Community Health Action Plan 2014

Designed to address Community Health Assessment priorities

County: Mecklenburg **Partnership, if applicable:** **Period Covered: 2014-2017**

LOCAL PRIORITY ISSUE

- Priority issue: Access to Care
- Was this issue identified as a priority in your county's most recent CHA? _X_ Yes __ No

LOCAL COMMUNITY OBJECTIVE Please check one: __ New _X_ Ongoing (was addressed in previous Action Plan)

- By (year): 2017
- Objective (specific, measurable, achievable, realistic, time-lined change in health status of population): All individuals and families in Mecklenburg County will have access to health care regardless of ability to pay
- Original Baseline: 21% of adults (18 and older) in Mecklenburg County reported that they needed to see a doctor but did not due to cost during the past 12 months
- Date and source of original baseline data: BRFSS, 2009 (rate was 17% in 2007)
- Updated information (For continuing objective only): 20% of adults (18 and older) in Mecklenburg County reported that they needed to see a doctor but did not due to cost during the past 12 months
- Date and source of updated information: BRFSS, 2012

POPULATION(S)

- Describe the local population(s) experiencing disparities related to this local community objective: Uninsured adults (18-65) In Mecklenburg County
- Total number of persons in the local disparity population(s): 159,000 uninsured prior to the implementation of the Affordable Care Act. It is estimated that there are 32,000 adults in Mecklenburg who do not qualify for federal subsidies and do not qualify for Medicaid (in the "coverage gap")
- Number you plan to reach with the interventions in this action plan: All uninsured

HEALTHY NC 2020 FOCUS AREA ADDRESSED

Check **one** Healthy NC 2020 focus area:

__ Tobacco Use
__ Physical Activity and Nutrition
__ Substance Abuse
__ STDs/Unintended Pregnancy
__ Environmental Health
__ Social Determinants of Health (Poverty, Education, Housing)
__ Maternal and Infant Health
__ Injury
__ Mental Health
__ Oral Health
__ Infectious Diseases/ Food-Borne Illness
__ Chronic Disease (Diabetes, Colorectal Cancer, Cardiovascular Disease)
X Cross-cutting (Life Expectancy, Uninsured, Adult Obesity)

List HEALTHY NC 2020 Objective: (List the Healthy NC 2020 objective(s) that align with your local community objective.) (Detailed information can be found at publichealth.nc.gov/hnc2020/ website)

Reduce the percentage of non-elderly uninsured individuals (aged less than 65 years)

RESEARCH REGARDING WHAT HAS WORKED ELSEWHERE*

List the 3-5 evidence-based interventions (proven to effectively address this priority issue) that seem the most suitable for your community and/or target group. **Training and information are available from DPH. Contact your regional consultant about how to access them.*

Intervention	Describe the evidence of effectiveness (type of evaluation, outcomes)	Source
Decrease out of pocket costs to patients	Efforts to reduce or remove cost barriers to breast cancer screening services have been effective at increasing utilization of screening services.	http://www.thecommunityguide.org/cancer/screening/ClientProviderOriented2012_Findings.pdf
Affordable Care Act	*A full evaluation of the impact of the Affordable Care Act may highlight portions of the law that are effective at increasing access to care among underserved populations*	https://www.cms.gov/about-cms/aca/affordable-care-act-in-action-at-cms.html

WHAT INTERVENTIONS ARE ALREADY ADDRESSING THIS ISSUE IN YOUR COMMUNITY?

Are any interventions/organizations currently addressing this issue? Yes_X_ No__ If so, please list below.

Intervention	Lead Agency	Progress to Date
ACA Open Enrollment	Legal Services of Southern Piedmont, NC MedAssist, CW Williams (Navigator organizations), 20+ Certified Application Counselor sites (full list can be found at Healthcare.gov)	Thousands of residents have been enrolled in health insurance. County numbers have not yet been released, however, a total of 357,584 individuals across NC have signed up for a health plan in the Marketplace

WHAT RELEVANT COMMUNITY STRENGTHS AND ASSETS MIGHT HELP ADDRESS THIS PRIORITY ISSUE?

