

2016 Community Health Needs Assessment High Point Regional Action Plan

High Point Regional Health is a 351-bed, private, not-for-profit regional health care system that joined UNC Health Care in 2013. High Point serves more than 120,000 patients a year in the Guilford County area. High Point Regional Health has a deep, rich history in the community that began in 1904. In 1950, a new facility opened 100 beds, 80 beds in the old building were still in use. In 1985, High Point Memorial officially changed its name to High Point Regional Hospital, to reflect the new focus on quality health care for High Point and surrounding communities in Guilford, Randolph, Davidson and Forsyth counties and throughout the Triad.

On January 8, 1986 the hospital opened a new facility. In response to the need for additional outpatient services and more sophisticated care High Point Regional added programs such as: High Point Surgery Center, the MRI Center, the Pain Management Center, the Cancer Registry, the Sleep Disorders Center, High Point Behavioral Health, the Restorative Care Unit and reconfigured inpatient units to provide more intensive and intermediate care. In January 2001 the Carolina Regional Heart Center, The Women's Resource Center and Women's Imaging Suite opened. In 2003 High Point Regional opened Hayworth Cancer Center. In 2002 the Health System opened its newly expanded and renovated Emergency Center, and the Piedmont Joint Replacement Center offering education, surgery, post-operative care and individual and group physical therapy for patients undergoing joint replacement.

On April 1, 2013 High Point Regional Health joined UNC Health Care. Today High Point Regional Health serves a region encompassing over 475,000 people.

The University of North Carolina Health Care System is a not-for-profit integrated health care system owned by the state of North Carolina and based in Chapel Hill. Originally established Nov. 1, 1998, by N.C.G.S. 116-37, UNC Health Care currently comprises UNC Hospitals and its provider network, the clinical programs of the UNC School of Medicine, and seven affiliate hospitals and hospital systems across the state.

The mission of High Point Regional is to provide exceptional healthcare to the people of our region.

In order to gauge public opinion regarding the priority health issues facing Guilford County, two public meetings were scheduled during April and May, 2016. Facilitators at these meetings shared recent county data based on the indicators in the population health model. Attendees shared their views about health issues and health needs in their communities. Data on priority health issues facing the county were collected from meeting participants. In addition to community meetings, community input was obtained through an online webinar in which the same data were presented and webinar participants identified priority health issues through an online survey. Meetings and a webinar were publicized through a press release to print and electronic media. Assessment partners assisted in publicizing these meetings. Assessment data were also presented to the CHA Steering Committee and staff of the Guilford County Department of Health and Human Services.

The priority health issues identified were:

- #1: Healthy Eating/Active Living
- #2: Social Determinants of Health
- #3: Behavioral Health
- #4: Maternal and Child Health

On August 31, 2016 the Guilford Assessment Team participated in a "Results Based Accountability" workshop. This approach was then utilized to conduct 9 additional community meetings focused on each of the priority areas. From these meetings results statements were developed, current resources, gaps and potential strategies were identified.

This report summarizes the efforts and strategies of High Point Regional Health in collaboration with the Guilford Assessment Team to address the prioritized needs identified in the 2016 Guilford County Community Health Needs Assessment. The High Point Regional Team utilized the data from the Guilford County Community Health Needs Assessment and additional information gathered from the community "Results Based Accountability" forums to develop action plan strategies to address the identified needs. The implementation strategies were then prioritized by the High Point Regional Executive Leadership Team and the final strategies were adopted by the High Point Regional Board on November 14, 2016.

