NORTH CAROLINA BAPTIST HOSPITAL

Community Health Needs Assessment Implementation Plan

October 2013

Background

North Carolina Baptist Hospital (NCBH) is committed to understanding, anticipating, assessing, and addressing the healthcare needs of the communities it serves. With a mutual interest in the health and well-being of residents, a collaborative community health needs assessment was conducted in Forsyth County, North Carolina from February 2011 to March 2012. The community health needs assessment (CHNA) represented a comprehensive community-wide process with a wide range of public and private partners such as the Forsyth County Department of Health, Forsyth Medical Center, Forsyth Futures, educational institutions, health professionals, local government officials, human service organizations, and faith-based organizations. Their common goal was to evaluate the community's health and social needs. NCBH's CHNA was completed and approved by the Board as of June 30, 2013.

The results of the county's varied data collection methodologies, including a community opinion survey of Forsyth county residents, focus groups of vulnerable populations, and key informant interview of community leaders which resulted in an overall assessment of the needs of Forsyth County residents. The community's health needs identified through the assessment include the following: (1) Physical Activity & Nutrition; (2) Chronic Disease Prevention & Management; (3) Maternal & Infant Health; (4) Social Determinants of Health; (5) Access to Care; (6) Mental Health; and (7) Substance Abuse Prevention**. NCBH prioritized the following four significant community health needs for its current CHNA based on internal strategic priorities: (1) Physical Activity & Nutrition; (2) Chronic Disease Prevention & Management; (3) Access to Care; and (4) Behavioral/ Mental Health**.

Implementation Plan

The CHNA implementation strategy is intended to serve as a roadmap for how the hospital plans to meet each prioritized health need. It will identify the programs and resources committed to each health need, identify any planned collaboration with other facilities or partners, report the anticipate goals for our strategies and actions and provide a plan for evaluating the results of such strategies and actions. Certain hospital departments (Strategic Planning, Faith and Health Ministries, and PR & Marketing) will collaborate on the development of a common platform for tracking and measuring performance and identify and the identification of new partners who will support the implementation strategies.

A. How NCBH will address health needs

The NCBH action plans outline the problems, strategies, activities and desired outcomes for each of the prioritized health needs identified in the CHNA. The action plans were developed through evaluation of NCBH programs and the U.S. Department of Health and Human Services "Healthy People 2020" topics. To determine anticipated impact, Healthy People 2020 objectives were reviewed and integrated into each priority area. As a leader committed to improving the nation's health, Healthy People's goal of achieving health equity and eliminating disparities aligns closely with NCBH's role in community health. (See Appendix 1 for Healthy People 2020 objectives that were evaluated.)

There is intentional overlap in efforts as many of the strategies and activities outlined in the action plans address risk factors associated with multiple disease groups. For example, strategies to promote healthy eating and physical activity will affect obesity as well as heart disease and diabetes. Further, we expect many of these strategies will closely align with the wellness plans of our community partners.

Priority 1: Physical Activity and Nutrition

The Forsyth County Health Needs Assessment identified physical activity as the leading prioritized health need. Forsyth County reports 42% of adults meet physical recommendations versus the North Carolina target of 61%; in addition, local community feedback derived from the assessment process indicated that obesity is the top community concern especially as it relates to the pediatric population.

Programs, Resources and Intended Actions to Address Obesity Health Need:

NCBH offers several programs to address the community's obesity needs, including Brenner FIT (Families in Training), a comprehensive pediatric weight management program founded on the principles of behavior change and family-centered care.

- Brenner FIT aims to improve the health of children in North Carolina and beyond and to date has served more than 500 children and their families (55% represent Medicaid and uninsured families). Brenner FIT is delivered by a multi-disciplinary team of health care professionals providing research-based care for children and families with weight problem. The team is comprised of pediatricians, behavioral counselors, dietitians, physical therapists, social workers, and exercise specialists.
- Best Health, the community wellness outreach program of WFBH, sponsors free cooking classes held throughout the year to the community at the WFBH Country Club Road Joslyn Diabetes Center test kitchen.
- Additionally, NCBH collaborates with various community partners to support nutrition and fitness programs throughout Forsyth County. These programs include:

    - The Downtown Community Health garden which provides fresh fruits and vegetables to low income patients (1,500 lbs of food).
    - Nutrition education at Downtown Health Plaza (DHP) for Medicaid and uninsured patients focusing on nutrition and healthy eating to support health, through co-located OB/Centering Pregnancy and WIC programs(1,000 Centering patients; 100 diabetes patients; 280 high-risk pregnant women)

