Forsyth County Department of Public Health
Promoting Health, Improving Lives

NCPH North Carolina Public Health

Forsyth County Community Health Action Plan 2011

Designed to address Community Health Assessment priorities

County: Forsyth County **Partnership:** Healthy Community Coalition **Period Covered:** 2012-2015

LOCAL PRIORITY ISSUE

- Priority issue: Chronic Disease Management
- Was this issue identified as a priority in your county's most recent CHA? X Yes __ No

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

- By: December 2015
- Objective 1: To increase community awareness resources and services available for improved chronic disease management; Objective 2: To reduce the number of hospital readmissions within 30 days on discharge by 5% and improved access to support services by providing outreach and networking with 4 community agencies and/or hospitals
- Original Baseline:
  - Cancer, Heart Disease/High Blood Pressure, Diabetes and Weight Management/ Eating habits were the most frequently health topics/diseases that respondents wanted to learn about-*2011 Community Health Opinion Survey*
  - July 2008-June 2011-Pneumonia Readmission Rates: 23.7% @ Wake Forest Baptist Hospital; 17.9% @ Forsyth Medical Center- *NC Center for Hospital Quality and Patient Safety*
  - The most often mentioned major health-related problems stakeholders perceived in Forsyth County were Overweight and obesity (18);Mental health issues; lack of mental illnesses services (8); and Chronic illnesses such as diabetes, high blood pressure, heart disease (8)- *2011 Community Stakeholders Interview*
  - Had been told by a doctor that they had the following: 8.7%Diabetes; High Blood Pressure-33.1%;High Blood cholesterol-44.6%; heart Disease-4%-2009 BRFSS Forsyth County
  - 6.9% of respondents said they needed more information about going to the doctor for yearly check-ups and screenings-*2011 Community Health Opinion Survey*
  - High blood pressure, high cholesterol and overweight/obesity were the most frequently reported health conditions among respondents-*2011 Community Health Opinion Survey*
- Date and source of original baseline data: NC Center for Hospital Quality and Patient Safety; 2009 BRFSS Forsyth County results; 2011 Community Health Opinion Survey; 2011 Community Stakeholders Interview
- Updated information (For continuing objective only): N/A
- Date and source of updated information: N/A

POPULATION(S)

- Describe the local population(s) experiencing disparities related to this local community objective: Forsyth County Adults 50 and older who are newly diagnosed with or have poorly managed chronic disease such as diabetes, heart disease and high blood pressure.
- Total number of persons in the local disparity population(s): 13,000
- Number you plan to reach with the interventions in this action plan: 2,000

HEALTHY NC 2020 FOCUS AREA ADDRESSED

__ 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
X Chronic Disease (Diabetes, Colorectal Cancer, Cardiovascular Disease)
__ Cross-cutting (Life Expectancy, Uninsured, Adult Obesity)

- Check **one** Healthy NC 2020 focus area: (Which objective below most closely aligns with your local community objective?)
- **List HEALTHY NC 2020 Objective**: (Detailed information can be found at http://publichealth.nc.gov/hnc2020/ website)
  Objective 1: Reduce the cardiovascular disease mortality rate.
  Objective 2: Decrease the percentage of adults with diabetes.
  Objective 2: Increase the percentage of adults reporting good, very good or excellent health.

RESEARCH RE. 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
Addressing Chronic Disease through Community Health Workers: A policy and Systems-Level approach	In addition, CHWs educate health care providers and administrators about the community's health needs and the cultural relevancy of interventions by helping these providers and the managers of health care systems to build their cultural competence and strengthen communication skills. Using their unique position, skills, and an expanded knowledge base, CHWs can help reduce system costs for health care by linking patients to community resources and helping patients avoid unnecessary hospitalizations and other forms of more expensive care as they help improve outcomes for community members	http://www.cdc.gov/dhdsp/docs/chw_brief.pdf
Diabetes Prevention and Control: Self- Management Education	The Community Preventive Services Task Force recommends that diabetes self-management education (DSME) interventions be implemented in: • Community gathering places on the basis of sufficient evidence of effectiveness in improving glycemic control for adults with Type 2 diabetes • Homes of children and adolescents who have Type 1 diabetes on the basis of sufficient evidence of effectiveness in improving glycemic control among adolescents with Type 1 diabetes	http://www.thecommunityguide.org/diabetes/selfmgmteducation.html
Diabetes Prevention and Control: Self-Management Education in the Home for Children and Adolescents with Type 1 Diabetes	The home can be a good setting for DSME interventions because the educator can address issues that can be more difficult to deal with in the clinical setting, such as cultural, family, and environmental factors affecting lifestyle, self-monitoring of blood glucose, and barriers to optimal self-care. On the basis of Community Guide rules of evidence, there is sufficient evidence that DSME in the home is effective for improving glycemic control among adolescents with Type 1 diabetes, whether using home visits or computer-assisted instruction.	http://www.thecommunityguide.org/diabetes/supportingmaterials/RRhome1.html Task Force on Community Preventive Services. Recommendations for healthcare system and self-management education interventions to reduce morbidity and mortality from diabetes. [PDF - 67KB] *Am J Prev Med* 2002;22(4S):10-4.