High Point Regional Community Health Needs Assessment Action Plan

Priority Area: Needs overarching all priority areas

| Gap | County Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed / Available | Evaluation Metric |
|--|-----------------|--|--|---|---|---|--|
| No central repository of Community Assessment information that is updated on a continual basis | Yes | Launch Piedmont Health Counts Website | Work with Healthy Communities institute to create the website, administrators from partner agencies to upload the data | Shared repository of Community Needs Assessment with statistical data that will be continuously updated | Website domain and platform have been purchased, ongoing maintenance fees | Community Health Assessment partners | Website live and up to date |
| Collaboration in house and in the community | | Development of a HPR Community Health Team to manage the Community Health Needs Assessment and 990 reporting process | Collaborate with the Guilford Assessment Team to perform ongoing assessment and strategy planning and implementation | Coordinate program to assure assessments are performed and action plans are developed and implemented. | Staff, budget | UNC, Guilford Community Assessment Team | Track hours of participation, Improved results on the Community Needs Assessment |
| Community Collaboration | Yes | Continued collaboration with the Guilford County Community Assessment Team to assess, plan and implement evidenced based interventions | Collaborate with the Guilford Assessment Team to get schools, community health, churches, and food banks involved | Would help meet goal | Staff to participate, funding for the collaborative | Guilford Community Assessment Team | Track hours of participation, Improved results on the Community Needs Assessment |

Priority Area: Healthy Eating / Active Living

Priority Statement: Chronic diseases, especially cancer and heart disease, are the leading causes of mortality and drivers of health care costs in Guilford County. About two-thirds of all deaths in Guilford County are due to chronic diseases. Modifiable risk factors for chronic disease include obesity, physical inactivity, diet and nutrition, and tobacco use. Promoting healthy eating and active living can improve rates of morbidity and mortality.

Guilford County Results Statement: All residents of Guilford County have easy and informed access to healthy, affordable food and opportunities to be physically active.

High Point Regional Goal: High Point Regional, in collaboration with community partners, will provide accessible resources to our community and employees to address obesity, physical activity, diet and nutrition and substance use.

| Gap | County Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources needed | Collaborative Partners Needed / Available | Evaluation Metrics |
|---|-----------------|--|---|---|---|---|----------------------|
| Lack of resource knowledge | Yes | Work with the Guilford Community Assessment Team to create a resource map for Healthy Eating and Active Living. Provide education on the resources to the community, staff and physicians. | Hold a community resource fair, provide LMS training to employees, provide information at provider offices, and get schools, community health, churches and food banks involved. | Increase knowledge of community resources. | Staff to participate in creation of the resource, printing and distribution | Guilford Assessment Team, Guilford Adult Health | Resource Map created |
| Lack of paid staff time and/or volunteers needed to perform screening and education | | Incentivize employees to volunteer. | Track and reward community volunteer hours provided by employees. | Increase volunteer hours for community events. | Volunteers | | Volunteer hours |
| Education and social support | Yes | Create a multi-component childhood obesity intervention | Collaborate with High Point University to develop a child/ adolescent group intervention for children who are either obese or at risk for obesity to provide clinical services to the community (free of charge), train undergraduates to provide some behavioral interventions, and collect data for professional presentation and publication. Pilot Spring 2017. | Decrease incidence of childhood obesity in the community. | Space, supervision, supplies, coordination and marketing | High Point University | Children served |

| Gap | County Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed/ Available | Evaluation Metrics |
|----------------------------------|-----------------|---|---|--|---|--|---|
| Lack of access to healthy foods | | Identify patients who have food insecurity and offer resources at discharge. | Institute a food insecurity screening during admission. | Patients identified at risk will be provided resources at discharge. | Screening form | Nursing Staff | Patients screened and provided resources |
| Physical activity social support | Yes | Provide community social support intervention for physical activity. | The Fitness Center: Increase participants of the Fitness Center a medically supervised fitness program which provides physical fitness training and support, health education and nutritional counseling. Expand current strategy to provide scholarships for low income residents. | Provides community access to physical activity and support. | Expand current strategy with grant funding | HPR Foundation, Healthy High Point Foundation | # of participants actively using the center |
| Accessibility of resources | | Plan educational programs and screening events at locations most accessible to the target audience. | Partner with other community events, food pantries to provide nutritional and physical fitness education. Consider an incentive program to encourage participation. | Resources are provided at the most accessible location. Provides an incentive for people to participate. | Staff to coordinate the events and provide the education | Food Alliance, Farmers Market at Library, High Point Parks and Recreation, Get Healthy High Point Foundation | # of participants |
| Access to screening services | | Increase the number of health screening and education events. | Additional health screening and education events will be coordinated through the contact center and marketing department. | Increases early detection and treatment of chronic disease. | Expand Current Strategy additional supplies, staffing, marketing, event locations | High Point University, Community Locations | # of screening performed, morbidity and mortality statistics, cost of supplies and staff time |

