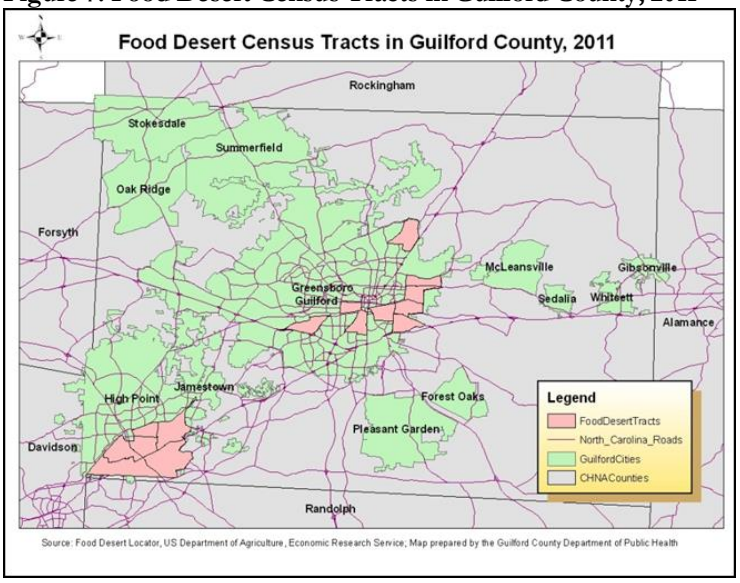
Residence	Percent of Population Who Are Low Income and Do Not Live Close to a Supermarket
North Carolina	7%
Alamance	11%
Davidson	6%
Forsyth	12%
Guilford	7%
Randolph	7%
Rockingham	11%
National Benchmark	1%

Source: USDA Environmental Food Atlas, County Health Rankings, 2013, http://countyhealthrankings.org

The community health needs assessment area includes numerous food desert census tracts. Food desert tracts are in Greensboro and High Point in Guilford County, Thomasville in Davidson County, Randleman in Randolph County, Burlington in Alamance County and Reidsville in Rockingham County.

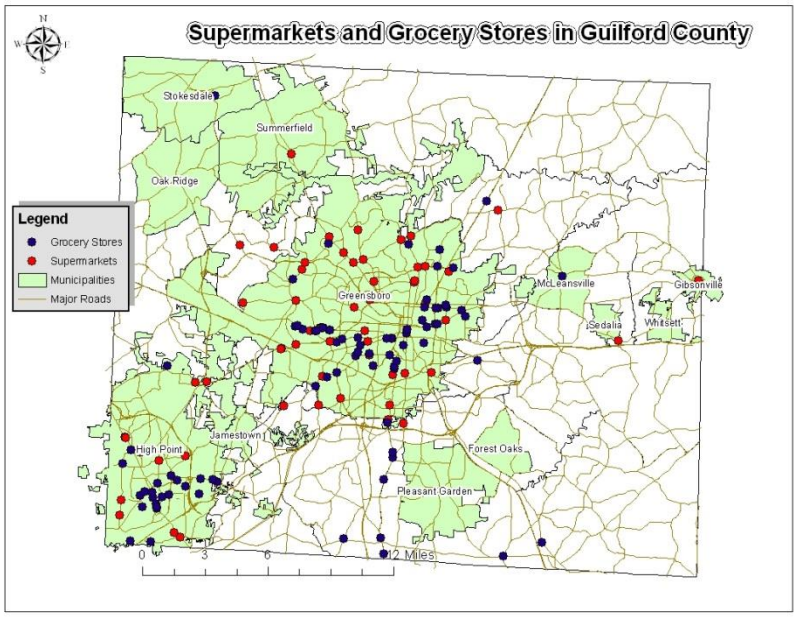
North Carolina counties have a range from 0 to26 percent of residents who are low income and do not live near a supermarket, with an average of 7 percent. Counties within the community health needs assessment area with poor access to food range from 6 percent in Davidson County to 12 percent in Forsyth County.

Figure 7. Food Desert Census Tracts in Guilford County, 2011



In Guilford County, residents living in 15 census tracts across an arc from south to east and northeast Greensboro have low income and limited access to supermarkets. Nine census tracts in central and south High Point have limited food access.

