Community Health Action Plan 2015-2018

Designed to address Community Health Assessment priorities

County: Durham County **Partnership, if applicable: Partnership for a Healthy Durham** **Period Covered: 2015-2018**

LOCAL PRIORITY ISSUE

- Priority issue: Access to Healthcare
- 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): 2018
- Objective (specific, measurable, achievable, realistic, time-lined change in health status of population):
  1) Increase percentage of children (1-5 years old) enrolled in Medicaid who receive any dental service in previous six months from 58.1% to 60%.
  2) Decrease percentage of adults who have had a permanent tooth removed due to tooth decay or gum disease from 37.8% to 36.8%.
  3) Increase the percentage of formerly homeless people and low-income people with HIV/AIDS in permanent supportive housing who are receiving non-cash mainstream benefits, including Medicaid or Medicare from 82% to 90%
  4) Reduce the percentage of non-elderly uninsured individuals (aged less than 65 years) from 19% to 18%.
- Original Baseline: Children enrolled in Medicaid receiving dental services in previous six months: 58.1%; Tooth removed in adults: 37.8%; Formerly homeless receiving benefits: 82%; Uninsured: 19.0%
- Date and source of original baseline data: 2014 Durham County Community Health Assessment http://www.healthydurham.org/docs/file/about/CHA%20Final%20Document.pdf

POPULATION(S)

- Describe the local population(s) at risk for health problems related to this local community objective (At risk populations are members of a particular group that are likely to, or have the potential to acquire a certain health conditions. Examples of at risk populations include racial/ethnic disparities, gender, age, income, insurance status or geographical location.
  - Formerly homeless people, Hispanic/Latinos, foreign-born residents, underinsured and uninsured residents, children and adults living in poverty
- Total number of persons in the local disparity population(s) (include data and source of data):
  - 294 formerly homeless persons (2015 homeless one-night Point in Time Count)
  - Foreign-born individuals in Durham County is 38,000. The Hispanic population of Durham County is 36,000- including foreign-born and US-born residents. (United States Census Bureau and The Latino Migration Project at UNC-Chapel Hill)
  - 32,788 children and adults are uninsured (2015 estimate from the Lincoln Community Health Center)
- Number you plan to reach with the interventions in this action plan:
  - 1 out of 4 immigrants and refugees
  - 200 homeless individuals
  - 325 uninsured

HEALTHY NC 2020 FOCUS AREA ADDRESSED At a minimum, two out of the three local priority issues must have a corresponding Healthy North Carolina 2020 focus area that align with your local community objective Please check **one of the following 13** Healthy NC 2020 focus area (if applicable):

- 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)

- **Resource for detailed information of HEALTHY NC 2020 Objective**: http://publichealth.nc.gov/hnc2020/foesummary.htm}

- **List county baseline data associated with the HEALTHY NC 2020 Objective listed above.** (Include data date and source. Some county-level data is available at http://healthstats.publichealth.nc.gov/indicator/index/Alphabetical.html):

RESEARCH REGARDING WHAT HAS WORKED ELSEWHERE*

The Action Plans corresponding to Healthy NC 2020 focus areas must include at least two evidence-based strategies (EBS), or expand current EBS for new target populations if an EBS is already being used. (proven to effectively address this priority issue) that seem the most suitable for your community and/or target group. Or, if evidence-based interventions are already being used, expand the interventions into new target populations. **Training and information are available from DPH. Contact your regional consultant about how to access them.*

Evidence-Based Intervention	Source	Level of change	Intervention goal	Intended population	Implementation venue(s)	Resources required
NC Oral Health Collaborative	http://oralhealthnc.org	__ Individual/ interpersonal behavior _X_ Organizational/ Policy __ Environmental	1) oral health literacy through collaboration with faith organizations 2) Medical dental collaboration to incorporate preventative care and education	North Carolina residents	Clinical and community providers, church/agro-medicine, social media	Volunteers, health professionals, health literacy resources
Dental Aid Clinics Boulder, CO	http://www.dentalaid.org	__ Individual/ interpersonal behavior _X_ Organizational/ Policy __ Environmental	Provide reduced cost care for low income individuals and populations at risk	Various	3 dental clinics and one satellite clinic at center for homeless	Dentists, clinics, case managers
Community health workers evidence-based models toolbox	HRSA Office of Rural Health Policy U.S. Department of Health and Human Services Health Resources and Services Administration, August 2011	_X_ Individual/ interpersonal behavior _X_ Organizational/ Policy __ Environmental change	Improve access to care, increase knowledge, prevent disease, and improve select health outcomes for populations.	Rural and vulnerable communities (Adults)	Neighborhoods, Clinics, Faith institutions, nonprofits, community based organizations	Funding, infrastructure, training
Addressing Chronic Disease through Community Health Workers A Policy Brief On Community Health Workers A Policy And Systems-Level Approach	National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Diseases and Stroke Prevention, April 2015	_X_ Individual/ interpersonal behavior __ Organizational/ Policy __ Environmental change	Implementing recommendations to integrate community health workers (CHWs) into community-based efforts to prevent chronic disease.	Rural, Urban and Vulnerable Communities (Adults)	Neighborhoods, Clinics, Faith institutions, nonprofits, community based organizations	Funding, infrastructure, training

