



Community Health Action Plan 2018

County: Mecklenburg

Period Covered: 2018 - 2021

Partnership/Health Steering Committee, if applicable: MedLink

Community Health Priority identified in the most recent CHA: YES (#2 priority)

Local Community Objective: (Working description/name of community objective) All individuals and families will receive appropriate health care regardless of ability to pay.

(check one): ___ New X Ongoing (addressed in previous Action Plan)

- **Baseline Data:** (State measure/numerical value. Include date and source of current information): 19% of adults in Mecklenburg County report not being able to see a doctor due to cost (BRFSS, 2016)
- **For continuing objective provide the updated information:** (State measure/numerical value. Include date and source of current information): 20% of adults in Mecklenburg County report not being able to see a doctor due to cost (BRFSS, 2017)
- **Healthy NC 2020 Objective** that most closely aligns with focus area chosen below: Cross Cutting: Reduce the % of non-elderly uninsured individuals

Population(s)

- I. Describe the local target population that will be impacted by this community objective: Uninsured individuals in Mecklenburg County, Individuals with no usual source of care, individuals living in the identified priority ZIP codes
 - A. Total number of persons in the target population specific to this action plan: 155,000
 - B. Total number of persons in the target population to be reached by this action plan: 4,500 (2,500 via Strategy 1 + 2,000 via Strategy 2)
 - C. Calculate the impact of this action plan: 2.9%

(Total # in B divided by total # in A) X 100% = 2.9% 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/>

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> STDs/Unintended Pregnancy | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Social Determinants of Health |
| <input type="checkbox"/> Physical Activity & Nutrition | <input type="checkbox"/> Maternal & Infant Health | <input type="checkbox"/> Infectious Disease/Foodborne Illness | <input type="checkbox"/> Environmental Health |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Oral Health | <input type="checkbox"/> Chronic Disease |
| | | | <input checked="" type="checkbox"/> Cross-cutting |

Selection of Strategy/Intervention Table

- Complete this table for all strategies/interventions that you plan to implement.
- At least two of the three selected community health priorities must be from the 13 Healthy North Carolina 2020 (HNC 2020) focus areas. For these 2 priorities, there must be 2 evidence-based strategies (EBS) for each action plan. (Insert rows as needed if you choose more than 2 EBS.)

Strategy/Intervention(s)	Strategy/Intervention Goal(s)	Implementation Venue(s)	Resources Utilized/Needed for Implementation
<p>Name of Intervention: One Charlotte Health Alliance Mobile Units</p> <p>Community Strengths/Assets: Partnership between Novant Health, Atrium Health and Mecklenburg County Public Health; buses have been ordered, shared data agreements have been established</p>	<p>S.M.A.R.T Goals: Increase appropriate health care access points in the public health priority area from 2 clinic sites to 4 by 2019</p>	<p>Target Population(s): Persons living in 28205, 28206, 28208, 28212, 28216, 28217</p> <p>Venue: Various community locations at target ZIP codes above</p>	<p>Resources Needed: 2 mobile units (ordered) Staff, Supplies, Technology, Appropriate marketing and outreach to community members and community partners</p>
<p>Name of Intervention: HealthCare.gov Enrollment</p> <p>Community Strengths/Assets: Trained application specialists, navigator consortium, community support</p>	<p>S.M.A.R.T Goals: Between November 2018 and October 2019, provide navigation services to 2,000 Mecklenburg County residents to connect them with appropriate health care resources</p>	<p>Target Population(s): Uninsured individuals with no usual source of care, insured individuals who have plans through Healthcare.gov</p> <p>Venue: Various community events</p>	<p>Resources Needed: Trained application specialists, event marketing, computers & printers</p>

Interventions Specifically Addressing Chosen Health Priority *(Insert rows as needed.)*

INTERVENTIONS: SETTING, & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
<p>Intervention: One Charlotte Health Alliance Mobile Units</p> <p><input checked="" type="checkbox"/> New <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed</p> <p>Setting: Various community locations at target ZIP codes</p> <p>Target population: Persons living in 28205, 28206, 28208, 28212, 28216, 28217</p> <p>New Target Population: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Start Date – End Date (mm/yy): Jan 2019 to Dec 2021</p> <p>Targets health disparities: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p>	<p><input checked="" type="checkbox"/> Individual/Interpersonal Behavior</p> <p><input checked="" type="checkbox"/> Organizational/Policy</p> <p><input checked="" type="checkbox"/> Environmental Change</p>	<p>Lead Agency: One Charlotte Health Alliance</p> <p>Role: Oversight, management and sustainability of mobile units, supplies and staffing</p> <p><input checked="" type="checkbox"/> New partner <input type="checkbox"/> Established partner</p> <p>Target population representative: Representatives from the Council of Elders and other community-based organizations</p> <p>Role: Provide feedback and engagement on the implementation of the OCHA mobile units</p> <p><input checked="" type="checkbox"/> New partner <input type="checkbox"/> Established partner</p> <p>Partners: MedLink of Mecklenburg member agencies</p> <p>Role: Inform the strategic outreach</p> <p><input checked="" type="checkbox"/> New partner <input type="checkbox"/> Established partner</p> <p>How you market the intervention: Social Media platforms, dedicated website, MedLink outreach, branded bus wraps, both hospital systems have marketing</p>	<p>Expected outcomes: Increased access to appropriate health care within the target ZIP codes</p> <p>Anticipated barriers: Any potential barriers? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N If yes, explain how intervention will be adapted: Community and stakeholder response to mobile units may inhibit use. Depending on response and feedback, outreach efforts will be tailored, will get additional feedback from mobile unit patients</p> <p>List anticipated intervention team members: Drivers, clinical staff, health educators, interpreters, navigators, community health workers, marketing team members</p> <p>Do intervention team members need additional training? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N If yes, list training plan: mobile workflow training, cultural competence training to meet needs of clients</p> <p>Quantify what you will do: Deploy mobile units to 6 priority ZIP codes at easily accessible community locations at specific dates and times (will recur on a regular basis, specific schedule yet to be determined). Mobile units will offer dental care, behavioral health care, and advanced primary care. Appropriate linkages to other community resources will be provided</p> <p>List how agency will monitor intervention activities and feedback from participants/stakeholders: Shared data agreements between hospital systems will allow for quarterly review of data on patients served. Patients will provide feedback via surveys and direct follow up (when appropriate)</p> <p>Evaluation:</p>