| Gap | County Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed / Available | Evaluation Metrics |
|---|-----------------|---|--|---|-----------------------------|---|---|
| Access | | Transitional Care Clinic | Provides follow up and medication services for up to 90 days after discharge. Attempts to link patient with a PCP for ongoing care. | Will see a reduction in readmissions, patients will receive needed follow up care. | Current Strategy | Regional Physicians | Readmissions, patients linked to primary care, cost of charity care and care provided to the uninsured. |
| Access | | Continue collaboration with the Community Clinic of High Point to provide access to care for uninsured residents. | Provide in kind services and funding to the Community clinic of High Point. | Provides access to care for the uninsured. | Current Strategy | Community Clinic of High Point | Amount of funding and In kind services provided |
| Access and lack of resource knowledge | | Community Collaboration | Continue to engage Guilford Adult Health to be the community link for collaboration related to healthy eating, active living and access. | Reduces duplication of services, increases participant knowledge of available resources | Current Strategy | Guilford Adult Health | Participation and attendance |
| Access to screening services | | Continue the Breast and Cervical Cancer Control Program. | Provides free mammograms and PAP smear to women who qualify for the program. | Early detection of breast and cervical cancer. | Current Strategy | North Carolina Breast and Cervical Cancer Control Program | # of participants, unreimbursed cost of the program |
| Access to transportation and medication | | Continue LoveLine services and the annual LoveLine Event. | Funds the cancer transportation program, medication assistance and other services for cancer patients. | Provides needed resources to cancer patients. | Current Strategy | HPR Foundation | Patients served |

| Gap | County Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed / Available | Evaluation Metrics |
|---------------------------------|-----------------|--|--|---|-----------------------------|--|-------------------------------|
| Education | Yes | Provide health education to area students. | Millis Regional Health Education Center: Provides health education for school aged children on site and within the community, with scholarships available for title 1 schools. Cooking classes at title 1 schools. | Provides education to children. | Current Strategy | Ward Street Church, Junior League of High Point, Elementary/Middle Schools | # of classes and participants |
| Education | | Provide regular Women's Wellness education sessions. | Provides free education to the community on women's wellness issues throughout the year. | Provides women health education. | Current Strategy | Volunteer speakers | # of classes and participants |
| Education | | Provide educational classes to the community on a variety health related topics. | Respond to specific requests from the community for educational programs and events. | Provides health education services to the community. | Current Strategy | Volunteer speakers | # of classes and participants |
| Education | | Provide education resources to our patients with a diagnosis of cancer. | The Tommie Thomas Cancer Resource Center | Educational resource for cancer patients. | Current Strategy | HPR Foundation Guideposts of Strength Volunteers | |
| Lack of access to healthy foods | Yes | Provide resource for healthy food to the employees and the community. | Host a weekly farmer's market May-October, accepting EBT. | Provide food, education, connection to community resources. | Current Strategy | High Point Food Alliance, | # of markets held |
| Social Support | Yes | Offer monthly support groups. | Current support groups include: Look Good Feel Better, Breast Cancer Support, Bariatric Surgery Support, Living with Cancer, Stroke Support, Ostomy Support, Men's Cancer Support, Amputee Support | Provides social support to patients. | Current Strategy | Physicians, volunteer speakers | Participation and attendance |

Priority Need: Social Determinants of Health

Priority Statement: Social conditions, such as income, employment and crime, have a significant impact on the health of individuals, families and communities. Assessment data showed very strong relationships between educational attainment and income with life expectancy, chronic disease, mortality and other health conditions. Differences in the social determinants of health result in large racial and geographic disparities in health outcomes.

Guilford County Results Statement: All residents of Guilford County have access to a high quality education, are able to secure jobs that pay a livable wage and live in safe homes and neighborhoods.