Refugee Healthcare Project	New York State Health Foundation	X_ Individual/ interpersonal behavior __ Organizational/ Policy __ Environmental change	Identify the barriers that previous refugee health programs faced and create strategies to overcome them and develop and implement a more sustainable model to serve Rochester's newly arriving refugees.	Refugees in Rochester, New York	Rochester General Hospital	Case managers, refugee resettlement agencies, health professionals
Center for Diabetes & Translation Research	Vanderbilt University	_X_ Individual/ interpersonal behavior __ Organizational/ Policy __ Environmental change	Reduce Gestational Diabetes Risk in the Hispanic Population Improving Health Communication to Help Prevent Childhood Obesity Decreasing weight gain in the perinatal period- Latina pregnant women and their infants	Hispanic community in Nashville (Tennessee) and the surrounding region.	Vanderbilt University, Meharry Medical College, The Foreign Language Institute and YMCA Young Hispanic Achievers, Nashville WIC Clinic	Health care providers, health literacy resources, health educators
Charitable Assistance to Community's Homeless	http://www.catchprogram.org/	_X_ Individual/ interpersonal behavior X Organizational/ Policy __ Environmental change	Re-house homeless families with children and provide support for six months to increase self-sufficiency	Homeless families with children	Community	Private/public partnerships, funds, case managers
Ask Me 3	http://www.npsf.org/?page=askme3	_X_ Individual/ interpersonal behavior X Organizational/ Policy __ Environmental change	Improve communication between patients and health care providers, encourage patients to become active members of their health care team, and promote improved health outcomes	People with limited literacy skills	Healthcare	Materials, training

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** (include any process/outcome measures, barriers to implementation)
Dental care for uninsured adults (Basic+ cleanings, fillings, extractions, emergency procedures, root canals; also fluoride varnishing for children)	Lincoln Community Health Center	2014 – 3,173 unduplicated patients & 6,117 visits; Sliding scale with nominal fee of $40; accept private and public insurance
Basic (x-rays, cleanings, extractions, fillings, pulpotomies, sealants and fluoride for children) for children and OB patients	Durham County Dept. of Public Health	1,134 last year; Medicaid & sliding scale with nominal fee of $25; no one turned away; no private insurance
Project Access Dental Pilot Project for existing patients	Project Access of Durham County working with Lincoln Community Health Center and Durham County Department of Public Health to conduct screening and create treatment plan	60 individuals seen in pilot phase; no charge to individual
Donated basic dental services free of charge for adults	CAARE Clinic, Samaritan Health Center, North Carolina Missions of Mercy (NC MOM)	450 individuals seen– no charge to individual at CAARE; 100-150 clients, 224 visits; no charge to individual at Samaritan Health Center; A two day event occasionally scheduled in Durham once every year or so for NC MOM
Discounted dental care & students volunteer at certain clinics	UNC School of Dentistry	Senior dental students are working at CAARE clinic now The school has a special clinic for geriatric and other complex work.
Refugee Advocacy	Church World Service	Language and cultural barriers.
Diabetes support for Hispanic patients with diabetes	DARA	Primarily support and health education, approximately 25 individuals
Nutrition counseling for diabetics	Northern Piedmont Community Care	English-language only. Available at Duke Outpatient clinics and some high schools (group setting)
Diabetes prevention	Duke Children's Healthy Lifestyles	
Diabetes education	Local Access to Coordinated Healthcare (LATCH)	Limited to patients enrolled in the program. Focus on management rather than prevention.
Health insurance education and enrollment	Coalition of Certified Application Counselor organizations and Navigators that formed a local workgroup	2 years of education and enrollment experience including serving this special population.

