# Community Health Action Plan 2016

*Designed to address Community Health Assessment priorities (Form updated Jan. 2016)*
*Three priorities identified during the 2015 CHA process are required to be addressed. Each priority should have a separate "Community Health Action Plan". Action plans are due by* ***the first Monday in September following the March submission of the CHA, per consolidated agreement.***

**County:** Jackson **Period Covered:** 2016-2018

**Partnership/Health Steering Committee, if applicable:** Healthy Carolinians of Jackson County

**Community Health Priority identified in the most recent CHA:** Chronic Disease

**Local Community Objective:** **Chronic Disease**
X **New** ___ **Ongoing**

- **Baseline Data:**
  - 2011 Adult Obesity Prevalence (CDC BRFSS): 32.6% of Jackson County adults are obese
  - 2012 Adult Diabetes Prevalence (CDC BRFSS): 12.4% of Jackson County adults have diabetes
  - 2013-2009 Heart Disease Mortality (NC SCHS): 163 per 100,000 Jackson County adults have died from heart disease
  - 2013-2009 Colorectal Cancer Mortality (NC SCHS): 17.6 per 100,000 Jackson County adults have died from colorectal cancer
- **For continuing objective provide the updated information:** N/A as chronic disease is a new community objective
- ***Healthy NC 2020 Objective*** that most closely aligns with focus area chosen below: Chronic Disease, Cross-cutting

**Population(s)**

**I. Describe the local population at risk for health problems related to this local community objective:**

**All residents** in Jackson County can benefit from strategies that focus on chronic disease prevention. There are many health risk behaviors that put one at greater risk for developing a chronic condition—**lack of exercise or physical activity**, **poor nutrition**, **tobacco use**, and **drinking too much alcohol**. Additional vulnerable populations, such as **low-income**, **the un- or under-insured**, and **those of low socioeconomic status,** are all at greater risk for developing a chronic condition. **Adults, age 18 years and up, will be the target for this Action Plan.**

**II. Describe the target population specific to this action plan:**

**A. Total number of persons in the target population specific to this action plan:** 41,265

**B. Total number of persons in the target population to be reached by this action plan:** 34,209

**C. Calculate the impact of this action plan:** 82.9%

***Healthy North Carolina 2020* Focus Area Addressed:** Each of the two CHA priorities selected for submission must have a corresponding *Healthy NC 2020* focus area that aligns with your local community objectives.

- **Check below the applicable Healthy NC 2020 focus area(s) for this action plan.**
  *For more detailed information and explanation of each focus area, please visit the following websites:*
  **http://publichealth.nc.gov/hnc2020/foesummary.htm**
  **http://publichealth.nc.gov/hnc2020/**

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| ☐ Tobacco Use | ☐ Maternal & Infant Health | ☐ Social Determinants of Health |
| ☐ Physical Activity & Nutrition | ☐ Substance Abuse | ☐ Environmental Health |
| ☐ Injury | ☐ Mental Health | ☒ Chronic Disease |
| ☐ Sexually Transmitted Diseases/Unintended Pregnancy | ☐ Infectious Disease/Foodborne Illness | ☒ Cross-cutting |
| | ☐ Oral Health | |

**Evidence Based Strategy/Intervention (EBS) Table:** Researching effective strategies/interventions

| **Evidence Based Strategies Used with Like Population(s)** *(Include source)* | **Strategy/Intervention Goal(s)** | **Implementation Venue(s)** | **Resources Utilized/Needed for Implementation** |
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| Name of Intervention: National Public Health Improvement Initiative- New Mexico Department of Public Health<br><br>RBA is an evidence-based planning, monitoring, evaluation, and continuous improvement framework that focused on results for communities and individuals.<br><br>Source: HC Healthy Improvement APP (IMAPP); http://www.ncimapp.org/resources/6-plan/<br><br>Community Strengths/Assets: External funding source (CDC); Collaboration and support from the University of New Mexico School of Medicine Public Health Program; Collaboration & support from the New Mexico Public Health Training Center | S.M.A.R.T Goals:<br>To improve health and agency business process and to improve performance and quality of internal and external services by the end of year 4 (2013)<br><br>To build quality and performance improvement competencies by providing 2 RBA trainings for trainers and coaches and workshops for agency leaders and managers and key community partners by the end of year 3 (2012)<br><br>To identify a minimum for 2 program and system performance improvement opportunities, apply the RBA Performance Accountability process, and implement and track performance using appropriate data to evaluate and sustain improvement by the end of year 3 (2012)<br><br>To develop, publish, update, and promote public access to the Scorecard by the end of year 3 (2012) | Target Population(s): Agency- New Mexico Department of Health; Population of New Mexico (2.087 million)<br><br>Venue: New Mexico Department of Health | Resources Needed: RBA training for trainers, coaches, workshops for agency leaders and managers and key community partners; Access to Scorecard |
| Name of Intervention: Diabetes Prevention Program (DPP)<br><br>Source: Healthy NC 2020 EB Strategies; Diabetes Prevention Program; www.ncdiabetes.org<br><br>Community Strengths/Assets: 2 Lifestyle Coaches already trained; Structure in place as program is currently being implemented in community; Multiple venues willing to host program; Waiting list of participants interested in the program | S.M.A.R.T Goals:<br>To decrease the percentage of adults with diabetes<br><br>To hold 2 classes annually with a minimum of 8 participants per class<br><br>To help participants lose 5% of their starting body weight within 16 weeks and maintain that weight loss throughout the duration of the program<br><br>To help participants participate in physical activity weekly for the duration of the year-long program. | Target Population(s): People diagnosed with pre-diabetes or who have multiple risk factors for diabetes<br><br>Venue: Community or clinical, i.e. health department, church, community center, hospital | Resources Needed: Curricula, Food & Activity logs, Incentives, Meeting space, Lifestyle coach, Food models, IT, Easel paper, Markers |