High Point Regional Goal: Support the Guilford County results statement for all residents to have access to high quality education, are able to secure jobs that pay a livable wage and live in safe homes and neighborhoods.

| Gap | County Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed / Available | Evaluation Metrics |
|--------------------------------|-----------------|---|---|---|---|---|---|
| Low Healthy Literacy | Yes | Provide education in a manner the patient can understand. | Provide appropriate education to individual patient based on the patient skill level; provide interpretation services as needed to all non-English speaking patients. | Education provided at the appropriate level for each patient. | Alternative education materials for patients with reading level below the 5th grade | NC Health Literacy Counsel, NC Institute of Medicine, High Point University | Resources available for low literacy patients |
| Access to services | | Increase collaboration with faith communities in our area | Apply to participate in the Faith Health Fellowship Program, after program completion determine implementation plan for Faith Health Initiative in the High Point community. | Increase the ability to identify and connect people with resources within the community | Staff time to participate in the fellowship program | Faith Health, NC | Application accepted |
| 17% of residents are uninsured | | Provide access to care for uninsured, increase the number of patients approved for charity and/or Medicaid. | Fully utilize Financial Access Policies (Charity Care) at High Point Regional and Regional Physicians practices. Expand financial assistance screening to maternity patients. | Patients are able to access needed care regardless of insurance coverage. | Expand current strategy | UNC Chapel Hill | Amount of Charity Care provided |

| Gap | County Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed / Available | Evaluation Metrics |
|---|-----------------|--|---|--|-----------------------------|---|---|
| Less than 26% of those residents attending college graduate | Yes | Increase the attainment of college degrees. | Provide tuition reimbursement for employees. | Provides financial resources assist with tuition expense. | Current strategy | | Number of employees receiving tuition reimbursement, number of employees completing degrees |
| Low Healthy Literacy | Yes | Improve health literacy of Guilford County residents. | Millis Health Education Center provides education for school aged children with scholarships for Title 1 schools. | Provides health education to students. | Current strategy | Schools | # and type of class held, number of participants |
| Less than 26% of those residents attending college graduate | Yes | Continue to provide Career Coaching through the Path Program. | Introduces High School students to health careers. | Helps students identify interest which may increase those completing a degree. | Current strategy | | Volunteer hours |
| Unemployment | Yes | Provide jobs that pay a livable wage. | Regularly survey positions to assure salary and benefits competitive to the market. | Retain employees. | Current strategy | | Salary survey results |
| Less than 26% of those residents attending college graduate | Yes | Collaborate with area colleges and universities to provide learning opportunities. | Provide learning experience applicable to completion of college degree. | Students receive appropriate learning experience needed for graduation and preparation to enter the workforce. | Current strategy | Area colleges and universities | Student preceptor hours |

| Gap | County Identified Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed / Available | Evaluation Metrics |
|--|----------------------------|---|--|---|-----------------------------|---|---|
| Lack of primary care access for adults | | Provide access to discharge follow up for high risk patients who do not identify a PCP. | UNC Regional Physicians Transitional Care Clinic provides follow care for high risk patients up to 90 days after discharge. | High risk patients receive appropriate discharge follow up and are linked to a primary care medical home. | Current strategy | Inpatient Units and hospitalists | # served, readmissions |
| Unemployment | | Project Search | Project SEARCH is an international high school transition program that is a unique, business-led, one-year, school-to-work program that takes place entirely in the workplace. The goal for each student participant is competitive employment. The Project SEARCH model involves an extensive period of training and career exploration, innovative adaptations, long-term job coaching, and continuous feedback from teachers, job coaches, and employers. | Provides real-life work experience combined with training in employability and independent living skills to help youths with significant disabilities make successful transitions from school to productive adult life. | Current strategy | Schools | # of participants who are successfully employed after program completion |
| Lack of access to primary dental and integrated care services for uninsured adults | | Guilford Adult Health | Continue partnership with Guilford Adult Health assures appropriate access to healthcare services in the community and collaboration between service providers. | Uninsured have access to primary, dental and specialty care. | Current strategy | Guilford Adult Health, grant partners | # of residents served, \$ amount of services provided to patients through the program |

Priority Need: Behavioral Health

Priority Statement: About a quarter of community health survey respondents reported that they have issues with depression and anxiety, with many reporting a significant number of mental health days. Mental health providers are not as plentiful in Guilford as in some peer counties.

Guilford County Results Statement: All residents of Guilford County have access to strong social support; high quality behavioral health interventions; and effective prevention, treatment and recovery programs for mental health and substance use disorders. Providers are not as plentiful in Guilford as in some peer counties.