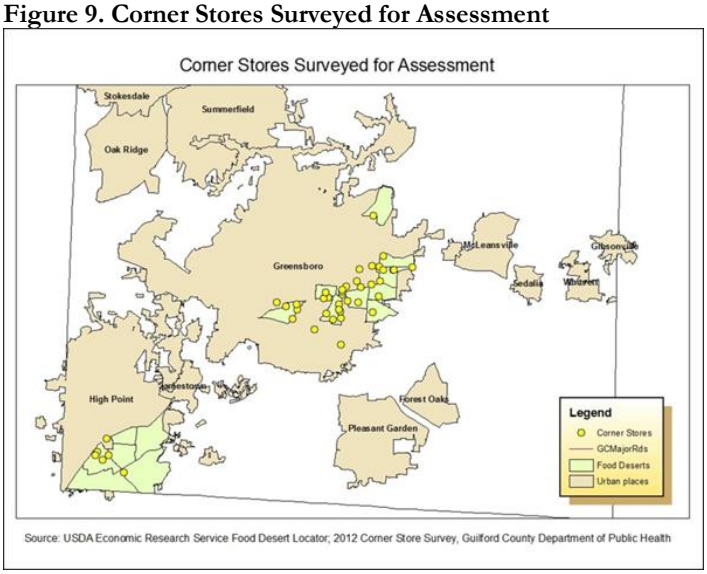
Figure 8. Supermarkets and Grocery Stores in Guilford County



Source: Guilford County Community Health Assessment, 2010. Guilford County Department of Public Health

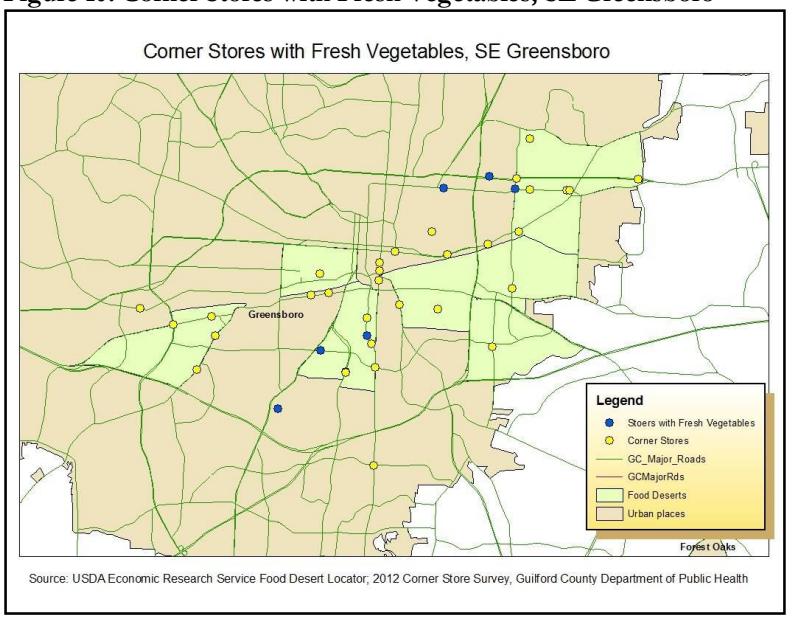
Food deserts are characterized by poor access to supermarkets or large grocery stores that carry a wide range of healthy foods, including fresh fruit and vegetables, whole grain bakery products and low-fat dairy foods. Full-service supermarkets tend to be located in higher-income areas, while food desert neighborhoods have numerous convenience stores and small grocery stores, which accept Electronic Benefit Transfer (EBT) cards but typically offer few healthy food options. Local residents, who sometimes lack transportation to shop at supermarkets outside their neighborhoods, often do their grocery shopping at these markets.

Figure 9. Corner Stores Surveyed for Assessment



In the fall of 2012 the health department collaborated with UNCG and North Carolina A&T State University on an assessment of food available in "corner stores" in food desert census tracts in southeast Greensboro and High Point. Fifty-seven stores located in or near food desert census tracts were identified for the assessment. The assessment utilized the Food Retail Outlet Survey Tool (FROST). Additional supplemental data were collected from store staff and customers. Students from UNCG and NCA&T completed 48 store surveys in November and December 2012.