(Insert rows as needed)

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** (existing program/resource, access to target population, staff/venue/financial support, evaluation, etc.)
Agencies, providers, etc. providing access to dental care	Project Access	Review and share resources that are currently available and work together to help fill in some gaps in care.
Children who have Medicaid, CHIP (NC Health Choice) or a plan on the federal exchange (an essential health benefit for children)	Navigators and CACs (certified application counselors), DSS caseworkers	Many children are eligible for dental benefits and may not be aware or understand how to use the benefit.

Hispanic immigrants, refugees, other immigrant groups, obese children without insurance and a medical home	El Centro Hispano, Church World Service, Local Access to Coordinated Healthcare, Lincoln community Health center, Duke Health system	Immigrant and refugee groups and children receive access to health care services and a medical home
Hispanic immigrants, refugees ending health coverage, other immigrants who may qualify for insurance.	ACA workgroup, including MDC, Legal Aid, Lincoln Community Health Center, Enroll American, Project Access of Durham, United Way of the Greater Triangle, Planned Parenthood, Durham County Department of Public Health	Planning outreach and enrollment events for Open Enrollment (November through January) and available throughout the year to help individuals learn about and access health insurance coverage.
Poverty Reduction Initiative: Health Committee	City Council, Duke Division of Community Health, Lincoln Community Health Center, Durham County Department of Public Health, Durham County Department of Social Services, Partnership for a Healthy Durham, Healing with CAARE, Durham T.R.Y.	Group meets monthly to develop and implement action plan, Initiative spearheaded by Mayor
Partnership for Health Durham Access to Care Committee	Durham County Health Department, Local Access to Coordinated Healthcare, Duke Cancer Institute, Durham County Social Services, Lincoln Community Health Center, Durham Center Access, Durham Congregations Associations Neighborhood (CAN), Project Access of Durham County, SeniorPHARM*Assist*, Community Health Coalition, Durham Housing Authority, Durham Partnership for Children, Duke Regional Hospital, First Calvary Baptist Church, Healthcare for NC, NC Central Dept. of Health Education, Durham Center, InterDenominational Ministerial Alliance of Durham	Group meets monthly; responsible for development and implementation of action plan, Established linkages to target population

(Insert rows as needed)

INTERVENTIONS: SETTING, & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: Educate families about dental coverage benefits for children available via Medicaid, CHIP (NC Health Choice) and plans purchased via the federal exchange. Intervention: _X_ new __ ongoing __ completed Setting: Target population: Children with incomes below 200% FPL Start Date – End Date (mm/yy): (7/15 – ongoing) Targets health disparities: _X_Y __N	X_ Individual/ interpersonal behavior _X_ Organizational/ Policy __ Environmental change	**Lead Agency:** Durham County Department of Public Health (DCODPH), Partnership for a Healthy Durham Access to Care committee Dental working group **Role:** Work with Navigators and CACS and DSS Medicaid & CHIP (NC Health Choice) workers to ensure they understand the dental benefits of these programs. **Target population representative:** Youth Empowerment Solutions (YES) representatives who live in Durham Role: Ensure that outreach and education is relevant and effective **Partner agencies:** LCHC, Project Access, CAARE, Samaritan Clinic, DSS, YES, City of Medicine Academy, Early Head Start and preschool representatives, Oral Health Initiative Role: Screen children for these programs/benefits and help explain the advantages of such coverage Include how you're marketing the intervention: The Dental working group can assist with writing articles for local newspapers such as the Durham Herald-Sun about the benefits and how they are underutilized (Note: Articles can be submitted on behalf of the Partnership for a Healthy Durham, but should be approved by PHD leadership first)	**1. Expected outcomes: Explain how this will help reach the local community objective** (what evidence do you have that this intervention will get you there?) • Increase percentage of children (1-5 years old) enrolled in Medicaid who receive any dental service in previous six months. • Decrease average number of decayed, missing, or filled teeth among kindergarteners. **2. Anticipated barriers:** Any potential cultural, political, financial or administrative barriers? X Y__N If yes, explain how intervention will be adapted: Lack of enrollment in available dental services may be because of lack of knowledge of the importance of good preventive oral health early in life and it could point to the other stresses poor families face. In addition, it is not clear if there are enough providers who will accept these dental benefits. **3. List anticipated project staff:** Partnership for a Healthy Durham Coordinator, Gina Upchurch with Senior PharmAssist, Gary Greenberg with Duke University Medical Center, Alyse Lopez-Salm with LATCH, Natalie Atyco with Duke University, community member Andy Landes, Jonathan Kotch with UNC, Alissa Ridenour with Durham Head Start, Sally Wilson with Project Access of Durham County and Norma Marti with NC DHHS **4. Does project staff need additional training?** X_Y__N If yes, list training plan: The dental working group will create a basic fact sheet about dental benefits for children including who is eligible, what the benefits are and how to enroll. This will help educate the general public and the partners screening children for benefits. **5. Quantify what you will do** (# classes & participants, policy change, built environment change, etc.) The dental working group will meet regularly as a sub-committee to determine the best methods (ex. an outreach