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| Name of Intervention: Diabetes Self-Management Education Program (DSME)<br><br>Source: The Community Guide to Preventative Services; http://www.thecommunityguide.org/diabetes/selfmgmteducation.html<br><br>Community Strengths/Assets: Existing program in place at the Health Department and Hospital; Good relationship with providers for referrals | S.M.A.R.T Goals:<br>To increase the percentage of adults who adequately manage their diabetes<br><br>To offer DSME to 100 patients annually<br><br>To decrease HgA1C of patients by 1.9% by the end of the program<br><br>To decrease the patients' weight by 5.2 pounds by the end of the program | Target Population(s):<br>Adults, age 18 years and older, with Type 1, Type 2, or gestational diabetes<br><br>Venue: Community settings like community gathering places, the home, recreational camps, worksites, schools, health departments, hospitals | Resources Needed: Curricula; Dietitian; Food models; Insulin models; Glucose test meters; Glucose test strips; Scale; Blood pressure cuff; Educational material |
| Name of Intervention: FLU-FOBT Program<br><br>Source: American Cancer Society through the National Colorectal Cancer Roundtable; www.flufit.org<br><br>Community Strengths/Assets: Relationship in place between the Health Department and Department on Aging; Screening events held frequently; Aging population | S.M.A.R.T Goals:<br>To increase colorectal cancer screening rates by offering home FOBT to eligible patients during annual flu shot activities<br><br>To offer FOBT to any patient receiving a flu shot who is aged 50-75 years.<br><br>To mail out FOBT reminder cards to 80% of patients who received a kit but haven't returned the kit in 1-months' time. | Target Population(s):<br>Adults 50-75 years, especially men and African Americans<br><br>Venue: Health departments, physician offices, participants' homes, community | Resources Needed: FLU-FOBT announcements; advertising posters; Visual aids on how to complete the FOBT; Multilingual materials; Pre-addressed FOBT mailing pouches; Pre-stamped FOBT mailing pouches; FLU-FOBT log sheet |

**Interventions Specifically Addressing Chosen Health Priority**

| INTERVENTIONS: SETTING, & TIMEFRAME | LEVEL OF INTERVENTION CHANGE | COMMUNITY PARTNERS' Roles and Responsibilities | PLAN HOW YOU WILL EVALUATE EFFECTIVENESS |
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| **Intervention**: Results Based Accountability (RBA) approach to collaborative action planning process<br><br>☒ New ☐ Ongoing ☐ Completed<br><br>**Setting**: Jackson County Department of Public Health (JCDPH)<br><br>**Target population:** Chronic Disease Action Team members<br><br>**Start Date – End Date (mm/yy):** Feb 2016- Dec 2018<br><br>**Targets health disparities**: ☐ Y ☒ N<br><br>**RBA Summary**: JCDPH held a Community Meeting, sharing the RBA Basics and completing the Whole Distance Exercise. From there, Action Teams developed based on interest and health priorities. Each Action Team completed the Whole Distance Exercise. Action Teams meet monthly to determine which strategies to implement, which performance indicators to track, and how to communicate this | ☐ Individual/ Interpersonal Behavior<br><br>☒ Organizational/Policy<br><br>☐ Environmental Change | **Lead Agency:** JCDPH<br><br>Role: Convener/facilitator<br><br>☐ New partner ☒ Established partner<br><br>**Target population representative**: Kae Livesy<br><br>Role: Implement RBA principles in programmatic activities<br><br>☐ New partner ☒ Established partner<br><br>**Partners**: Healthy Carolinians of Jackson County, Western Carolina University (WCU) Nursing Department<br><br>Role: Provide support in RBA implementation, provide access to students to update RBA scorecard<br><br>☒ New partner ☐ Established partner<br><br>**Include how you're marketing the intervention:** Individual conversations with the Chronic Disease Action Team leadership; Integrate RBA basic | **Expected outcomes**: Chronic Disease Action Team members understand and can articulate the difference between population and performance accountability; Chronic Disease Action Team members can talk about their program performance and how it contributes to population indicators; Chronic Disease Action Team members can use RBA in their own work; Chronic Disease Action Team members use Results Scorecard to track program performance<br><br>**Any potential barriers?** ☒ Y ☐ N<br>**If yes, explain how intervention will be adapted:** Learning curve as agencies implement new principles; Gaining support from internal leadership and community at large<br><br>**List anticipated project staff:** Melissa McKnight, Jo Bradley, Kae Livesy, WCU nursing students<br><br>**Does project staff need additional training?** ☐ Y ☒ N<br>If yes, list training plan: _____<br><br>**Quantify what you will do:**<br>How Much Did We Do: Attend 1 or more training and/or coaching session with WNC Healthy Impact RBA consultants; Introduce RBA ideas to the Chronic Disease Action Team; Utilize Results Scorecard to develop a publically available e-CHIP<br>How Well Did We Do It: % of Chronic Disease Action Team who have been exposed to RBA; % of Chronic Disease Action Team members who have participated in a Whole Distance Exercise<br><br>**List how agency will monitor intervention activities and feedback from participants/stakeholders:** RBA will be |