Community, neighborhood, and/or demographic group	Individual, civic group, organization, business, facility, etc. connected to this group	How this asset might help
MedLink of Mecklenburg	Network of safety net providers	They promote free or low-cost health care services and allow for collaboration between safety net providers. They also serve as an information "hub" for ACA enrollment.
Mecklenburg Area Partnership for Primary Care Research (MAPPR)	Mike Dulin, MD, Elizabeth Family Medicine	Collaborative effort to assess the healthcare needs of the growing Latino community.
Dickson Advanced Analytics	Carolinas Medical Center, Mike Dulin, MD	Conduct research on utilization of healthcare services

See next pages for details on interventions, partners and evaluation.

Intervention 1	MedLink of Mecklenburg: A collaboration of safety net clinics and other health and human service providers in the county. This group has been meeting regularly for 10+ years to share needs, resources, referrals, and strategize on how best to serve the uninsured population.
New/Ongoing	Ongoing
Start Date:	01/01/02
End Date, if any:	-
Program/Intervention Target	Health Disparities, Policy or Environmental Change
Lead Agency	MedLink of Mecklenburg
Lead Agency Role	MedLink helps organize meetings, communication, as well as host meetings.
Partner Agencies & Roles	Current agencies represented on the Executive Committee: Matthews Free Medical Clinic, Care Ring, Shelter Health Services, Dickson Advanced Analytics. Member agencies include Carolinas Health Care System, Novant Health, Mecklenburg County Health Department, Center for Prevention Services, Mental Health Association, Legal Services of the Southern Piedmont, Charlotte Community Health Clinic, Lake Norman Community Health Clinic, Bethesda Health Clinic, NC MedAssist
Marketing/Promotion	Targeted email, Word of mouth, Community meetings, Website
Implementation	MedLink meets on the 2nd Tuesday of each month, with call in options for those who cannot attend in person.
Expected Results	Meetings allow for safety net providers to make appropriate referrals, discuss common challenges and collaborate around current efforts and events.

Intervention 2	Legal Services of Southern Piedmont (LSSP) provides navigation services to the residents of Mecklenburg County, helping families and individuals choose plans that are best for them within the health insurance marketplace implemented under the Affordable Care Act. LSSP navigators are located in several locations across Mecklenburg County, providing outreach and enrollment assistance to low-income and underserved populations.
New/Ongoing	Ongoing
Start Date:	10/01/13
End Date, if any:	-
Program/Intervention Target	Health Disparities, Individual Change
Lead Agency	LSSP and Enroll America
Lead Agency Role	LSSP and Enroll America provide training and supervision of navigators, community outreach, publicize events, and offer community and client education on ACA open enrollment.

Partner Agencies & Roles	The Health Department provides meeting space. MedLink provides funding for events, partner agencies promote enrollment efforts. MedAssist is also a navigator organization. We work with together Clinics (CCHC, Bethesda, Lake Norman) to host navigators on a weekly basis. Other social service agencies (Crisis assistance ministry, YMCA, International House, Latin American Coalition, Metrolina Association for the Blind, others) have/continue to host navigators on a weekly basis. Mecklenburg County Libraries hosts info sessions, etc. Media (local TV stations, Charlotte Observer, 102.3 Latina) help get the word out about events and activities.
Marketing/Promotion	Facebook, Twitter, Word of mouth, Printed flyers, Television, Newspapers, Radio, Community meetings
Implementation	Ongoing outreach and education to community partners and uninsured individuals. Also, one-on-one enrollment appointments.
Expected Results	As a result of navigation services, Mecklenburg County residents will understand their health insurance options under the Affordable Care Act. Eligible families will sign up for subsidized health insurance in the marketplace. Access to affordable health insurance will improve health status for those who would have otherwise delayed or foregone care.