			project plan) for reaching parents and other stakeholders working with children eligible for dental coverage and how many of these stakeholders can feasibly be reached (dependent on community partners engaged and using the tool(s) developed. 6. **List how agency will monitor intervention activities and feedback from participants/stakeholders** (is intervention being delivered as intended? How are staff receiving feedback throughout the intervention?) The dental workgroup will work with to obtain feedback from those it reaches with educational materials about insurance options to determine their usefulness to the target group (stakeholders with direct/indirect contact with children potentially eligible for dental coverage). 7. **Evaluation:** Are you using an existing evaluation? _X_Y __N If no, please provide plan for evaluating intervention impact: Use same source of data for NCIOM and Healthy NC 2020. Impact will be measured by assessing the aforementioned Local Community Objective #.
Intervention: Identify a plan for expanding dental care in Durham based on Durham assets & best practices from around the country. Intervention: __ new X_ ongoing __ completed Setting: It is likely that this expansion will build off the efforts already begun in Durham. Target population: Adults and children in Durham with incomes below 200% FPL Start Date – End Date (mm/yy): 7/15 – 6/2018	X_ Individual/ interpersonal behavior X_ Organizational/ Policy __ Environmental change	**Lead Agency:** Partnership for a Healthy Durham Access to Care committee Dental working group **Role:** Community convener **Target population representative:** Project Access of Durham County **Partner agencies:** DCoDPH, LCHC, Project Access, CAARE, Samaritan Health Center and will engage the local dental society and UNC Dental School representatives Partners will meet regularly to discuss planning and eventual	1. **Expected outcomes: Explain how this will help reach the local community objective** (what evidence do you have that this intervention will get you there?) • Increase the capacity of existing programs and/or work with interested stakeholders to introduce new programs or services. • Decrease percentage of adults who have had a permanent tooth removed due to tooth decay or gum disease 2. **Anticipated barriers:** Any potential cultural, political, financial or administrative barriers? X_Y__N If yes, explain how intervention will be adapted: Unfortunately, oral health has long been isolated from other health concerns and is not regularly discussed with medical providers. In addition, there are major capacity issues related to number of people who do not have dental

Targets health disparities: X_Y __N Those with incomes below 200% FPL are much less likely that those with incomes above to have access to dental care		implementation (ex. grant opportunities/partnerships) to expand dental care access among low-income adults in Durham County. Include how you're marketing the intervention: The plan, once implemented, can be marketed to interested dental students/dentists and other potential stakeholders through word of mouth and recruitment efforts of physicians/other dentists interested in the efforts of the workgroup. There is not a need to market to community members, as recipients of Project Access, the Samaritan Clinic, Lincoln services, etc. have an abundance of patients in need of dental care that can be screened and recruited to receive services.	coverage. Even for those who do have some level of access to care, they may not be able to easily access an affordable provider. **3. List anticipated project staff:** Partnership for a Healthy Durham Coordinator, Gina Upchurch with Senior PharmAssist, Gary Greenberg with Duke University Medical Center, Alyse Lopez-Salm with LATCH, Natalie Atyco with Duke University, community member Andy Landes, Jonathan Kotch with UNC, Alissa Ridenour with Durham Head Start, Sally Wilson with Project Access of Durham County and Norma Marti with NC DHHS **4.** Does project staff need additional training? __Y_X N If yes, list training plan: **5. Quantify what you will do** (# classes & participants, policy change, built environment change, etc.) 1) Complete an inventory of programs that already provide free or discounted dental care; keep this document up-to-date. 2) The working group will review the oral health chapter of the 2014 Durham County Community Health Assessment and the three CMS May 2015 Oral Health Initiative documents in order to better understand the needs of Durham residents and what programs or policies might help Durham residents. 3) Weigh the pros/cons of expanding these services, esp. as it relates to the use of volunteers and/or paid professionals 4) Examine with other communities have done to expand dental access 5) Design and administer dental access questionnaires to dental professionals and residents in Durham who have little to no dental access now 6) Consider potential funding opportunities and long-term sustainability of the expansion options 7) Host a major stakeholder conversation by early fall 2016 to discuss expansion ideas for 2017 **6. List how agency will monitor intervention activities and feedback from participants/stakeholders (is intervention being delivered as intended?** How are staff