High Point Regional Goal: High Point Regional will collaborate with Community Partners to provide information, education, social support and high quality behavioral healthcare.

| Gap | County Identified Strategy | Strategy to Address the Priority Need | How Specifically - (Action) | Impact of the Action | Additional Resources needed | Collaborative Partners Needed / Available | Evaluation Metrics |
|--|----------------------------|--|---|---|---|--|---|
| Access to intensive substance abuse treatment | Yes | Collaboration with community partners | Collaborate with community partners to improve access to Opioid Treatment; including, pregnant women. | Improve access to services. | Possibly grant funding | Grant funding partners, treatment provider partners. Caring Services, ADS, Family Services | Overdose statistics, # of babies born with Narcotic Abstinence Syndrome |
| Access to outpatient behavioral health providers is lower than peer counties | Yes | Care Coordination | Consider expansion of Regional Behavioral Health services to pediatrics and substance abuse. | Improve access to care. | Space, staff expertise in pediatric behavioral health and substance use, supplies | Grant funding partners | # of providers |
| Access to Care | | Collaborate with community partners to provide access to care in the community | Expand pilot program High Point Citizens Against Violence to additional schools. | Identification and counseling for violent children in the schools | Grant funding for additional provider time | Guilford county Schools, High Point Police Department, High Point Regional | # of children reached by the program, number of schools where program is provided |
| Lack of knowledge of services and resources offered | | Partner with community services and other behavioral health providers. | Actively participate in mental health community collaborative. Continue Mental Health Care Committee meetings monthly and quarterly for providers in the community on the unit. | Staff is better informed about the resources available and can build upon available resources and address gaps. | Staff time to work with the collaboration | Guilford Community Assessment Team, Mental Health Alliance | Meeting participation |

| Gap | County Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed / Available | Evaluation Metrics |
|---|-----------------|---|--|---|--|--|-------------------------------|
| Lack of knowledge of services and resources offered | | Create a community resource map for behavioral health. | Collaborate with community partners to create a resource map for Mental Health services. Give Resource list/map to patients. | Providers and patients are better informed of available resources and how to access them. | Staff time to work with the collaboration, printing expense | Community Assessment Team | Creation of the resource map |
| Lack of education and training | Yes | Train staff to be first responders to Mental Health needs. | Provide access to "Mental Health First Aide Training" to HPR and Regional Physicians employees. | Staff and providers are better equipped to be first line responders | Training materials and time for employees to take the 8 hour training. | Guilford County DHHS, NC Department of Health and Human Services | % of employees trained |
| Lack of education and training | Yes | Collaborate with community partners to provide provider education | Provide education on identification of substance use and how to access referral resources when drug abuse is identified. | Improve identification of patients who could benefit from Substance Abuse counseling and treatment. | Training materials and time for employees to take the training. | AHEC, ADS | # of providers trained |
| Access to Care | | Explore potential for the opening a "Memory Care Unit" to provide dementia care while patients are waiting for permanent placement. | Perform a cost benefit analysis for opening a dementia care unit. | Provides appropriate level of care for patients awaiting placement | Planning Resources | UNC | Analysis completed |
| Lack of access to mental health care for Pediatrics | Yes | Integrated Behavioral Health | LCSW co-located at the Regional Physicians pediatric practice. | Provides behavioral health services at the primary care practice. | Current Strategy- may need increased staff as program grows. | Regional Behavioral Health | Referral and outreach metrics |

| Gap | County Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed / Available | Evaluation Metrics |
|--|-----------------|---|--|--|-----------------------------|--|--------------------------------------|
| Fragmented Care | Yes | Care coordination (information sharing) | Family Services Care Manager in the behavioral health unit 5 days a week. | Improves coordination of care. | Current Strategy | Family Services, Healthy High Point Foundation, United Way | Clients served and relapse rates |
| Fragmented Care | Yes | Care coordination | Caring Services social worker visits to educate patients on the Narcan program after any heroin overdose. | Improves coordination of care. | Current Strategy | Caring Services | # of patients served, # readmissions |
| Lack of access to affordable medications | | Care Coordination | Pay for medications at discharge and 1 refill for patients in need. | Allows patient time to access other prescription assistance resources. | Current Strategy | | # of patients served, # readmissions |
| Need for early education and training | | Substance abuse education for school aged children. | Millis "Be in the Know" substance abuse education. | Children are educated on substance use. | Current Strategy | | # of children served |
| Need for training and education | | Family Education | Behavioral Health Family education and support group weekly for patients admitted to the behavioral health unit. | Provide information and education on community resources available. | Current Strategy | | # of families in attendance |