		staff working on direct outreach in targeted ZIP codes	Please provide plan for evaluating intervention: Patients will be assessed to determine if they have a medical home, patients will receive navigation services tracking of number of patients served and services provided, tracking of unnecessary ER utilization, tracking of 30-day readmission rates
--	--	--	---

INTERVENTIONS: SETTING, & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
<p>Intervention: HealthCare.gov Enrollment</p> <p><input type="checkbox"/> New <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Completed</p> <p>Setting: Various community locations</p> <p>Target population: Uninsured individuals and those without access to care</p> <p>New Target Population: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>Start Date – End Date (mm/yy): Sept 2018 to Dec 2021</p> <p>Targets health disparities: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p>	<p><input checked="" type="checkbox"/> Individual/Interpersonal Behavior</p> <p><input type="checkbox"/> Organizational/Policy</p> <p><input type="checkbox"/> Environmental Change</p>	<p>Lead Agency: Get Covered Mecklenburg</p> <p>Role: Plan, promote and provide staffing for HealthCare.gov enrollment appointments and mass enrollment events, provide health insurance literacy and community outreach about affordable health insurance options</p> <p><input type="checkbox"/> New partner <input checked="" type="checkbox"/> Established partner</p> <p>Target population representative: Clients who have received healthcare navigation services</p> <p>Role: On-going communication with navigation clients allows for feedback on ease of enrollment and questions to address at enrollment appointments</p> <p><input checked="" type="checkbox"/> New partner <input type="checkbox"/> Established partner</p>	<p>Expected outcomes: Increased access to care either through (1) insurance enrollment (2) enrollment in Medicaid/Medicare or (3) referral to free/low-cost clinics. Increased insurance coverage rates, decreased rates of unnecessary ER use</p> <p>Anticipated barriers: Any potential barriers? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N If yes, explain how intervention will be adapted: With decreased funding for ACA marketing, Get Covered Meck will rely on partner agencies for marketing support and utilize free marketing tools</p> <p>List anticipated intervention team members: Get Covered Meck partner agencies include Charlotte Center for Legal Advocacy, Charlotte Community Health Clinic, Legal Aid of North Carolina, MedLink of Mecklenburg</p> <p>Do intervention team members need additional training? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N If yes, list training plan: Navigators will need training to be briefed of changes in the enrollment process, qualifying life events/special enrollment periods</p> <p>Quantify what you will do: Get Covered Meck will</p>

		<p>Partners: MedLink of Mecklenburg member agencies</p> <p>Role: Help plan enrollment events, provide financial support if needed, promote enrollment events within individual agencies, table at events,</p> <p><input type="checkbox"/> New partner <input checked="" type="checkbox"/> Established partner</p> <p>How you market the intervention: Word of mouth, direct marketing/flyers/outreach with in partner agencies, outreach at free clinics, outreach and health and social service agencies</p>	<p>coordinate enrollment outreach, host mass enrollment events, and take individual enrollment appointments during the Open Enrollment period as well as throughout the year to address individuals who meet the criteria for a “special enrollment period.” Navigators meeting with clients will provide education on health insurance basics (defining deductible, co-pays, etc.), will help set up email accounts if necessary, will describe how to use benefits and what is included in the selected plan and will educate clients on the “automatic enrollment” feature. Clients who do not/cannot purchase affordable plans are either enrolled in Medicaid/Medicare or given referrals to free/low cost clinics.</p> <p>List how agency will monitor intervention activities and feedback from participants/stakeholders: Feedback from 2017 open enrollment period will be reviewed and enrollment process/appointments will be adapted accordingly. Clients will have the opportunity to share feedback via survey on appointment and enrollment events so that plans can be altered in real time. Clients are also asked to provide the source of their referral to track marketing and outreach methods.</p> <p>Evaluation: Please provide plan for evaluating intervention: Centers for Medicare and Medicaid will track the number of total enrollments. Enrollments can be broken down by new or established customers, ZIP, age, race, gender, poverty status and plan selection. Navigators also track how many people were enrolled in Medicaid/Medicare or referred to free/low-cost clinics.</p>
--	--	---	--