			receiving feedback throughout the intervention?) The dental working group will design two dental care access questionnaires that will be administered to: a) Durham residents with incomes below 200% FPL; and b) to dental providers in Durham. The dental working group will use this information and their review of best practices to recommend next steps that major stakeholders will be asked to respond to by Fall 2016. **7. Evaluation:** Are you using an existing evaluation? X_Y_X_N If no, please provide plan for evaluating intervention impact: Adult permanent tooth lose question is included in BRFSS. Evaluation of program development is TBD.

Intervention: Improve health literacy among patients and improve communication between patients and health care providers Intervention: ___new _X_ ongoing __ completed Setting: Target population(s): • Adults over the age of 65 • Minority populations • Recent refugees and immigrants • People with less than a high school degree or GED • People with incomes at or below the poverty level • Non-native speakers of English Start Date – End Date (07/2015 – 06/2018): Targets health disparities: X Y _N	X Individual/ interpersonal behavior X Organizational/ Policy __ Environmental change	**Lead Agency**: Community Health Coalition, Inc. and Partnership for a Healthy Durham Access to Care committee Health Literacy Workgroup **Role**: Coordinate and implement intervention **Partners:** Community Health Coalition, Inc. LCHC Clinic For The Homeless, Durham Public Libraries, Duke University Medical Center Library, Durham Partnership For Seniors, *others that should be listed here? Who else do we need to bring to the table?* **Target population representatives:** LATCH **Role:** Help identify participants **Include how you're marketing the intervention**: This program will be marketed through the established channels of the Lead Agency and the Partnership for Health Durham, i.e. traditional and social media, PSAs, invitations, press releases, etc.	**1. Expected outcomes: Explain how this will help reach the local community objective** (what evidence do you have that this intervention will). • Improved communication skills to ensure agreement between patient and provider & a better understanding about individual care plans. Increase the dissemination and use of evidence based health literacy practices and interventions. • Increased use of clear health communication techniques can significantly improve the care and outcomes of vulnerable patients with limited health literacy. **2. Anticipated barriers:** Any potential cultural, political, financial or administrative barriers? _X_Y__N If yes, explain how intervention will be adapted: • Health literacy, both conceptually and in practice, has often been siloed from other interventions designed to overcome cultural and linguistic barriers. • Stigma related to low literacy can presents challenges as there is a growing emphasis on the need for patient participation in health care decision making. There is an anxiety associated with revealing literacy difficulties which sometimes causes people to self-isolate due to fear of being judged harshly. **3. List anticipated project staff:** Partnership for a Healthy Durham Coordinator, Kim Monroe and Kenisha Bethea with Duke University Health System, Jennifer Bynum and Dr. Elaine Hart-Brothers with Community Health Coalition, community members Andy Landes and Ramon Llamas; Charita McCollers with Lincoln Community Health Center Clinic for the Homeless, Dr. Angeloe Burch with the Interdenominational Ministerial Alliance **4.** Does project staff need additional training? __Y_X N If yes, list training plan: **5.** Quantify what you will do (# classes & participants, policy change, built environment change, etc.) 1) Research health literacy and health care communication interventions. 2) Research and identify health literacy resources already available through organizations in the community.