Figure 10. Corner Stores with Fresh Vegetables, SE Greensboro



Of the stores surveyed, 48 percent were convenience stores, 29 percent were gas station–convenience store combinations and 19 percent were small grocery stores. Also 79 percent of stores accepted SNAP benefits, but only 15 percent of stores carried fresh vegetables.

Figure 11. Corner Stores with Fresh Vegetables, High Point

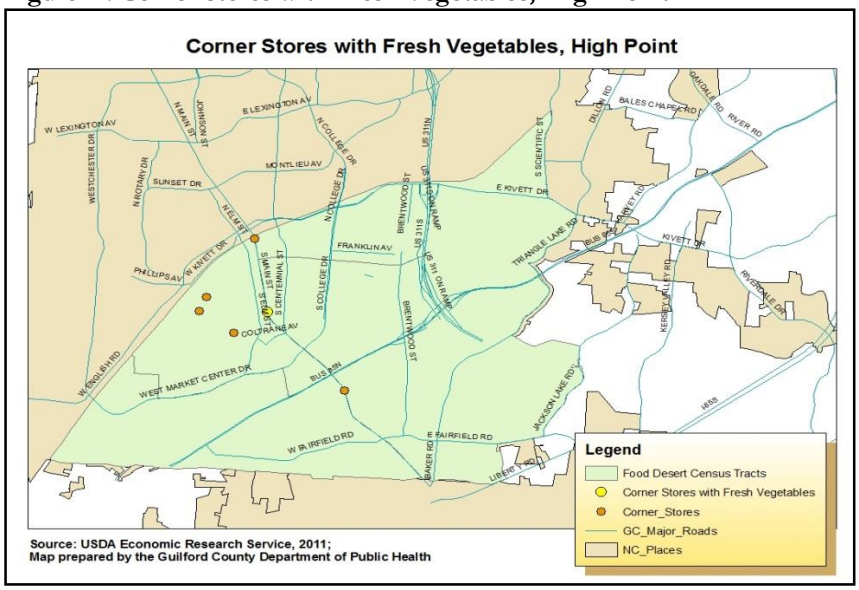
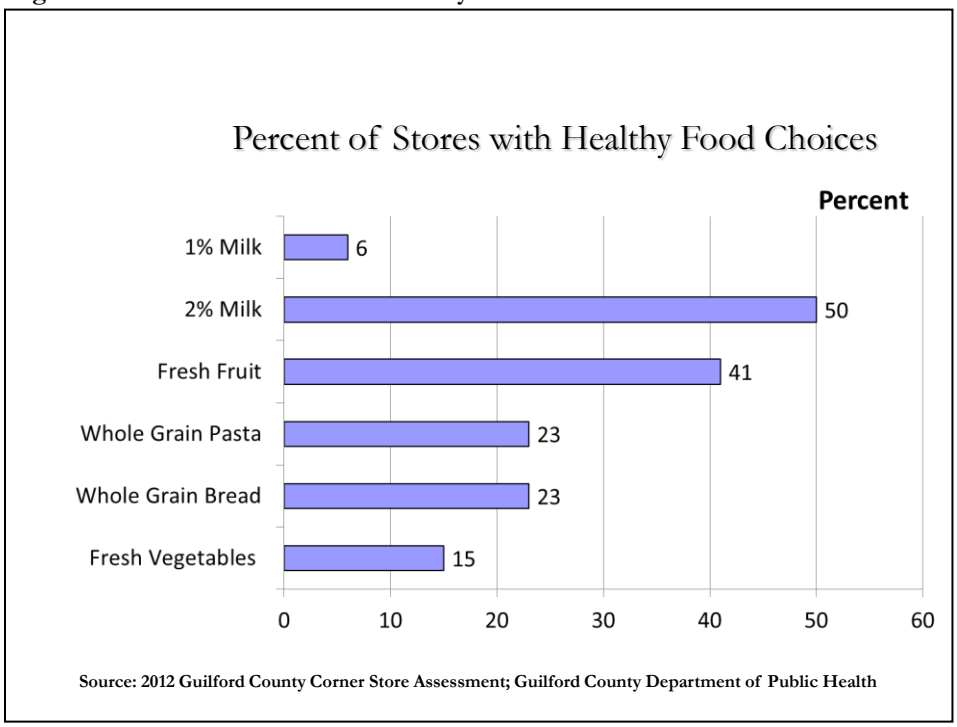