Intervention 3	NC MedAssist: A free pharmacy program serving low-income, vulnerable and uninsured children and adults with lifesaving prescription medication. The organization manages two prescription medications programs. First is the individual patient assistance program where we apply to individual pharmacy companies on behalf of the patient. Second, is the bulk replenishment program where we contract with 7 pharmacy companies to provide us with their medication in bulk supply; not patient-by-patient. We also offer over-the-counter (OTC) medications through a relationship with Second Harvest Food Bank of Metrolina. We receive pallets of over-the-counter medications on a monthly basis and volunteers count and distribute to local clinics. MedAssist has a giveaway day once a month for local patients and other low-income people to par take.
New/Ongoing	Ongoing
Start Date:	03/01/97
End Date, if any:	-
Program/Intervention Target	Health Disparities, Individual Change
Lead Agency	NC MedAssist
Lead Agency Role	NC MedAssist provides the pharmacy services.
Partner Agencies & Roles	Free clinic providers see the patient and write the prescription. Together we provide a medical/pharmacy home for the low-income and uninsured residents of Mecklenburg County.
Marketing/Promotion	Targeted email, Facebook, Word of mouth, Printed flyers, Community meetings

Implementation	Patients get a survey upon their enrollment into the MedAssist program and then again a year later. The surveys are matched to determine if compliance with taking medication and overall health has improved.
Expected Results	Patients will be more compliant with taking their medication since cost is no longer a barrier. As a result, conditions will be better managed and their health will improve.

Intervention 4	Charlotte Community Health Clinic: This health center has grown consistently over the past 12 years to improve access to low income uninsured residents of Mecklenburg County. The Clinic has grown from less than 200 patients in 2002 to close to 7,000 unique patients at present. The Clinic provides primary care, pediatrics, women's health and chronic disease programs. The clinic requests a $10.00 donation for each patient visit and a $5.00/co-pay for some services.
New/Ongoing	Ongoing
Start Date:	03/01/01
End Date, if any:	-
Program/Intervention Target	Health Disparities
Lead Agency	Charlotte Community Health Clinic
Lead Agency Role	Healthcare clinic for uninsured residents of Mecklenburg County.
Partner Agencies & Roles	• MedAssist Pharmacy provides medications, • Novant Health provides clinic space, HR support, IT support, radiology, • United Way provides funding for various programs, • Blue Cross Blue Sheild of NC provides funding for chronic disease programs, • Lab Corp provides patient labs
Marketing/Promotion	Word of mouth, website, inter-agency referral
Implementation	Patients are referred by local care agencies (CareRing, Novant Health, Carolinas Medical Center, and Mecklenburg County Health Department) and financially screened and admitted as appropriate for primary care.
Expected Results	As a result of the Clinic, Individuals will have access to health services and be provided the tools to manage their health (medications, educations, supplies) and have better health outcomes. CCHC provides care management and specialty clinics for Diabetes and Cardiovascular disease. These programs are based on best practice guidelines and provides provider and patient with ongoing outcome information and funders the evidence based information that support our work.

Intervention 5	Carolinas Medical Center Ambulatory Care Clinics: Community clinics focused on providing Primary and Specialty Medical Care for uninsured and underinsured residents of Mecklenburg County. The clinics are geographically located in areas of high need and provide 250,000 annual visits.
New/Ongoing	Ongoing
Start Date:	01/01/65
End Date, if any:	-
Program/Intervention Target	Health Disparities, Individual Change
Lead Agency	Carolinas Medical Center
Lead Agency Role	Carolina's Medical Center provides funding for the Community Clinics.
Partner Agencies & Roles	Many organizations partner with the CMC Community Clinics including the Mecklenburg County Health Department and Community Care of North Carolina for Care Coordination and DSS for Medicaid enrollment.
Marketing/Promotion	Word of mouth, ED referrals
Implementation	Patients receive medical office visits at a frequency based on their disease state and medical needs.
Expected Results	As a result of medical office visits, there will be reduced patient visits to the ED for primary care; conditions will be treated at a more appropriate time leading to better outcomes for patients and decreased expense of hospitalizations if a patient must be hospitalized.