			3) Identify organizations that could incorporate health literacy activities into current activities and services (invite libraries, literacy councils, etc.,) 4) Identify potential funding sources to help support effort 5) Create plan for implementing activities to improve health literacy among patients and communication between health care providers and patients. a. Work to ensure sustainability of activities to improve health literacy among patients and communication between health care providers and patients. Two Part Intervention: Phase One: In May 2016, the Community Health Coalition annual meeting will focus on health literacy as it relates to enhanced patient-provider communication. This meeting will serve as a kick-off intervention for the health literacy program. Participants include health care providers, patients, caregivers, politicians and pastors. Information gathered during the meeting will be used to develop health literacy materials and program implementation. • At the kick-off meeting, participants will have the option to attend one of four workshops designed for specific populations audiences. i.e. providers, patients, pastors, and politicians. Approximately 150 – 175 community members are anticipated to attend the kick off meeting. Discussion topics will be communicating health concerns, understanding bottled prescriptions and treatment regiments, understanding dietary needs, health insurance forms, etc. Phase Two: The second phase of the intervention includes: 1. Evaluation and creation (or redesign) of health education materials (to include graphic designs/pictures) based on best practices in health communication, patient decision making for low-literacy populations. • Mass distribution of health materials will be implemented through the Partnership's current distribution methods new strategies developed from community feedback. 2. Partner with community and healthcare agencies to

			coordinate smaller community-based workshops in "pockets" throughout Durham County to reinforce health literacy practices and messages and obtain community feed-back. • Four community–based workshops will be held in each quadrant of the city. These workshops focus on training providers and patients on the basic reading, math, and communication skills needed for health literacy practices and comprehension of health information. **6. List how agency will monitor intervention activities and feedback from participants/stakeholders** (is intervention being delivered as intended? How are staff receiving feedback throughout the intervention?) Information relative to the intervention (to include community feed-back) will be shared on a quarterly basis at the Partnership For A Healthy Durham Access to Care committee meetings. **7. Evaluation:** Are you using an existing evaluation? X Y__N If no, please provide plan for evaluating intervention impact: The team will use the RE-AIM (reach, effectiveness, adoption, implementation, maintenance) framework to evaluate the impact of this intervention by evaluating the factors considered most relevant to real-world implementation, such as the capacity to reach underserved populations and to be adopted within diverse settings. Use pre, mid, and post-test/surveys to obtain feedback at community workshops and education sessions. Team will utilize evidence based tools to assess health literacy levels.

Intervention: Conduct outreach and enrollment efforts of immigrants, refugees, and low-income special populations in coverage through the Federal Health Insurance Marketplace, Medicaid, or through local programs that offer free/slide-scale coverage to vulnerable populations. Intervention: x new __ ongoing __ completed Setting: All of Durham County. Target population: Immigrants, refugees, low-income special populations Start Date – End Date (mm/yy): 8/2015-6/2018 Targets health disparities: X Y __N	X_ Individual/ interpersonal behavior __ Organizational/ Policy __ Environmental change	**Lead Agency:** MDC **Role:** Convener______________ Target population representative: Scott Edmonds – program manager, MDC **Partners:** Legal Aid, Lincoln Community Health Center, Enroll American, Project Access of Durham County, United Way of the Greater Triangle, Planned Parenthood, Durham County Department of Public Health, Partnership for a Healthy Durham Access to Care Committee Special Populations workgroup **Role:** Develop and implement intervention Include how you're marketing the intervention: Radio PSAs, community tabling and enrollment events, bus ads and letters to the editor	1. **Expected outcomes: Explain how this will help reach the local community objective** (what evidence do you have that this intervention will get you there?) • Increasing enrollment of populations potentially eligible for Marketplace coverage, Medicaid, or free/sliding scale programs 2. **Anticipated barriers:** Any potential cultural, political, financial or administrative barriers? X Y__N If yes, explain how intervention will be adapted: • Residual politic resistance to the ACA/public benefit programs • Cultural barriers with Spanish speaking populations / Hispanics 3. **List anticipated project staff:** Affordable Care Act Navigators and Certified Application Counselors (CACs) from Lincoln Community Health Center, MDC, Legal Aid, Enroll America 4. **Does project staff need additional training?** X Y__N If yes, list training plan: Organizations plan to renew federal training 5. **Quantify what you will do** (# classes & participants, policy change, built environment change, etc.) Conduct 8 outreach and enrollment events over three years throughout Durham County targeting populations potentially eligible for Marketplace coverage, Medicaid, or free/sliding scale programs. 6. **List how agency will monitor intervention activities and feedback from participants/stakeholders** (is intervention being delivered as intended? How are staff receiving feedback throughout the intervention?) Information related with the outreach efforts (including community feedback) will be shared at the Partnership for a Health Durham Access to Care Committee meeting. Open Enrollment ends on January 31 each year so information will

			be shared the following March or April. **7. Evaluation:** Are you using an existing evaluation? __Y X N If no, please provide plan for evaluating intervention impact: Marketplace enrollment data is reported to the Federal Government. Enrollment evaluation data will be shared with the Access to Care Committee.