Figure 12. Percent of Stores with Healthy Food Choices



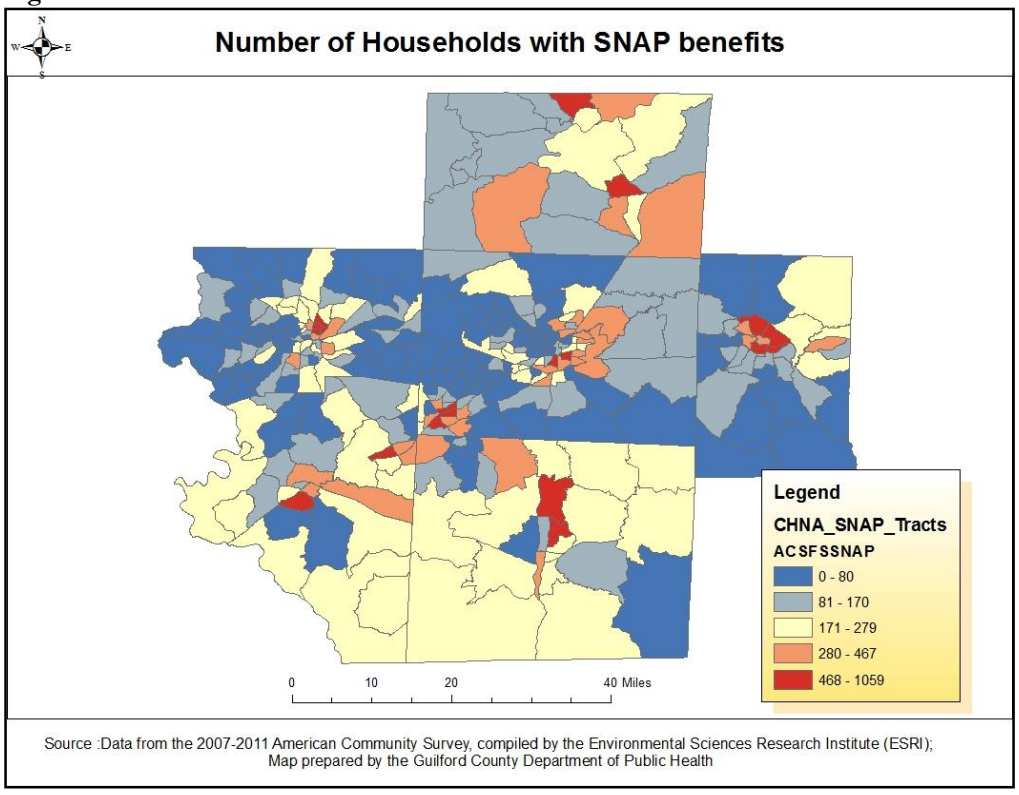
Corner stores are more likely to carry 2% milk and fresh fruit than wholesome foods listed, but the selection is often limited. Most stores carry bread, pasta and milk, but only 23 percent carry either

whole grain bread or whole grain pasta; 50 percent carry 2 percent milk and only 6 percent carry 1 percent milk.

SNAP Benefits

Immigrant and refugee residents of Guilford County noted challenges accessing healthy foods to eat. The most notable barrier was the high cost associated with healthy food. Many refugee families in particular are eligible for the Supplemental Nutrition Assistance Program (SNAP); however, even with this program, affording healthy foods remains a barrier. Immigrant and refugee residents stated that it was difficult living off SNAP alone.