Intervention 6	Novant Health Community Care Cruiser: Mobile clinic that visits churches or community centers in identified areas of low income.
New/Ongoing	Ongoing
Start Date:	11/07/14
End Date, if any:	-
Program/Intervention Target	Health Disparities
Lead Agency	Novant Health Presbyterian Medical Center
Lead Agency Role	Novant Health provides the vehicle, staff, and funding.
Partner Agencies & Roles	Funding is provided by grants and donations. Major funders include the Charlotte Bobcats, Synders-Lance, Wells Fargo, UTC Aerospace Systems.
Marketing/Promotion	Word of mouth, Printed flyers, Newspapers, Radio, Community meetings, School Nurses, MCHD
Implementation	Immunizations are provided to children with no health insurance or with Medicaid.
Expected Results	Increased immunization rate in Meckenburg, Union, and Rowan counties. Reduced exclusion rates in CMS due to non-compliance to immunization requirements.

Intervention 7	Free Clinic at Our Lady of Guadalupe
New/Ongoing	Ongoing
Start Date:	03/01/08
End Date, if any:	-
Program/Intervention Target	Health Disparities, Individual Change
Lead Agency	Mecklenburg Area Partnership for Primary Care Research / Carolinas HealthCare System Dept. of Family Medicine
Lead Agency Role	The Department provides healthcare providers (nurses, doctors, etc)
Partner Agencies & Roles	Our Lady of Guadalupe assists in providing space, internet, laptops and volunteers.
Marketing/Promotion	Word of mouth
Implementation	A free clinic, overseen by Dr. Dulin is provided the 3rd Sunday of the month from 10-12pm.
Expected Results	As a result of the free clinic, there will be increased access to care for the uninsured.

Intervention 8	HIV Community Services: Mecklenburg County Health Department offers free and confidential HIV/STD counseling and testing at community sites during non-traditional hours, in addition to the clinical services offered at both Heath Department facilities.
New/Ongoing	Ongoing
Start Date:	06/08/14
End Date, if any:	-
Program/Intervention Target	Health Disparities, Individual Change
Lead Agency	Mecklenburg County Health Department
Lead Agency Role	The MCHD secures funding and staff resources; as well as provides management oversight.
Partner Agencies & Roles	The HIV Community Services program has 20+ community partner sites that help bringMCHD HIV Community Services to theirprogram participants. These partners provide a space to meet with clients and ensure that clients are aware of the services offered.
Marketing/Promotion	Word of mouth, Printed flyers, Newspapers, Radio, Community meetings
Implementation	Prevention education, client centered HIV/STD counseling, and resource information provided for each individual tested in the community. At some sights, the prevention education is done in a group setting.
Expected Results	Participants will learn their HIV status, understand how to reduce their risks of STDs, and are linked to needed resources, reduction in viral load with early treatment

Intervention 9	Shelter Health Services: Clinic for homeless women and children. Clinic is located within the population we serve, facilitating ease of access and use. All services are free of charge to residents staying in the Salvation Army Center of Hope shelter, eliminating the barrier of cost.
New/Ongoing	Ongoing
Start Date:	06/01/06
End Date, if any:	-
Program/Intervention Target	Health Disparities
Lead Agency	Shelter Health Services
Lead Agency Role	Shelter Health Services provides healthcare.
Partner Agencies & Roles	The Salvation Army Center of Hope shelter for homeless women and children provides clinic space, utilities, security and maintenance at no charge.
Marketing/Promotion	Targeted email, Word of mouth, Printed flyers
Implementation	Walk-in clinic is open Monday through Friday from 11:30 am to 6:00 pm. Provide free healthcare to more than 1,000 unique individuals totaling more than 4,000 clinic visits by uninsured, homeless women and children living in poverty and lacking access to healthcare. Only requirement is a shelter ID.
Expected Results	Access to health care, improved outcomes for acute and chronic conditions.