- DHP Food Pantry provides free nutritious foods to approximately 10 families a week or approximately 500 families a year.
- Free BMI community screenings to approximately 250 residents per year.
- Sponsorship of a work-site placed farmer's market to increase fresh fruits/vegetables availability to hospital employees.
- Support of healthy lifestyle programs for NCBH employees (12,000+ employees) through Action Health which offer weekly education meetings, individual fitness and nutrition assessments along with free membership to the Fitness Center at Comp Rehab at a very low cost with some scholarships available.
- NCBH also participates in the Forsyth County Community Preventive Services Task Force- Be Health Coalition focusing on obesity. All programs and partnerships are intended to increase access to healthy food, decrease weight and lower overall health risk factors.

Goal
• Heighten awareness of nutrition and healthy lifestyle choices for uninsured and Medicaid patients and families.

Anticipated Impact
• Increase the number of children and families that understand body mass index and weight guidelines. • Increase the number of families that understand healthy food choices, incorporating increased numbers of fruits and vegetables.

Priority Population
☒ Broader Community ☒ Vulnerable Population

Specific Action	Annual Baseline	Growth Target	Intervention Strategies	Tactics	Collaborative Partners
Share the Care Health Fair- Body mass index (BMI) community screenings at DHP	250 persons	10%	1.1 Increase number of participants in BMI screenings	1.1.1 Identify new locations to offer BMI screenings	Forsyth County Health Department
DHP - nutrition education for Medicaid and uninsured patients	250 persons	5%	2.1 Increase number of participants in nutrition education classes	2.1.1 Identify new community partnerships	

Brenner FIT program enrollment of families including Medicaid and uninsured	150 new families per year (approx. 600 participants)	20%	3.1 Increase number of children and family members participating in BrennerFit	3.1.1 Increase family participation	1. YMCA
Brenner FIT Community Outreach	8,665 participants	10%	4.1 Increase the number of families that receive information on childhood obesity, nutrition and exercise in the community	4.1.1 Continue outreach at over 100+ community sites/programs	1. YMCA 2. NW AHEC 3. Forsyth-County Schools
Best Health –free community wide Cooking Classes for cardiology/heart health *held at Country Club clinic location	7 classes (136 participants)	10 classes (up to 22 participants)	5.1 Increase number of community members receiving healthy cooking classes	5.1.1 Increase community awareness of free classes	
Best Health – free community exercise events (yoga, resistance band classes, abs classes, zumba)	20 events (120 attendees)	25 events	6.1 Increase number of community members receiving free exercise classes	6.1.1 Increase community awareness of free community exercise classes	

Evaluation Plan: NCBH will accurately track screening data through Lyon Software (CBISA) and monitor class enrollment and completion rates for programs offered through Best Health, Downtown Health Plaza and BrennerFit. Impact will be measured based on above growth target, as compared to baseline statistics.

Priority 2: Chronic Disease Prevention and Management-Diabetes

Between 2006-2010, Diabetes ranked seventh (7th) in leading causes of death in Forsyth County. Further research reveals it is the 4th leading cause of death for the non-white population of Forsyth County and that the African American population has a much higher mortality rate for diabetes with a ratio of 1:3.3.

Programs, Resources and Intended Actions to Address Diabetes Health Need:

NCBH offers community based services including a diabetes education group at Downtown Health Plaza as well as glucose screenings. Additionally, the NCBH Joslin Diabetes Center provides coordinated care for diabetes patients offering the convenience of all patient appointments in one setting- an endocrinologist, an ophthalmologist, a podiatrist and a diabetes educator work together in one location to treat and develop the patient care plan. All of the aforementioned programs are intended to increase awareness of diabetes, provide prevention and management techniques and support patients in their diagnosis. NCBH works in conjunction with the Jerry Long Family YMCA to support their diabetes prevention program, which assesses pre-diabetes and provides a 16 week course, with nutrition, exercise and coaching to reduce risk factors associated with the onset of diabetes.