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| information to the public. Using the RBA framework, each Action Team focuses in on three questions per strategy/program: How much did we do? How well did we do it? Is anyone better off? | | ideas into regular meetings; RBA 101 trainings for leadership and/or members | monitored in the web-based platform, Results Scorecard. Feedback will be gathered from participants/members via an annual "Collaborative Group Member Survey" and will be displayed under Story Behind the Curve for the intervention using the RBA approach.<br><br>**Evaluation**<br>**Are you using an existing evaluation?** ☐Y ☒N<br>**If no, please provide plan for evaluating intervention:** JCDPH plans on using RBA, a planning, monitoring, evaluation, and continuous improvement framework that focused on results for communities and individuals. Performance measures for interventions will be identified and regularly monitored to document the quantity, quality, and participant impact of the intervention. We will track: How much did we do? How well did we do it? Is anyone better off? |

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| **Intervention**: Diabetes Prevention Program (DPP)<br><br>☐ New ☒ Ongoing ☐ Completed<br><br>**Setting:** Community & clinical<br><br>**Target population:** Adults, age 18 years and older, with pre-diabetes & those who have multiple risk factors for diabetes<br><br>**Start Date – End Date (mm/yy):** Jan 2016- Dec 2018<br><br>**Targets health disparities**: ☒ Y ☐ N | ☒ Individual/ Interpersonal Behavior<br><br>☐ Organizational/Policy<br><br>☐ Environmental Change | **Lead Agency:** JCDPH<br><br>Role: Leads classes<br><br>☐ New partner ☒ Established partner<br><br>**Target population representative**: Lee Lillard, JCDPH Dietitian<br><br>Role: Provide feedback on curricula, ways to improve<br><br>☒ New partner ☐ Established partner<br><br>**Partners**: Department on Aging, WCU, SCC, JCPS, MountainWise, Jackson County Public Library<br><br>Role: Provide access to participants, venue for class, assist with promotion, help purchase supplies<br><br>☒ New partner ☐ Established partner<br><br>**Include how you're marketing the intervention:** Flyers, website, newspaper, social media, movie screenings | **Expected outcomes**: Fewer Jackson County adults diagnosed with diabetes<br><br>**Any potential barriers**? ☒ Y ☐ N<br>If yes, explain how intervention will be adapted: Host class where participants are comfortable; Adapt curricula to meet more frequently during the last 6 months<br><br>**List anticipated project staff:** Melissa McKnight, Lee Lillard<br><br>**Does project staff need additional training?** ☐ Y ☒ N<br>If yes, list training plan: _____<br><br>**Quantify what you will do:**<br>How Much Did We Do**:** Hold 2 DPP classes annually with a minimum of 8 participants per class in a variety of community settings<br>How Well Did We Do It: % of program participants satisfied with DPP; % of program participants who would recommend DPP to others<br>Is Anyone Better Off: % of participants who lowered their HgA1C<br><br>**List how agency will monitor intervention activities and feedback from participants/stakeholders:** Agency will rely on monitoring techniques in place through the CDC as required to achieve CDC recognition<br><br>**Evaluation:**<br>Are you using an existing evaluation? ☒ Y ☐ N<br>If no, please provide plan for evaluating intervention: _____ |