<table>
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<td>Intervention: Support Community Health Workers

Intervention:
__ new _X_ ongoing __ completed

Setting:

Target population: Residents and patients in Northeast Central Durham (Census tract 10.01 and 10.02)

Start Date – End Date (07/2015-06/2018):

Targets health disparities: _X_Y __N</td>
<td>_X_ Individual/ interpersonal behavior

_X_ Organizational/ Policy

__ Environmental change</td>
<td>Lead Agency: Poverty Reduction Initiative (PRI) Health Task Force (made up of City Council members, Durham County Department of Public Health, Lincoln Community Health Center, Durham Social Services, Community Health Coalition, Together for Resilient Youth Coalition, Duke Community Health

Role: Develop and implement intervention

Target population representative: Identified Community Health Worker (CHW)

Role: Lay member serve as a bridge between the individual, home, community, provider, and the health and human services system; to improve health outcomes by addressing community health issues specific to residents in 10.01 and 10.02.

Partners: Partnership for a Healthy Durham: Access to Care Committee, East Durham Children's Initiative, InterDenominational Ministerial Alliance of Durham

Role: Support the efforts of the PRI Health Task Force

Include how you're marketing the intervention:

Partnership for a Healthy Durham: Access to Care Committee and Communications Committee will support and assist with marketing this intervention via the existing established network of the PRI Health Task Force and the networks made up of the Partnership.</td>
<td>1. Expected outcomes: Explain how this will help reach the local community objective (what evidence do you have that this intervention will get you there?)

What is the expected outcomes? How will people be impacted by this initiative?

Utilizing a Peer Education Model: Community Health Worker (CHW); the task force hope to address poverty by:
• Address social determinants of health to increase access to health care services, healthy foods, and reduce language/literacy barriers within census tract 10.01 and 10.02 and the Durham community at large.
• Identify families within the target population that suffer from chronic illness; CHWs will link identified families to evidence based/best practice programming related to reducing chronic illness (i.e. diabetes self-management, smoking cessation, healthy eating/nutrition classes, asthma education).
• CHWs will be identified and trained by utilizing identified evidenced based practices to recruit and educate local community members to serve as CHWs (involving existing community organizations and resources);
• Address sustainability CHWs in the community by developing an infrastructure to support community CHWs and policies that will allow for reimbursement of CHW services.

2. Anticipated barriers: Any potential cultural, political, financial or administrative barriers? _X_Y__N
If yes, explain how intervention will be adapted:

Creating infrastructure and adopting policies to support the CHWs by allowing for reimbursement of services to ensure sustainability.

3. List anticipated project staff:
Identified CHWs, additional support provided via the network of institutions that make up the PRI Health Task Force, Kenisha Bethea, Valarie Worthy and Kimberly Monroe with Duke University, community member Angeloe Burch Sr.</td>
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		Strategies include but not limited to community outreach (residents/businesses), social media, press releases, PSAs, newsletters, list serves, etc.	**4. Does project staff need additional training?** _X_Y__N If yes, list training plan: Training of newly identified CHWs; utilize curriculums developed by existing partners **5. Quantify what you will do** (# classes & participants, policy change, built environment change, etc.) • The community health worker subcommittee will provide support in identifying the CHWs within the community by identifying at least 5 community partner websites, community organizations, nonprofits, to advertise career opportunities (job announcements) related to CHWs. • The community health worker subcommittee will assist with identifying resources in the community (i.e. resource guides for CHWs, referrals) and disseminate to CHWs. **6. List how agency will monitor intervention activities and feedback from participants/stakeholders** (is intervention being delivered as intended? How are staff receiving feedback throughout the intervention?) • The community health worker subcommittee will meet regularly to determine best methods for collaborating with partners to create an outreach plan to share job announcements related to CHWs through their networks; including but not limited to community based organizations, local non-profits, community clinics, faith based institutions, Durham Technical Community College. Updates will be shared monthly as needed to the Access to Care Committee. • The community health worker subcommittee will meet regularly to ensure partner and community resource guides are integrated and current; information will be disseminated to CHWs via the committee and community partners. Updates will be shared monthly as needed to the Access to Care Committee. **7. Evaluation:** Are you using an existing evaluation? X Y__N If no, please provide plan for evaluating intervention impact:

Intervention: Implementation of H2 (Housing and Healthcare) Initiative Action Plan Intervention: X new __ ongoing __ completed Setting: City of Durham Target population: Formerly homeless people in permanent supportive housing and people with HIV/AIDS receiving tenancy support with HOPWA funds Start Date – End Date (mm/yy): 09/15—08/18 Targets health disparities: X Y __N	_Individual/ interpersonal behavior X Organizational/ Policy X Environmental Change Environmental change	**Lead Agency**: City of Durham's Community Development Department & Partnership for a Healthy Durham's Access to Care Committee Role: Help coordinate work of the subcommittee **Partner Agencies & Roles**: DUMC Partners in Caring, Housing for New Hope, Alliance Behavioral Healthcare, Health For the Homeless Clinic, Lincoln Community Health Center, Duke University Health System, Homeless Service Advisory Committee, Partnership for a Healthy Durham HIV/STI committee ______________________ **Target population representative***:* Target population representative is not yet identified, but two formerly homeless people do serve on Durham's Homeless Services Advisory Committee, which serves as Durham's primary community decision-making body concerning housing and services for homeless and formerly homeless people. **Include how you're marketing the intervention:** • Communicate with key audiences through various mediums including but not limited to: housing and healthcare service providers, non-profit and civic organizations, city and local government boards, committees, and commissions. • Invite members of the HIV/STI Partnership for a Healthy	**1. Expected outcomes: Explain how this will help reach the local community objective** (what evidence do you have that this intervention will get you there?) • Improved housing stability for formerly homeless people and people with HIV/AIDS in HOPWA supported housing. • Improved health outcomes for the target populations. • Identification of opportunities to coordinate strategies and sustain partnerships through targeted funding opportunities. • Increased service coordination and improved collaboration within existing programs to make organizational, policy and process changes and to respond effectively to consumer needs. **2. Anticipated barriers:** Any potential cultural, political, financial or administrative barriers? X Y__N If yes, explain how intervention will be adapted: • Medicaid has not been expanded in NC, which impacts the ability for programs to claim Medicaid reimbursements for services they provide. Dialogue with the State suggests it may be possible to use Medicaid to fund "tenancy support services." • Definition of homelessness varies among organizations. Initial focus will be on people who have met HUD's definitions of homelessness and chronic homelessness. • Multiple data collection systems impacts the ability to share information across organizations regarding service utilization, costs, outcomes and client eligibility. Suggested strategies include exploring ways to increase data sharing to improve health and housing outcomes. **3. List anticipated project staff:** Partnership for a Healthy Durham Coordinator, Kim Monroe with Duke University, Lloyd Schmeidler with the city of Durham, community member Ramon Llamas and Charita McCollers with Lincoln Community Health Center. **4. Does project staff need additional training?** __Y X N If yes, list training plan: **5. Quantify what you will do** (# classes & participants, policy

		Durham committee to participate in this intervention. • Collaboration is growing out of HUD-sponsored Technical Assistance (TA) received in late April 2015. The overall goal is to increase and improve access to health care and services that support housing stability. Nearly two dozen Durham health care and housing professionals participated in the TA session	change, built environment change, etc.) • Form a Housing Support Services Subcommittee. Convene bi-monthly meetings • Review draft action plan from the HUD-sponsored Technical Assistance (TA) session conducted in late April 2015. • Identify local interventions already being implemented and determine where gaps are. • Identify one or two strategies on the community or state strategies that would require a minimum of investment and energy, but that could still make a tangible difference in Durham • Identify 3-5 strategies from the community level list that would be priority strategies for the subcommittee's work for the next 1-3 years. **6. List how agency will monitor intervention activities and feedback from participants/stakeholders** (is intervention being delivered as intended? How are staff receiving feedback throughout the intervention?) Levels of Medicaid participation by residents of Continuum of Care funded permanent supportive housing projects and persons receiving HOPWA assistance will be monitored annually. **7. Evaluation:** Are you using an existing evaluation? __Y__N If no, please provide plan for evaluating intervention impact: Primary evaluation will be the percentage of formerly homeless and homeless people and people receiving HOPWA assistance who are receiving health insurance benefits via Medicaid, Medicare, or VA Medical Benefits.

(Insert rows as needed)