Goal
• Increase awareness of diabetes risk factors and provide educational resources and tools to prevent and manage the condition.
Anticipated Impact
• Increase the number of persons with diabetes whose condition has been diagnosed. • Increase the number of persons with newly diagnosed diabetes who receive formal education.
Priority Population
☒ Broader Community ☒ Vulnerable Population

Specific Action	Baseline	% Growth Target	Intervention Strategies	Tactics	Collaborative Partners
Best Health and DHP Share the Care Health screening-Community glucose/A1c screenings	300 persons	10%	1.1 Increase number of participants in screenings	1.1.1 Targeted outreach to high risk populations	1. Wake Forest School of Medicine 2. Forsyth County Health Department
Community diabetes education at Joslin Diabetes Center and Downtown Health Plaza	125 patients	10%	2.1 Increase number of DHP patient participants in diabetes education classes	2.1.1 Automatically enroll newly diagnosed diabetes patients into formal education program	
Best Health Diabetes prevention free community classes at Country Club clinic location	3 classes (30)	10%	3.1 Increase number of community members in diabetes education classes	3.1.1 Increase community awareness of free community diabetes education classes	

Evaluation Plan: NCBH will accurately track screening data through Lyon Software (CBISA) and monitor class enrollment and completion rates for programs offered at the Joslin Diabetes center and Downtown Health Plans. Impact will be measured based on above growth target, as compared to baseline statistics.

Priority 2: Chronic Disease Prevention and Management-Heart Disease

Cardiovascular disease, commonly called heart disease, refers to a group of heart conditions and is the second leading cause of death in Forsyth County, NC.

Programs, Resources and Intended Actions to Address Heart Disease Health Need: NCBH currently offers heart risk assessments, vascular screenings, and cardiac education that are designed to increase the community's awareness of risk factors, prevent unnecessary cardiac related problems, and connect individuals to prevention and management services. These activities will continue to be provided through NCBH's Heart Center, Best Health, and Action Health initiatives for employer groups, and civic organizations. NCBH will also work to ensure that current and future programming is targeting the

highest risk patients with more attention given to key geographical areas and community sites that represent a higher prevalence of patients and residents.

- Continue to provide heart and stroke *lunch and learns* to educate the public on signs, symptoms, prevention and treatment of heart attacks and stroke.
- Continue to sponsor heart-related screenings each year including: free EKG screenings, Heart Health talks, free community CPR classes, and heart and stroke prevention classes at health fairs and county government worksites.
- Continue to be a proactive participant in Forsyth County YMCA Health Fairs.

Goal
• Increase the awareness of heart disease risk factors and provide subsequent education for prevention.
Anticipated Impact
• Increase the number of adults who have had a comprehensive biometric risk assessment within the preceding 5 years. • Increase the number of adults with abnormal biometric levels who have been advised by a healthcare provider regarding a healthy diet, physical activity, and weight control.
Priority Population
☐ Broader Community ☒ Vulnerable Population

Specific Action	Baseline	Growth Target	Intervention Strategies	Tactics	Collaborative Partners
Heart risk assessment - EKG , blood pressure, PAD, Cholesterol/HDL	440	10%	1.1 Increase number of participants in heart risk assessments	1.1.1 Targeted outreach to high risk populations	WFBH Heart Center
Community education provided by BEST Health 1) Heart classes 2) Vascular Classes 3) Stroke Prevention	*13 events (190 persons*	10%	3.1 Increase awareness of cardiac risk factors	3.1.1. Identify new locations to offer cardiac education	1. YMCA Health Fair

*Country Club clinic, Clemmons Clinic, Brookridge Retirement community, Arbor Acres community					

Evaluation Plan: NCBH will accurately track screening data through Lyon Software (CBISA) and monitor class enrollment and completion rates for programs offered at both NCBH and community partner locations. Impact will be measured based on above growth target, as compared to baseline statistics.

Priority 2: Chronic Disease Prevention and Management- Cancer

Cancer remains the leading cause of death for Forsyth County residents (NC Center for Health Statistics, 2011) and is the leading cause of death among all races. The burden of battling cancers within our community varies; with disparities clearly present (DHHS, 2011). For example, the adjusted death rate for prostate cancer is 7.6 for the Forsyth County white population versus 17.4 for the black population, which means that for every one white resident that dies from prostate cancer there are 2.3 black residents that die from prostate cancer.

Programs, Resources and Intended Actions to Address Cancer Health Need: NCBH will continue to provide the services outlined below:

- Continue to provide education on the hazards of smoking specific to lung cancer (as well as stroke and heart disease) though community outreach events such as “Share the Care” health fair, BestHealth and the Speakers Bureau.
- Continue to provide the annual free skin cancer screening in July of each year at the Country Club Dermatology clinic.
- Support Action Health’s six week “Freedom from Smoking Class” for employees to encourage smoke free living.
- Support the development of new programs to help promote cancer prevention including NCBH’s Inpatient Smoking Cessation initiative to eliminate tobacco use by patients, visitors, contractors, students, and employees.