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
Diabetes Healthsource helps patients learn new ways to manage their diabetes with confidence. The program is recognized by the American Association of Diabetic Educators, and its diabetes educators (nurses and dietitians) specialize in working with people who have diabetes and pre-diabetes. Services include expert medical supervision, education, counseling and compassionate support to help patients manage their disease and achieve maximum wellness. Diabetes HealthSource specialists work collaboratively with patients' physicians to ensure proactive medical care and early intervention for any problems that may arise.	Wake Health	Classes and programs are offered regularly to patients and community members; an average year has 110 classes with 512 participants.
Cardiovascular Risk Management Program -We offer a comprehensive preventive cardiology program that evaluates your cardiac risk factors and develops an action plan emphasizing optimal management of all risk factors, including your lipid and hypertension management and diabetes control. Risk management plan may also include nutrition counseling, education and exercise therapy	Novant Health	Classes and programs are offered regularly to patients and community members. Novant currently run more than 20 programs related to cardiovascular risk, including biometric screenings, stress management classes, nutrition/weight management programs and more. Classes are both one-time and multi-week series. Typically, a minimum of one program is held per week, averaging approximately 20 individuals per class.
Living a Healthy Life with Chronic Disease	Northwest Piedmont Council on Aging	Classes and programs are offered regularly to patients and community members.

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
Forsyth County Department of Public Health	Novant Health, Wake Health, City of Winston-Salem, Wake Forest University, Forsyth Futures, Pioneering Healthy Communities, Webster's, Forsyth County Cooperative Extension, Winston Salem State University	Lead agency for bringing different groups together to collaborate and support one another on the issues of chronic disease management
Forsyth Futures	Novant Health, Wake Health, City of Winston-Salem, Wake Forest University, Forsyth County Dept. of Public Health, Pioneering Healthy Communities, Forsyth County Cooperative Extension, Winston Salem State University	Lead agency for collecting community data; serving as a clearinghouse; and bringing different groups together to collaborate and support one another on the different data collection efforts/issues.

INTERVENTIONS: SETTING, & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
INTERVENTIONS SPECIFICALLY TARGETING HEALTH DISPARITIES		
Intervention: Support current initiatives that address chronic disease hospital to home program(s) among senior population Intervention: X new __ ongoing __ completed Setting: Community Agencies in Forsyth County Start Date – End Date (mm/yy): June 2012- December 2015 Level of Intervention - change in: X Individuals __ Policy &/or Environment	Partners: FCDPH, Novant Health, Forsyth County Cooperative Extension, Wake Health, Senior Services Roles to be determined Marketing to be determined	**1. Quantify what you will do** • Keep record the number of referrals to social support programs and services • Document number of meetings, attendance, and agency contributions • Document number agencies working together on this project • Document number of new agencies/ collaborations established from this project **2. Expected outcomes:** • Reduction in the number of readmissions due to lack of social support and access to care • Increase in number of referrals and utilization of social support programs • Improved medication management • Increase in improved health outcomes
INDIVIDUAL CHANGE INTERVENTIONS		
Intervention: Ongoing education of chronic disease management services/ programs offered at hospital and clinical level Intervention: __ new X ongoing __ completed Setting: Hospital systems in Forsyth County Start Date – End Date (mm/yy): Jan. 2012- December 2015	The lead agencies are Novant Health and Wake Health. The hospitals will review/assess the need for programs and services to assist clients with management of specific chronic diseases (hypertension, diabetes and cardiovascular disease) Forsyth County Department of PF, Senior Services, Community Care Clinic, Downtown Health Plaza Marketing the interventions or programs will be determined	**1. Quantify what you will do:** • Document number of classes offered quarterly • Document the number of participant attending programs **2. Expected outcomes**: • Increased access to targeted care • Increase management of disease (lower readmissions for chronic disease) lifestyle changes
POLICY OR ENVIRONMENTAL CHANGE INTERVENTIONS		
Intervention: Area agencies commit to pursuing one new community project to increase awareness and access to available resources Intervention: X new ___ ongoing ___ completed Setting: Agencies in Forsyth County Start Date – End Date (mm/yy): August 2012- July 2013	Novant Health; Wake Forest Baptist Health; Forsyth County Dept. of PH; Senior Services; University of NC at Greensboro; Winston-Salem State University ;TSI/PCEI; Faith-based organizations Other agencies to be determined Partners with assist with the study by reviewing internal policies and procedures; identify issues and mechanisms needed to support the program	**1. Quantify what you will do**: • Inventory and document community programs and social support networks in Forsyth County • Keep record of the number of new agency participation and/or collaborations established • Document how agencies cross promote external programs, services, etc. • Document number of meetings, attendance, participation and process of this project. **2. Expected outcomes:** • Higher utilization of clinical services and community resources to improve chronic disease management