Priority Need: Maternal and Child Care

Priority Statement: Poor birth outcomes are a significant problem for Guilford County, with rates of infant mortality and low birth weight considerably higher than national benchmarks and objectives. African-Americans experience preterm birth, low and very low birth weight and infant mortality at substantially higher rates than whites. Low birth weight and preterm births as well as teen pregnancies occur at higher rates in areas of the county characterized by higher rates of poverty and unemployment, and low educational attainment.

Guilford County Results Statement: All women in Guilford County will have access to and utilize health care before, during and after pregnancy; and their babies are born at a health birth weight.

High Point Regional Goal: All women in Guilford County will have access to education, behavioral health services, substance abuse services and health care before, during and after pregnancy; and their babies are born at a healthy birth weight with good outcomes. Social Services are available for those identified at risk for any socioeconomic risk factors.

| Gap | County Identified Strategy | Strategy to Address the Priority Need Gap | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed / Available | Evaluation Metric |
|--|-----------------------------------|--|--|---|--|---|---|
| Lack of resource knowledge | Yes | In collaboration with community partners create a Maternal Health Resource Map. | Launch a Health Communication Campaign to promote use of the resource map within the community. | Families and providers are aware of the resources available and how to access them. | Identify lead agency and collection of date, posting and printing of the resource map, marketing, staff time to participate in the team. | Community Health Assessment Team, United Way, Partnering with area obstetricians and pediatricians | Access to prenatal care, Infant Mortality |
| Lack of coordination between other community resources | Yes | Identify group to lead coordination and collaboration efforts. | Actively participate in the group identified to lead coordination and collaboration efforts. | Coordination of care improves, avoids duplication of effort. | Staff time to participate in the collaborative | Healthy Tomorrow Alliance Healthy Beginnings Program, Universal Home Visiting Program, United Way | Access to prenatal care, Infant Mortality, Birth Weight |
| Need to increase rates for exclusive breastfeeding | | Breast Feeding Support Group, information on breastfeeding shared prenatally. | Work with physician offices and community services prior to birth to educate pregnant women and community. | More women will be successful at exclusively breast feeding. | May need additional lactation consultant support | Guilford County Health Department, WIC | Infant Mortality Rate, number of women choosing to breast feed, exclusive breastfeeding rate reported |
| Lack of prenatal care in impoverished communities | | Collaborate with community resources to provide resources where women are accessing other resources. | Work with food banks and community centers to create a collaborative program where women are incentivized to come in during first 12 weeks of pregnancy, provide information on Pregnancy Medicaid and other prenatal resources. | Increase number of women receiving prenatal Care in the 1st trimester. | Community partners, locations, volunteers, staffing, materials and supplies, grant funding for expansion | Community Food Banks, Community Centers, Guilford County Department of Health and Human Services, United Way, Healthy High Point Foundation | Women receiving prenatal care within the 1st trimester. Women accessing and successfully applying for Pregnancy Medicaid. |

| Gap | County Strategy | Strategy to Address the Priority Need GAP | How Specifically - (Action) | Impact of the Action | Additional Resources Needed | Collaborative Partners Needed / Available | Evaluation Metrics |
|--|------------------------|---|---|---|--|---|---|
| Increasing number of babies born with Neonatal Abstinence Syndrome | | Social Work Intervention, Greater community education on drug use during pregnancy, | Multi-disciplinary team (Physician, Nursing, Social Worker) meeting for Neonatal Abstinence Syndrome (NAS) patients and networking with Guilford County Department of Social Services Child Protective Services for appropriate family plans and infant placement | Development of Family Plan post discharge | Expand current strategy Collaborative Team Members and community resources for Substance Abuse Treatment | Guilford County Department of Social Services Child Protective Services, Medical providers knowledgeable in substance abuse treatment during pregnancy. | Number of pregnant patients admitted with a positive drug screen, number of infants admitted with diagnosis of "Detox" for substance abuse. Infant Mortality Rate |