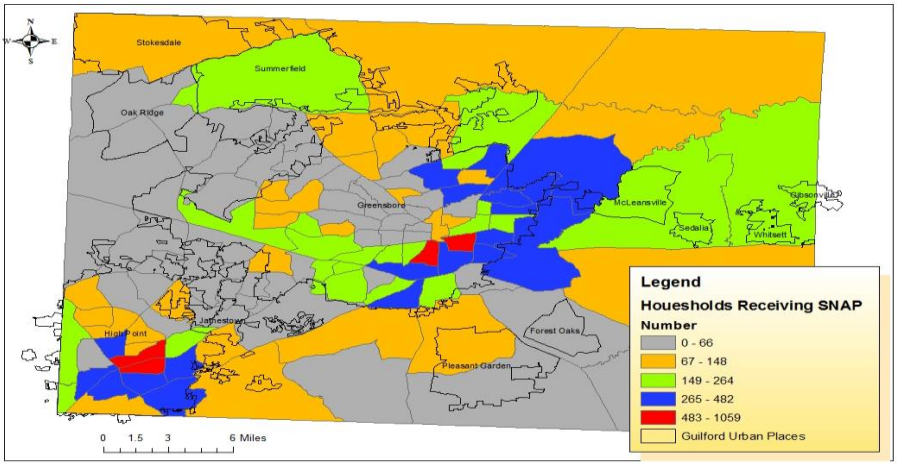
Figure 13. Number of Households with SNAP Benefits



Food desert census tracts tend to have high rates of households using SNAP benefits/EBT cards.

Figure 14. Households Receiving SNAP Benefits, Guilford County, 2007-2011

Households receiving SNAP benefits, Guilford County, 2007-2011



Source: American Community Survey Five-Year Estimates, 2007-2011; Map prepared by the Guilford County Department of Public Health

The majority of immigrant and refugee residents expressed interest in cultivating community gardens. Throughout the language-specific focus groups, only one apartment complex allowed residents to maintain a vegetable garden (Avalon Trace apartment complex in Greensboro). The gardens there started as part of an AmeriCorps initiative on behalf of an onsite community center staffed by the Center for New North Carolinians. The apartment management has been generous with allowing residents the opportunity to plant gardens throughout the complex. Gardens can be seen in the main quad, growing near the creek on the far side of the apartment complex and immediately surrounding residents' apartment units.

Not all apartment complexes allow residents to plant gardens, however. Apartment management often cited that there was not enough green space available to plant adequate gardens. The majority of participants stated that they were not allowed to even plant just small gardens immediately outside of their units. Many immigrant participants either owned their own home or rented a house complete with a yard. These participants were more likely to be able to grow their own vegetables. Some residents stated that even though they rented a house with a large yard, their landlords would not always allow them to have a garden. Renters in these situations were allowed to use the outdoor space but were not allowed to modify the outdoor space.

Refugee residents in particular noted that while they would like to have garden space, there is need for assistance and education. Many immigrant and refugee residents have relocated to Guilford County from countries of origin with very different climates. Residents expressed the need to learn about the different produce grown in this area and new gardening techniques that are more conducive to this climate. The one resident who had a garden noted that she did not know all of the vegetables growing in it or how to prepare them. She was given seeds to plant but was not given any further instructions on how to prepare the vegetables once they were ready to be consumed. Education about gardening in this climate would be a component necessary to the success of potential community gardens.

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 14. 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 15. 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 16. Community Health Rankings

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 17. 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 18. Community Prioritization Ranking

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 19. 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 Activity	
(8) Physical 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 included 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 to enhance mental health services and programming for patients. 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

Mental Health
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. 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.

Chronic Disease, Obesity, Exercise & Nutrition
Partners in Health and Wholeness (PHW). PHW is a program of the NC Council of Churches that partners with local churches to support health ministries in a variety of areas, from reducing obesity to tobacco cessation and improving access to healthy foods. PHW is currently partnering with the NC Blue Cross and Blue Shield Foundation to provide grants up to $5,000 to local churches to support community gardens. (http://www.ncchurches.org/programs/health-wholeness/)

Partnership for Community Care (P4CC). P4CC is a nonprofit organization comprised of primary care providers, hospitals/health care systems, county health departments and county departments of social services. P4CC is charged with improving the health outcomes and reducing the care costs of the Carolina Access Medicaid and NC Health Choice populations in Guilford, Rockingham and Randolph counties. P4CC is one of 14 similar networks participating in the statewide Medicaid quality improvement strategy called Community Care of North Carolina

(CCNC). In addition to serving NC Health Choice and Carolina Access Medicaid populations, P4CC helps uninsured patients in Guilford County access medical care. It provides monitoring and follow-up with chronic disease patients who have congestive heart failure, diabetes, hypertension and/or COPD. (http://www.p4communitycare.org/programs-initiatives/)