Intervention 10	Safe Alliance Mental Health Services: All mental health services are offered on a sliding fee scale so that no one is turned away because they cannot pay. One Spanish speaking counselor is available. Documentation/immigration status does not matter.
New/Ongoing	Ongoing
Start Date:	01/01/70
End Date, if any:	-
Program/Intervention Target	Health Disparities, Individual Change
Lead Agency	Safe Alliance
Lead Agency Role	Safe Alliance acts as the service provider.
Partner Agencies & Roles	Barium Springs shares best practices. Cardinal Innovations builds evidence based programming; refer clients; and is the pay source.
Marketing/Promotion	Facebook, Word of mouth, Printed flyers, Community meetings
Implementation	Clients are assessed for income and we offer the appropriate fee from our sliding fee. Clients and their service provider may request additional waivers based on need, including co-pay waiver.
Expected Results	Increased access to mental health care, improvements in physical health through healthy behaviors and management of conditions

Intervention 11	Parents as Teachers (PAT): The YMCA of Greater Charlotte adopted the PAT curriculum in 2007 with two bi-lingual Parent Educators serving 30 families on the East and West sides of Charlotte. The program has grown to five Parent Educators, serving 115 families in 2013. PAT works with under-resourced families in Mecklenburg County. Each family must have at least one child under the age of 5. Families usually have one or more risk-factors such as low income level, low education, numerous family relocations, newcomer in the community, psycho-social issues, Spanish-speaking, and/or uninsured. In regards to the Focus Area: The program has a YMCA Community Nurse that provides annual health and development screenings for each child age 0-5. The Nurse educates parents on child health, provides information about community health resources and explains the importance of establishing a medical and dental home within the community. For the families being served, the nurse & the YMCA Parent Educators are often the primary resource for information about navigating health resources in our community. During home visits and through group workshops families receive important information regarding community health fairs, sliding scale or low cost clinics, and/or general recommendations for addressing health concerns. Most of the families are dealing with numerous barriers related to socioeconomic status (transportation, child care, language barriers, etc.).
New/Ongoing	Ongoing
Start Date:	11/01/07
End Date, if any:	-
Program/Intervention Target	Health Disparities
Lead Agency	YMCA of Greater Charlotte
Lead Agency Role	YMCA of Greater Charlotte runs all functions of program
Partner Agencies & Roles	YMCA branch facilities provide program space for group workshops. PAT program utilizes the network of Enlace to collaborate on health presentations and keeping up to date on health resources within the community.
Marketing/Promotion	Targeted email, Facebook, Word of mouth, Printed flyers, Newspapers, Radio, Community meetings

Implementation	Monthly Home Visits: A YMCA PAT Parent Educator visits families in home. During each visit, the Parent Educator shares information about child development and offers age appropriate activities. The parents and the Parent Educator monitor how their child is playing and developing. The Parent Educator also connects the family to community resources and agencies through referrals. Screenings Four: Screenings take place annually with children and families. Children are screened within 90 days of enrollment. The ASQ questionnaire assesses the development of a child based on the Parents as Teachers Five Essential Domains: Communication, Gross Motor, Fine Motor, Social-Emotional and Problem Solving. Health screenings check a child's vision, hearing, dental needs and immunization records. Life Skills Progression is a tool that helps families set and measure annual goals. Group Connections Families enrolled in PAT meet together monthly to discuss a topic relevant to the program such as health, literacy and play. Group Connections provide a time for the families to create a community amongst themselves, as well as connect with community resources. These meetings typically take place at YMCA branches YMCA Community Nurse The YMCA Community Nurse provides annual health and development screenings for each child age 0-5. The Nurse educates parents on child health, provides information about community health resources and explains the importance of establishing a medical and dental home within the community.
Expected Results	Specifically in regards to Access to Care: Families are more connected to information and what is available within their own community or neighborhood. Often times there are services that families are just unaware of or aren't familiar with the process for accessing. The PAT program works closely with families to help navigation and teaching especially moms to advocate for their own health as well as their children.