2013-2014 Goal
• Increase early detection and awareness in an attempt to reduce the number of stage 3 & 4 cancer diagnosis.
Anticipated Impact
• Increase the number of uninsured/underinsured women who receive a breast cancer screening based on the most recent guidelines. • Increase the number of men who have discussed with their healthcare provider whether to have a prostate-specific antigen (PSA) test to screen for prostate cancer.
Priority Population
☐ Broader Community ☒ Vulnerable Population

Specific Action	Baseline	% Growth Target	Intervention Strategies	Tactics	Collaborative Partners
Conduct annual community skin cancer screening at Country Club Dermatology Clinic	250 participants	25%	1.1 Increase number of participants attending skin cancer screenings	1.1.1 Targeted outreach to high risk populations **Will send documentation to the City of Winston Salem for all employees*	1. American Academy of Dermatology 2. Non-affiliated Wake physicians
Conduct Breast and Cervical Cancer Screenings at DHP (all uninsured)	160	10%	2.1 Increase number of participants in cancer screenings	2.1.1. Targeted outreach to uninsured population	1. Forsyth County Health Department
Best Health Community Education classes for cancer prevention - -skin	7 classes (200)	10 classes	3.1 Increase number of community members in attending education classes	3.1.1 Increase community awareness of free annual	

cancer/prevention seminars -colon cancer -malignant melanoma -breast cancer -skin cancer basics				screening- **Mailing goes out to all Best Health members*	

Evaluation Plan: NCBH will accurately track screening data through Lyon Software (CBISA) and monitor class enrollment and completion rates for programs offered at both NCBH and community partner locations. Impact will be measured based on above growth target, as compared to baseline statistics.

Priority 3: Access to Care

Forsyth County continues to have a high percentage of uninsured residents when compared to state and national benchmarks. Despite the fact that the median income of Forsyth County residents is above the state and national average, many residents are without health insurance. Barriers like lack of health insurance and the high cost of medical care decrease access to quality health care and can lead to unmet health needs. This includes delays in receiving appropriate care, inability to get preventive services, and potentially preventable hospitalizations thus increasing mortality and morbidity (HHS, 2010). Approximately 23% of Forsyth County residents were without health insurance in 2012. Hispanics are more than 5 times as likely to be without health insurance in Forsyth County when compared to their white counterparts.

Programs, Resources and Intended Actions to Address Access to Care Need:

With coverage expansion beginning October 1, 2013 NCBH will continue to evaluate the need for expanded primary care and access issues. Current access strategies include:

- Continue support of Downtown Health Plaza- NCBH is specifically responsive to the needs of the Medicaid and uninsured community and provides $4 million in subsidy funding for the Downtown Health Plaza (DHP), a Level 3 NCQA site and National Health Service Corp site. DHP serves approximately 70,000 patients visits per year – 32,000 adults and 29% of which are self-

pay; 20,000 are OB/GYN patients of which 51% are self-pay; and 18,000 are pediatric patients, 3% of which are self-pay. Many of the self-pay patients are managing chronic diseases such as diabetes, kidney failure and heart failure. DHP provides significant benefit to the community through the following initiatives: Collaboration with Northwest Community Care Network with onsite pediatric and internal medicine case manager; participation as a WIC site; provision of a community garden providing fresh vegetables and herbs to patients; hosting of a free food pantry to patients; offering a co-located mental health counselor for children in partnership with The Children's Home; and a co-located parent educator program in partnership with Imprints to help families address developmental delays in children. DHP also provides after hours clinic hours and serves as follow-up clinic for uninsured ED and inpatients served by the medical center.

- Continue to support the **"**Share the Health" FREE Health Fair at DHP – this event provides free health screenings and other health-related services to adults and children regardless of age, insurance coverage, income level or immigration status. The health fair serves approximately 650 children and adults on an annual basis.
- Continue the hospital's financial assistance program and education to help uninsured individuals and families learn about enrollment in sources of insurance such as Medicaid, Medicare, CHIP, WIC and healthcare exchanges.
- Continue to support the DEAC Clinic at the Community Care Center whose mission is to provide free high quality health care to underserved individuals. Through this program, approximately 19,000 patients per year within the Piedmont Triad Area receive care. WFBH medical students provide free medical care once a week to the Community Care Center's uninsured patients. Services include:
    - Specialty nights including: cardiology, pulmonary, dermatology, sports medicine
    - Blood work on-site and outside labs
    - Free medications on-site
    - Social services
    - Mental health and STI screening
    - Community wellness and prevention