Congregational Nurse Program (CNP). The Congregational Nurse Program at Cone Health is a unique, specialized nursing practice established as a collaborative relationship between Cone Health and area faith communities. The CNP approach provides for a congregational coordinator based at Cone Health who is responsible for assisting community congregations with developing and implementing a Health Ministry Program. Each health ministry is tailored to meet individual congregations' needs and capabilities. Currently, the program collaborates with 48 faith communities, all of which have either a paid or volunteer congregational nurse. The CNP's Healing Opportunities for People Experiencing Sickness (HOPES) program benefits homeless individuals who have no other resources and would be back on the streets without the program's assistance. Candidates for HOPES are identified by Cone Health social workers. After being discharged from the hospital, the patient is assigned a congregational nurse and a Congregational Social Work Education Initiative (CSWEI) social worker. HOPES provides its participants with temporary housing, gift cards for food and necessities, accounts at drug stores for prescription drugs and a 30-day bus pass. Since many patients need daily check-ups, nurses who are assigned to each case visit and/or call on a regular basis to check on their patients' acute or chronic health issues such as diabetes, heart disease, hypertension, cancer or stroke. (http://www.p4communitycare.org/about-us/)

Access to Healthy Food

Guilford County Cooperative Extension. North Carolina Cooperative Extension "helps gardeners learn more about new plants, native plants and environmental stewardship. Extension-trained Master Gardener volunteers are instrumental in these efforts, sharing their knowledge of plant selection, cultural practices and pest management with fellow gardeners, school students and others," (NC Cooperative Extension, n.d.). Be Healthy—Grow What You Eat is a program that teaches gardeners the benefits of eating fresh produce they grow themselves. The Master Gardeners volunteer program developed the community gardens through the Cooperative Extension to create a sense of community among gardeners, allowing them to learn from each other and from Master Gardener volunteers. Ten percent of the harvest yield from each community garden is donated to local food pantries.
(http://www.ncstategardening.org/extension_master_gardener/guilford/index_county)

The Edible Schoolyard. The Edible Schoolyard is a teaching garden and kitchen where children and their families can learn how to grow healthy food and create delicious snacks and meals using fresh, local, organic ingredients. The Edible Schoolyard offers children a chance to build practical gardening and cooking skills, to connect with the natural world and to enjoy nourishing food. (http://www.gcmuseum.com/edible-schoolyard/)

Food Assistance, Inc. Food Assistance, Inc., delivers groceries to 450 families living in Greensboro and Guilford County. The groceries are provided at no cost to the families, and the program gives the opportunity for low-income families and the elderly to build stronger social and

food-based networks with Food Assistance's team of 150 community volunteers. (http://foodassistancenc.com/vol_ops.html)

FoodCorps, Inc. FoodCorps, Inc., matches motivated leaders with limited-resource communities. Service members sign up for a year of public service, and they work under the direction of local partners. FoodCorps, Inc., follows a "three-ingredient recipe" for healthy kids: 1) Deliver hands-on nutrition education. 2) Build and tend school gardens. 3) Bring high-quality local food to public school cafeterias. (www.foodcorps.org)

Greensboro Urban Ministry. Greensboro Urban Ministry provides food, shelter and health services to individuals in need of resources. Homeless individuals make up the majority of its clientele. The ministry also offers food bank supports, as well as a community kitchen that serves a daily lunch to anyone and everyone. (www.greensborourbanministry.org)

Guilford County Department of Public Health. Guilford County Department of Public Health supports a variety of programs designed to educate residents about healthy eating and works with community partners to improve access to healthy food through community gardens, farmers markets and other programs. The health department also maintains its own community garden at its Greensboro Maple Street facility and donates all of the produce to the Greensboro Urban Ministry (www.guilfordhealth.org).

Guilford County Department of Social Services (DSS): The DSS Food and Nutrition program is a federal food assistance program that helps low-income families or individuals to buy food. DSS administers the county's SNAP/EBT program. Eligible households receive monthly benefits to purchase food. (www.co.guilford.nc.us/government/socservices/food.html)

The Interactive Resource Center (IRC). The IRC assists people who are homeless, recently homeless or facing homelessness in reconnecting with their lives and the community at large. The center is becoming more and more involved in local food initiatives across Greensboro and Guilford County. Members are building a community garden and the center is serving as a food drop-off and pick-up location for local food redistribution programs. By focusing on food for the homeless community, staff members also make sure that Greensboro's food security needs are met. (http://gsodaycenter.org/)

Partnership for Community Care (P4CC) Partnership Pantry Program. "P4CC is in the process of stocking a Healthy Food Pantry for chronic disease patients in need. In an effort to help reduce food insecurity (or limited access to fresh and healthy foods) and improve the management of chronic disease. Food insecurity has continued to rise in North Carolina. In 2011, 18.2 percent of the population was considered food insecure—that number has increased to 19.6 percent this year.* Food insecurity and chronic disease are closely related. Many individuals who are food insecure rely on food banks, which often have a lot of salty and sugary foods that can make it difficult to manage a chronic disease. The Partnership Pantry Healthy Food Bank Program hopes to provide low-income patients with healthier foods and nutrition education that will help empower them to better manage their chronic diseases, (P4CC, 2013).
(http://www.p4communitycare.org/programs-initiatives/nutrition-program/partnership-pantry/)

Share the Harvest. Share the Harvest is a new project making it possible to reach more food-insecure people in Guilford County with fresh food provided by local farmers, churches and citizens. Share the Harvest is a food redistribution program. Volunteers gather extra produce grown by community gardens, urban and rural farms, and other community-based food programs. They then work with local food banks, shelters and outreach organizations to get food to the people who need it. (www.sharetheharvestguilfordcounty.org/)

HIV and Other STIs

Piedmont Health Services and Sickle Cell Agency (PHSSCA). The PHSSCA, which was established in 1970, provides sickle cell disease testing, education, genetic counseling and support services. PHSSCA currently serves six counties: Guilford, Forsyth, Alamance, Rockingham, Randolph and Caswell. (http://www.piedmonthealthservices.org/)

Triad Health Project. The Triad Health Project provides emotional and practical support to individuals living with HIV/AIDS, their loved ones and those at risk for HIV/AIDS. The Triad Health Project began in 1986 as a grassroots effort and is now one of the largest AIDS service organizations in North Carolina, with a culturally diverse staff of nearly 20 and a volunteer base that exceeds 500. The staff implements strategies to educate those at risk and the community about HIV/AIDS and advocate locally, regionally and nationally for individuals and groups infected with or affected by HIV/AIDS. As the primary community service provider, Triad Health Project offers case management, the Higher Ground day center, a client food pantry, education and prevention outreach, and HIV testing. (http://www.triadhealthproject.com/about/index.php)

Guilford County Department of Public Health (GCDPH) HIV and Sexually Transmitted Infection Counseling and Testing. The GCDPH offers free and confidential testing and treatment for syphilis, gonorrhea and chlamydia, as well as HIV testing and referral services. (www.guilfordhealth.org)

Access to Clinical Care

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Center for New North Carolinians. On April 12, 2001, the Board of Governors of the University of North Carolina established the UNCG Center for New North Carolinians to "provide research, training, and evaluation for the state of North Carolina in addressing immigrant issues; collaboration with government and social organizations to enhance responsiveness to immigrant needs; and community support to provide training and workshops," (UNCG CNNC, 2013). The Center subsumed pre-existing programs of the Accessing Cross-Cultural Education Service Systems Program (ACCESS) that were already housed in the Department of Social Work under Dr. Raleigh Bailey's direction. ACCESS began in 1994 with the AmeriCorps ACCESS Project, a domestic Peace Corps national service initiative funded by the federal government and local partners, has had as its mission, providing culturally and linguistically appropriate services to refugee and immigrant communities in North Carolina. About 60 people per year currently complete a year of service with the AmeriCorps ACCESS Project. Another initiative, the Interpreter ACCESS Project, has provided professional interpreter training to interpreters across the state. The Immigrant Health ACCESS Project has provided cross-cultural health services to immigrants in Guilford County. This collection of projects formed the initial core of the new center activities. Those projects have been supplemented with additional outreach, research and training activities to expand the range of center activities as it fulfills its mission. (http://cnnc.uncg.edu/)