Intervention 12	Council for Children's Rights Advocacy: Direct advocacy to assist children and families with obtaining Medicaid and health benefits and with navigating the healthcare system and overcoming any obstacles that might be contrary to a child's best interest.
New/Ongoing	Ongoing
Start Date:	01/01/00
End Date, if any:	-
Program/Intervention Target	Individual Change
Lead Agency	CFCR
Lead Agency Role	Meeting space, training
Partner Agencies & Roles	Collaboration with multiple county partners including DJJ, YFS, Mental Health Association, CMS and juvenile court.
Marketing/Promotion	Targeted email, Facebook, Twitter, Community meetings
Implementation	CFCR provides individual advocacy for children who need access to health related services.
Expected Results	With the help of a knowledgeable advocate, no child will be without medically necessary supports and services.

Intervention 13	MedLink Annual Forum: MedLink hosts an annual educational forum addressing access to care. The event provides an opportunity for networking, brainstorming and collaboration to address access to care.
New/Ongoing	Ongoing
Start Date:	02/01/12
End Date, if any:	-
Program/Intervention Target	Health Disparities, Policy or Environmental Change
Lead Agency	MedLink of Mecklenburg
Lead Agency Role	MedLink provides funding and planning.
Partner Agencies & Roles	The Mecklenburg Medical Society provided funding, Dickson Advanced Analytics assisted with planning, Legal Services of the Southern Piedmont provided a speaker, Davidson College provided a speaker, and NC Institute of Medicine provided a speaker and materials.
Marketing/Promotion	Targeted email, Twitter, Printed flyers, Community meetings
Implementation	Each year, the forum has grown in attendance. The first two sessions focused on the Affordable Care Act and the most recent forum addressed social determinants of health. Evaluations from the events showed that participants felt there were worthwhile networking opportunities and that new information was learned.
Expected Results	Increased communication and collaboration among safety net and social service providers allow for better service and utilization of resources to serve uninsured and underinsured populations.

Intervention 14	Transdisciplinary Approach to the Evaluation of Social Determinants of Health Research Study: Community wellness fairs in a school setting to provide information about health and social services for Latino community members.
New/Ongoing	Ongoing
Start Date:	9/1/2010 (study), 10/1/2012 (implementation)
End Date, if any:	7/31/2015 (study) 6/1/3/2013 (implementation)
Program/Intervention Target	Health Disparities, Individual Change
Lead Agency	Mecklenburg Area Partnership for Primary Care Research / Carolinas HealthCare System Dept. of Family Medicine
Lead Agency Role	Funding, facilitation
Partner Agencies & Roles	UNCC's Metropolitan Studies helps to co-facilitate the project.The Agency also has a Community Advisory Board consisting of: Latin American Coalition, Charlotte Mecklenburg School, Carolinas HealthCare System, UNC Charlotte's Departments of Geography and Public Health, City of Charlotte Neighborhood and Business Services, City of Charlotte Community Relations, YMCA, CMPD, CMFD
Marketing/Promotion	Word of mouth, Printed flyers
Implementation	Series of 4-5 community wellness fairs (once a month) at an elementary school within the geographic target area. Provide basic health screenings- BMI, blood pressure and glucose along with health education by primary care providers. Also- community partners provide information about their health and/or social services. Creation of a community group to provide educational and training opportunists for health and resource promotion in the neighborhoods.
Expected Results	decrease ED utilization - better health outcomes for partisans - group of lay "promotores"