2013 Goal
• Provide all individuals, regardless of ability to pay, an option for routine primary care and screenings.
Anticipated Impact
• Continued financial support of Downtown Health Plaza and congregational health programs leading to increased access to healthcare services.
Priority Population
☐ Broader Community ☒ Vulnerable Population

Specific Action	Baseline	% Target	Intervention Strategies	Tactics	Collaborative Partners
Contribute to county wide efforts to enroll uninsured residents in Health Exchanges/Medicaid at Downtown Health Plaza	23% uninsured adults (Forsyth County)	25% of approximately 4,000 patients in Year 01 who meet criteria	1.1 Ensure uninsured patients treated at the DHP are aware and receive assistance in enrolling in the Health Exchanges/Medicaid		Legal Aide of NW North Carolina Department of Social Services
Ensure Uninsured patients retain access to care through DHP	9,000 persons	Steady state-possible reduction given increased enrollment efforts in Health Exchanges/Medicaid	2.1 Ensure uninsured patients receive follow-up care post ED visits and inpatient admissions		

Evaluation Plan: NCBH will accurately track the number of uninsured residents served at Downtown Health Plaza and the Deac clinic along with the number of residents served through the FaithHealthNC congregational health promoters through Lyon Software (CBISA). Impact will be measured based on above growth target, as compared to baseline statistics.

Priority 4: Behavioral Health

The 2011 Community Stakeholders Interview (CSI), conducted between March and June 2011 revealed that stakeholders in multiple organizations across the county identified mental health issues as major challenges for residents. Stakeholders stated there were gaps in service for addressing mental health issues. When asked what was perceived to be the major health related problem in Forsyth County, the category of "Mental Health Issues; Lack of Mental Illnesses Services" ranked second highest along with "Chronic Illnesses."

Programs, Resources and Intended Actions to Address Access to Care Need: NCBH recognizes the overlap of mental, medical and social disparities and the important role of behavioral health in treating the whole person. NCBH will continue to support the following programs and activities:

- Continue to Support CareNet- Provides mental health screenings and services to the uninsured and underinsured across a broad region. This includes integrated behavioral health services at five clinics located in Forsyth County and surrounding areas.
- Continue the development of a community based behavioral health ED care strategy in collaboration with Forsyth Medical Center and Northwest Community Care Network. NCBH is working on the development of an ED care plan for those patients that are "shared" between both facilities; strategies include- increased ease of access for Centerpointe LME (the local mental health agency) employees on the NCBH psych unit & in the ED; potential housing options for the homeless; after hours telephone protocols; community pharmacies; and development of a wet shelter for substance abuse issues.
- Continue to support the implementation of a behavioral health pilot project in NCBH primary care community practices. In partnership with Northwest Community Care Network, three primary care practices- Peace Haven; Family Medicine Foothills and Wilkes are targeted. The pilot funds a full time Care Ambassador to screen for substance abuse issues as part of his primary care medical home and a referral for services when a need is identified. The pilot began January 2013 and to date has screened over 800 patients.
- Continue to support the "Homeless Opportunities & Treatment (HOT) Project" with Samaritan Ministries. NCBH provides staffing support to a mental health clinic designed to help homeless people stabilize their mental health. The HOT project provides free medication and counseling to a primarily uninsured population.
- Continue to support the CarePlus population management model for dually eligible Medicare and Medicaid patients to treat and manage behavioral health in coordination with chronic disease management. This model is in partnership with Centerpointe and Northwest Community Care Network.
- Continue to support an annual community conference "Bringing Advance Care Planning: New Initiative for North Carolina". The annual conference on patient-centered advance care planning is designed to educate and engage physicians, nurses, social workers, clergy and other health professionals on engaging patients in advance care planning as part of a coordinated/comprehensive system of care.
- Continue to support the DHP initiative to collaborate with the Kate B. Reynolds Foundation, Centerpointe and Daymark to move toward an integrated behavioral healthcare model.