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| **Intervention**: Diabetes Self-Management Education (DSME) Program<br><br>☐ New ☒ Ongoing ☐ Completed<br><br>**Setting:** Community & clinical settings<br><br>**Target population:** Adults, age 18 years and older, with Type 1, Type 2, or gestational diabetes<br><br>**Start Date – End Date (mm/yy):** Jan 2016- Dec 2018<br><br>**Targets health disparities**: ☒ Y ☐ N | ☒ Individual/ Interpersonal Behavior<br><br>☐ Organizational/Policy<br><br>☐ Environmental Change | **Lead Agency:** JCDPH<br><br>Role: Leads classes<br><br>☐ New partner ☒ Established partner<br><br>**Target population representative**: Lee Lillard, JCDPH Dietitian, & Melanie Batchelor, HRH Dietitian<br><br>Role: Provide feedback on curricula, ways to improve<br><br>☐ New partner ☒ Established partner<br><br>**Partners**: Harris Regional Hospital (HRH)<br><br>Role: Leads classes<br><br>☐ New partner ☒ Established partner<br><br>**Include how you're marketing the intervention:** Flyers, website, newspaper, social media | **Expected outcomes**: Greater percentage of Jackson County residents managing their diabetes<br><br>**Any potential barriers?** ☒ Y ☐ N<br>If yes, explain how intervention will be adapted: Cost of class is often a barrier; JCDPH offers the class at no cost to overcome financial constraints<br><br>**List anticipated project staff:** Lee Lillard, Melanie Batchelor<br><br>**Does project staff need additional training?** ☐ Y ☒ N<br>If yes, list training plan: _____<br><br>**Quantify what you will do:**<br>How Much Did We Do: Offer DSME to 100 participants annually<br>How Well Did We Do It: % of program participants satisfied with DSME; % of program participants who would recommend DSME to others<br>Is Anyone Better Off: % of participants who lowered their HgA1C<br><br>**List how agency will monitor intervention activities and feedback from participants/stakeholders:** Agency will rely on monitoring techniques in place through the ADA; In-house QI; State monitoring<br><br>**Evaluation:**<br>Are you using an existing evaluation? ☒ Y ☐ N<br>If no, please provide plan for evaluating intervention: _____ |

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| **Intervention**: FLU-FOBT<br><br>☒ New ☐ Ongoing ☐ Completed<br><br>**Setting:** Healthcare settings like Health Department (where flu shots are provided)<br><br>**Target population:** Adults age 50-75 years<br><br>**Start Date – End Date (mm/yy):** Jan 2016- Dec 2018<br><br>**Targets health disparities:** ☒ Y ☐ N | ☒ Individual/ Interpersonal Behavior<br><br>☒ Organizational/Policy<br><br>☐ Environmental Change | **Lead Agency:** JCDPH<br><br>Role: Plans, implements, and offers program<br><br>☐ New partner ☒ Established partner<br><br>**Target population representative**: Carla Morgan, JCDPH Nursing Supervisor<br><br>Role: Implement FLU-FOBT, offer feedback on promotion<br><br>☒ New partner ☐ Established partner<br><br>**Partners**: Department on Aging, Jackson County Public Library, Harris Regional Hospital<br><br>Role: Promote program<br><br>☐ New partner ☒ Established partner<br><br>**Include how you're marketing the intervention:** Flyers, website, newspaper, social media, | **Expected outcomes**: Increase colorectal cancer screening rates by offering home FOBT to eligible patients during annual flu shot activities<br><br>**Any potential barriers?** ☒ Y ☐ N<br>If yes, explain how intervention will be adapted: Difficultly may occur in getting the patients to send the FOBT in; JCDPH will work to overcome this by sending postcards as a reminder<br><br>**List anticipated project staff:** Melissa McKnight, Carla Morgan<br><br>**Does project staff need additional training?** ☒ Y ☐ N<br>If yes, list training plan: Online FLU-FOBT training<br><br>**Quantify what you will do:**<br>How Much Did We Do: Offer FOBT to eligible patients who get their flu shot annually<br>How Well Did We Do It: % of eligible patients sent reminder cards who didn't turn in their FOBT within 1-months' time; % of eligible patients who completed the FOBT<br>Is Anyone Better Off: % of FOBT completed correctly; % of patients with positive FOBT who went for a colonoscopy<br><br>**List how agency will monitor intervention activities and feedback from participants/stakeholders:** Agency will compare the number of kits mailed in to the number of FOBT distributed<br><br>**Evaluation:**<br>Are you using an existing evaluation? ☐ Y ☒ N<br>If no, please provide plan for evaluating intervention: JCDPH plans on using RBA, a planning, monitoring, evaluation, and |

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| | | | continuous improvement framework that focused on results for communities and individuals. Performance measures for interventions will be identified and regularly monitored to document the quantity, quality, and participant impact of the intervention. We will track: How much did we do? How well did we do it? Is anyone better off? |