Community Health Action Plan 2016 (year)

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: Hoke **Period Covered:** July 1, 2016-June 30, 2019

Partnership/Health Steering Committee, if applicable: Hoke County Public Health Advisory Council/Hoke County Health Department

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

Local Community Objective: (*Working description/name of community objective*) Cardiovascular Disease, Diabetes, Physical Activity and Nutrition
By June 2019, reduce the rate of heart disease related deaths in Hoke County by 10%. A decrease in 10% will reduce our rate of heart disease related deaths to 32 per 100,000.
(check one): _____ **New** X **Ongoing** (*addressed in previous Action Plan*)

- **Baseline Data:** In 2005, heart disease related deaths in Hoke County were 301 per 100,000). NC State Center for Health Statistics 2005 Mortality Statistics Summary-Heart Disease.
- **For continuing objective provide the updated information:** *(State measure/numerical value. Include date and source of current information)*: Age-adjusted mortality rates for heart disease and stroke related deaths according to latest available statistics for 2014-Heart Disease show 56 deaths (108.5. per 100,000 death rate); Cerebrovascular Disease-14 deaths (27.1 per 100,000 death rate). NC State Center for Health Statistics-Mortality Statistics Summary 2014-Heart Disease and Cerebrovascular Disease.
- ***Healthy NC 2020 Objective*** that most closely aligns with focus area chosen below:
  1. Reduce the cardiovascular disease mortality rate (per 100,000 population) to 161.5% by 2020.
  2. Decrease the percentage of adults with diabetes to 8.6 by 2020.
  3. Increase the percentage of adults getting the recommended amount of physical activity to 60.6% by 2020.
  4. Increase the percentage of adults who report they consume fruits and vegetables five or more times per day to 29.3% by 2020.

Population(s)

I. **Describe the local population at risk for health problems related to this local community objective:**
Minorities-African American, Native American and Hispanic
Economically disadvantaged-residents whose gross income is less than $15,000 per year
Adults-persons 35-64 years of age

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

A. **Total number of persons in the target population specific to this action plan:** 10577

B. **Total number of persons in the target population to be reached by this action plan:** 1058

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

(Total # in B divided by total # in A) X 100% = 10% **of the target population reached by the action plan.)**

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/

☐ 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

List 3-5 evidence-based interventions (proven to effectively address this priority issue) that seem the most suitable for your community and/or target group. (Insert rows as needed)

Evidence Based Strategies Used with Like Population(s) *(Include source)*	**Strategy/Intervention Goal(s)**	**Implementation Venue(s)**	**Resources Utilized/Needed for Implementation**
Name of Intervention: Eat Smart Move More Weigh Less Program Online Community Strengths/Assets: Network to provide educational information on an individual basis to each requesting organization.	S.M.A.R.T Goals: To enhance health programs that address emerging issues affecting Hoke County Citizens.	Target Population(s): Adult minorities 35-64 years of age Venue: Faith Community/Hospitals/ County Agencies	Resources Needed: Participants will need access to computer to do program
Name of Intervention: Stanford Chronic Disease Self-Management Program Community Strengths/Assets: Network to provide educational information on an individual basis to each requesting organization.	S.M.A.R.T Goals: To enhance health programs that address emerging issues affecting Hoke County Citizens.	Target Population(s): Adult minorities 35-64 years of age Venue: Faith Community/Hospitals /County Agencies	Resources Needed: Curriculum and educational pamphlets and books related to subject.
Name of Intervention: ADA Diabetes Self-Management Program Community Strengths/Assets: Network to provide educational information on an individual basis to each requesting organization	S.M.A.R.T Goals: To enhance health programs that address emerging issues affecting Hoke County Citizens.	Target Population(s): Adult minorities 35-64 years of age Venue: Hoke County Health Department	Resources Needed: Curriculum and educational pamphlets and books related to subject.
Name of Intervention: National Diabetes Prevention Program Community Strengths/Assets: Network to provide educational information on an individual basis to each requesting organization	S.M.A.R.T Goals: To enhance health programs that address emerging issues affecting Hoke County Citizens.	Target Population(s): Adult minorities 35-64 years of age Venue: Hoke County Health Department	Resources Needed: Curriculum and educational pamphlets and books related to subject.
Name of Intervention: Faithful Families Eating Smart and Moving More Community Strengths/Assets: Network to provide educational information on an individual basis to each requesting organization	S.M.A.R.T Goals: To enhance health programs that address emerging issues affecting Hoke County Citizens.	Target Population(s): Adult minorities 35-64 years of age Venue: Faith Community/Hospitals/ County Agencies	Resources Needed: Curriculum and educational pamphlets and books related to subject.
Name of Intervention: UNC Greensboro Health Coaching Program Community Strengths/Assets: Network to provide educational information on an individual basis to each requesting organization.	S.M.A.R.T Goals: To enhance health programs that address emerging issues affecting Hoke County Citizens.	Target Population(s): Adult minorities 35-64 years of age Venue: Hoke County Health Department	Resources Needed: Curriculum and educational pamphlets and books related to subject.

Interventions Specifically Addressing Chosen Health Priority

INTERVENTIONS: SETTING, & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: Faithful Families Eating Smart and Moving More ☒ New ☐ Ongoing ☐ Completed Setting: Faith Community-Churches Target population: 35-64 years-Minorities Start Date – End Date (mm/yy): 01/17-06/19 Targets health disparities: ☒Y ☐N	☒ Individual/ Interpersonal Behavior ☐ Organizational/Policy ☐ Environmental Change	**Lead Agency:** Hoke County Health Department and NC Cooperative Extension-Hoke Center Role: Collaboration ☐ New partner ☒ Established partner **Target population representative**: Health Educator and Family Consumer Science Agent Role: To contact area minority churches and civic organizations to present curriculum ☐ New partner ☒ Established partner **Partners**: _____ Role: _____ ☐ New partner ☐ Established partner **Include how you're marketing the intervention:** Distribute flyers and letters to faith/civic groups on educational programs and events available to encourage participation.	**Expected outcomes**: Participants will make at least one healthy lifestyle change (i.e. eating fresh fruits and vegetables, less fats, 8 glasses of water, exercising at least 3-5 times weekly for at least 30 min.) **Anticipated barriers:** Any potential barriers? ☐Y ☒N If yes, explain how intervention will be adapted: **List anticipated project staff:** Health Educator/Health Promotion Coordinator and Family Consumer Science Agent **Does project staff need additional training?** ☒Y ☐N If yes, list training plan: Staff will be on mailing list from NC State University, Agricultural and Human Services **Quantify what you will do:** Participants will maintain normal reading for hypertension, diabetes, and weight loss **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Activities will be monitored through participants reporting of healthy lifestyle changes made at each session. **Evaluation:** Are you using an existing evaluation? ☒Y ☐N If no, please provide plan for evaluating intervention: _____

Intervention: Provide educational sessions on topics related to Diabetes for Diabetes Support Group participants ☐ New ☒ Ongoing ☐ Completed **Setting:** Hoke County Health Department and Cooperative Extension **Target population:** 35-64 years-Minorities **Start Date – End Date (mm/yy):** 07/16-06/19 **Targets health disparities:** ☒ **Y** ☐ **N**	☒ Individual/ Interpersonal Behavior ☐ Organizational/Policy ☐ Environmental Change	**Lead Agency:** Hoke County Health Department/Hoke County Public Health Advisory Council Role**:** Collaboration ☐ New partner ☒ Established partner **Target population representative:** Health Educator/Health Promotion Coordinator Role**:** Assist in the planning and implementation of program activities ☐ New partner ☒ Established partner **Partners:** NC Cooperative Extension-Hoke Center Role**:** Assist in planning and implementation of healthy meal demonstrations and Holiday Dessert Workshop ☐ New partner ☒ Established partner **Partners**: Hoke County Health Department	**Expected outcomes**: Participants will make at least one healthy lifestyle change (i.e. eating fresh fruits and vegetables, less fats, 8 glasses of water, exercising at least 3-5 times weekly for at least 30 min.) **Anticipated barriers**: Any potential barriers? ☐ Y ☒ N If yes, explain how intervention will be adapted: **List anticipated project staff**: Health Educator/Community Presenters such as Medical Providers, RD, Student Nurses.etc. **Does project staff need additional training?** ☐ Y ☒ N If yes, list training plan: **Quantify what you will do**: Participants will maintain normal readings for hypertension, diabetes, cholesterol and weight loss. **List how agency will monitor intervention activities and feedback from participants/stakeholders**: Activities will be monitored through participants reporting of healthy lifestyle changes made at each session. **Evaluation:** Are you using an existing evaluation? ☒ Y ☐ N If no, please provide plan for evaluating intervention:

		Nutrition Staff Role: Assist in providing information on portion sizes, food labels, planning healthy meal demonstrations and other nutrition information related to diabetes. ☐ New partner ☒ Established **Include how you're marketing the intervention:** 1. Members will receive notification of programs via letters and e-mails. 2. Articles to the local newspaper quarterly on various health initiatives PSA's submitted to the local radio station and stations in surrounding areas on various health initiatives. Information will be posted on county website.	

Intervention: ADA Diabetes Self-Management Program

☐ New ☒ **Ongoing** ☐ Completed

Setting: Health Department

Target population: 35-64 years-Minorities

Start Date – End Date (mm/yy): 07/16-06/19

Targets health disparities: ☒ **Y** ☐ **N**

☒ Individual/ Interpersonal Behavior

☐ Organizational/Policy

☐ Environmental Change

Lead Agency: Hoke County Health Department

Role: Collaboration with local medical providers

☐ New partner ☒ Established partner

Target population representative: RD and Health Educator

Role:

1. Receive and maintain patient referrals. Entered information in Diabetes Chronicle Database.
2. Schedule initial visit, education sessions of a total of 8 hours and 3 month follow-up on a routine basis of participants in program.
3. Report patient progress back to referring medical provider.

☐ New partner ☒ Established partner

Include how you're marketing the intervention:

Expected outcomes: Reduced participants A1C levels and to make at least one healthy lifestyle change.

Anticipated barriers: Any potential barriers? ☒ Y ☐ N

If yes, explain how intervention will be adapted:

Transportation is a barrier for some participants. Plan educational session at least one month in advance so participants can arrange transportation.

List anticipated project staff: RD and Health Educator

Does project staff need additional training? ☒ Y ☐ N

If yes, list training plan:

Online webinars and in person conferences related to Diabetes, Obesity, Nutrition and Physical Activity.

Quantify what you will do:

Participants will maintain normal readings for hypertension, diabetes, cholesterol and weight loss.

List how agency will monitor intervention activities and feedback from participants/stakeholders:

Activities will be monitored through participants reporting of healthy lifestyle changes made at each session.

Evaluation:

Are you using an existing evaluation? ☒ Y ☐ N

If no, please provide plan for evaluating intervention:

		1. Advertisement on local radio station, newspaper and county website- Health Department page. 2. Routine visits to local medical providers office to discuss program with office manager to get referrals.	

Intervention: Certified Health & Wellness Coaching-UNCG Department of Public Health ☒ New ☐ Ongoing ☐ Completed Setting: HCHD Clinic/Local Provider Offices. Target population: 35-64 years-Minorities Start Date – End Date (mm/yy): 06/16-06/19 Targets health disparities: ☒Y ☐N	☒ Individual/ Interpersonal Behavior ☐Organizational/Policy ☐Environmental Change	**Lead Agency:** Hoke County Health Department Role: Health & Wellness Coaching ☐New partner ☒Established partner **Target population representative**: Health Coach/Health Educator Role: Promote program to county agencies and local health Providers **Partners**: Local Medical Providers Role: Refer patients at risk for Chronic Diseases. ☐New partner ☒ Established partner **Include how you're marketing the intervention:** Distribute information materials to county employees and local health providers as well as the county's website.	**Expected outcomes**: Participants will adopt their personal/desired health and wellness lifestyle goals. **Anticipated barriers:** Any potential barriers? ☒Y ☐N If yes, explain how intervention will be adapted: • Clients' ability/commitment to 6 coaching sessions. • Clients' ability to commit to a desired goal and make it a part of their lifestyle. **List anticipated project staff:** Health Coach/Health Educator **Does project staff need additional training?** ☒Y ☐N If yes, list training plan: Health Coach must complete a case study from one client that has completed 6 sessions; submit case study and complete NC certification exam. **Quantify what you will do:** Participants will maintain their desired goals to (i.e. loose weight, become more active, and stay committed to doctors treatment plans) **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Interventions are monitored during each face-to face session and throughout the 6 sessions with each client. Clients indicate if their desires have changed or if there is to be a shift in goal setting. **Evaluation:** Are you using an existing evaluation? ☒Y ☐N If no, please provide plan for evaluating intervention:

Intervention: AADE and CDC National Diabetes Prevention Program ☒ New ☐ Ongoing ☐ Completed **Setting:** Health Department **Target population:** Adult minorities 35-64 years of age **Start Date – End Date (mm/yy):** 07/2016- 06/2019 **Targets health disparities:** ☒ **Y** ☐ **N**	☒ Individual/ Interpersonal Behavior ☐ Organizational/Policy ☐ Environmental Change	**Lead Agency:** Hoke County Health Department Role: Collaboration with local medical providers ☐ New partner ☒ Established partner **Target population representative:** RD and Health Educators Role: 1. Receive and maintain patient referrals from local providers. 2. Enroll referred patients into the program and schedule group sessions. 3. Hold group sessions weekly for 16 weeks then monthly group follow-ups for the remainder of the year per National Diabetes Prevention Program guidelines. 4. Track and report participant anthropometrics to the CDC and AADE per program guidelines.	**Expected outcomes**: Participants will make lifestyle changes that result in weight reduction and the prevention of Diabetes. **Anticipated barriers**: Any potential barriers? ☒Y ☐N If yes, explain how intervention will be adapted: Transportation is frequently a barrier for participants. We will offer to travel to offsite locations that may be more convenient for participants to include places where participants may already be gathering i.e. churches, physicians' offices, and other community venues as the need dictates. **List anticipated project staff:** RD and Health Educators **Does project staff need additional training?** ☐Y ☒N If yes, list training plan: **Quantify what you will do**: Participants will make life long changes to maintain weight loss of 7% of his/her body weight in order to prevent prediabetes from progressing into diabetes. **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Participants will have the opportunity to provide feedback to lifestyle coaches at the conclusion of each session. Feedback will be shared with all lifestyle coaches to improve the experience for participants. Food intake journals, activity logs, and weight records will be reviewed by lifestyle coaches between sessions to monitor effectiveness of interventions as program is implemented. **Evaluation:** Are you using an existing evaluation? ☒Y ☐N If no, please provide plan for evaluating intervention:

		☐New partner ☒Established partner **Partners:** Local Medical Providers Role**:** 1. Refer appropriate patients into the program by faxing referral forms and pertinent medical information to the HCHD. Appropriate patients are defined on the referral forms that HCHD staff provide to the providers. 2. Encourage referred patients to participate and commit to attending all group sessions. **Include how you're marketing the intervention:** 1. Advertisement on local radio station, newspaper and county website-Health Department page. 2. Routine visits to local medical providers' offices to discuss program with office manager to get referrals.	