2013 Goal
• Provide all individuals, regardless of ability to pay, access to mental healthcare.
Anticipated Impact
• Increase the number of individuals utilizing CareNet services. • Increase the number of patients at primary care practices and Downtown Health Plaza providing behavioral health screening and treatment.
Priority Population
☐ Broader Community ☒ Vulnerable Population

Specific Action	Baseline	% Growth Target	Intervention Strategies	Tactics	Collaborative Partners
CareNet encounters -#/% Uninsured -#/% Medicaid	38,948 encounters 6, 041 people Medicaid= 762 persons Uninsured- 1,161 persons	39.6% increase in clinic hours	1.1 Increase the number of total clinic hours by 39.6% to increase access to mental health services		
DHP (inclusive of CarePlus) referrals for mental health services *50% (5,000) of DHP internal medicine patients have a diagnosis of mental health	2,500 (Medicaid/ Uninsured)	5%	2.1 Identify and increase the number of patients (Medicaid and uninsured) referred to mental health services	2.1.1. Targeted outreach to high risk populations	Centerpointe CareNET Children's Home Inc. School Health Alliance

Evaluation Plan: NCBH will accurately track the number of participants with community nurses services and congregational health promoters through Lyon Software (CBISA). Impact will be measured based on above growth target, as compared to baseline statistics.

Future Priorities and Strategy Development

The North Caroling Baptist Hospital Foundation Board voted in June of 2013 to commit $5 million over five years to the development of FaithHealth community strategy. This strategy is focused on building and aligning community health assets in our hospital's nineteen county region for the purpose of improving access and advancing health status. While this funding includes research and technical assistance across the hospital's service area, it has an explicit focus on the census tracts in Forsyth County where charity care is concentrated. These tracts are marked by racial and ethnic disparities as well as predictable patterns of poverty and exclusion from many kinds of provider systems, not just healthcare. The strategy efforts will include building collaborative relationships with other kinds of providers relevant to the social determinants of health, including those faith congregations that are often the primary source of trust and street level access in these difficult neighborhoods. The funding locally includes resources for training and deploying part time community health workers drawn from the hospital's lower-wage employees (i.e. environmental staff), who live in and are familiar with the targeted neighborhoods. This strategy will not be targeted narrowly at the priority disease conditions identified in the CHNA, but rather will be relevant to all of them. As always, the hospital will develop and implement the FaithHealth strategy in tight alignment with the community partners including the Department of Public Health.

B. Needs NCBH will not address

Maternal & Infant Health was not included in NCBH's top four prioritized health needs in its current CHNA because the hospital does not deliver babies in Forsyth County. Except in emergency situations, infants are delivered at Forsyth Medical Center, a tax exempt hospital located in Forsyth County. The Medical Center does collaborate with Forsyth Medical Center by staffing their obstetric department with Wake Forest University Health Sciences faculty and hospital residents. In addition, the Medical Center participates in the Infant Mortality Task force sponsored by the Forsyth County Health Department.

NCBH chose not to pursue Social Disparities as a significant priority due to the need to focus resources on programs and activities that directly impact patient care as part of the hospital's mission. Social disparities are of communitywide concern and NCBH participates in a variety of community task forces to include the HEAT (Health Equity Action Team) coalition sponsored by the Health Department and chaired by Dr. Sylvia Flack of Winston Salem State University. NCBH also supports the work of the Maya Angelou Center for Health Equity and Wake Forest Public Health Sciences, both of which study social disparities and focus on conducting translational research to impact population health, developing sustainable and mutually beneficial community partnerships and delivering educational initiatives to diversify the clinical, biomedical and public health workforce.

Substance Abuse is also not directly addressed as a prioritized health need for NCBH although significant overlap of interventions and services occur within the Behavioral Health priority area. Substance abuse prevention and intervention efforts are led by Center Point, which oversees mental health, substance abuse and developmental disability services in Davie, Forsyth, Rockingham and Stokes counties. It is important to note that Center Point is a partner with the DHP CarePlus pilot for high risk patient.

Appendix 1: Healthy People 2020 Indicators

Diabetes:

- D-14 Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education

Nutrition and Weight Status:

- NWS-8- Increase the proportion of adults who are at a healthy weight
- NWS-10- Reduce the number of children and adolescents who are considered obese
- NWS-14 Increase the contribution of fruits to the diets of the population aged 2 years and older
- NWS-15 Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older
- NWS-17 Reduce consumption of calories from solid fats and added sugars in the population aged 2 years and older
- NWS-9- Increase the proportion of adults who are at a healthy weight

Cancer:

- C-15 Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines
- C-17 Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines
- C-20 Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn

Behavioral Health:

- MHMD-9 Increase the proportion of adults with mental health disorders who receive treatment
- MHMD-12 Increase the proportion of homeless adults with mental health problems who receive mental health services
- MHMD-5 Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral

Access to Care:

- AHS-1.1 Increase the proportion of persons with medical insurance
- AHS-6.1 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines