Community Health Improvement Plan

McDowell County

RUTHERFORD POLK McDOWELL HEALTH DISTRICT

WNCHEALTHYIMPACT

2013 McDowell County

COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

July 2013

ACKNOWLEDGEMENTS

This document was developed by McDowell County, in partnership with the McDowell Health Coalition and McDowell Mission Hospital as part of a community-wide action planning process.

We would like to thank several agencies and individuals for their contributions and support:

McDowell County Health Coalition, 2012 Board of Directors including Tim Blenco, Chairman, McDowell Health Coalition, Caroline Rodier, Past Chair, McDowell Health Coalition, Phillip Hardin, Department of Social Services, Sharon Parker, Abena Asante, Kate B. Reynolds Charitable Trust, Jimmy Hines, Marjorie Vestal, Becky Koone, Kris Edwards, Alma Bartlett, RPM District Health Department, Molly Sandfoss, Cooperative Extension, Mary Smith, Joann O'Sullivan, Community Transformation Grant Program.

This CHIP format draws heavily on the work of the Wisconsin Association of Local Health Departments and Boards (WALHDAB), particularly their Template Implementation Plan, as well as actual examples from Bexar County, Texas. This product was also informed by many other organizations, which can be found in the reference section at the end of this document.

Our collaborative action planning process and community health improvement plan (CHIP) product were also supported by the technical assistance and tools available through our participation in WNC Healthy Impact, a partnership between hospitals and health departments in western North Carolina to improve community health.

DATA SOURCES

The principal source of secondary health data for this report was the NC State Center for Health Statistics (NC SCHS), including its County Health Data Books, Behavioral Risk Factor Surveillance System, Vital Statistics unit, and Cancer Registry. Other health data sources included: NC Division of Public Health (DPH) Epidemiology Section; NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services; National Center for Health Statistics; NC DPH Nutrition Services Branch; UNC Highway Safety Research Center; NC Department of Transportation; NC DETECT and the NC DPH Oral Health Section.

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Executive Summary
General Review of Data and Trends

The Community Health Improvement Plan (CHIP) is built upon relevant data from our Community Health Assessment as well as opportunities for improvement presented by community partners. The following is a summary of health related data for McDowell County (2012).

LIST OF HEALTH PRIORITIES

In 2009 these areas were designated as the 4 primary areas of focus for McDowell County:

- Obesity, Physical Activity, Nutrition & Diabetes
- Teen Pregnancy Prevention
- Access to Care
- Substance Abuse Prevention

2012 Health Priorities include:

- Healthy Eating & Active Living – Diabetes Reduction
- Access to Care
- Teen Pregnancy Prevention
- Tobacco Use
- Substance Abuse & Behavioral Health

This CHIP will be covering action plans to address Diabetes Reduction and Access to Care. The remaining health priority areas will be addressed by the McDowell Health Coalition's Action Teams and contributing partners such as the Kate B. Reynolds Healthy Places Initiative and the Community Transformation Program.

RACIAL DIVERSITY AND DEMOGRAPHIC HIGHLIGHTS

McDowell County is less racially diverse than either WNC or NC as a whole. In McDowell County the population is 90.6% white/Caucasian and 9.4% non-white. The proportion of the population that self-identifies as Hispanic or Latino of any race is 5.3% in McDowell County. 4.8% of residents speak a language other than English at home.

Poverty

High levels of poverty are unfortunately a reality in McDowell County. According to the U.S. Census Bureau, in 2010, 21.3% of McDowell County residents lived in poverty, compared to a state rate of 16.2%. In addition, 29.2% of residents were considered low-income, meaning that the family's income was less than twice the federal poverty level ($44,100 for a family of four in 2009). The average median household income in McDowell County is only $31,514, roughly 72% of the statewide average.

The N.C. Division of Social Services reported that the number of residents receiving food stamps increased from 6,877 in 2009 to 8,385 in 2010, totaling 18.6% of the county's population. Additionally, 69.1% of McDowell County children are enrolled in the Free/Reduced Price School Meals program, compared to a state rate of 53.7%.

The Annie E. Casey Foundation's Kids Count Data Center reports that a startling 2,831 children under age 18 (totaling 29.6%) live in poverty in McDowell County, an 8.5% increase from 2007. Compared to a state rate of 24.6%, our county's children are faring worse than most. While approximately 33.9% of children in McDowell County are eligible for Medicaid (compared to a state rate of 32.6%), an additional 10.3% of children have no health insurance at all.

Unemployment Rate

Unemployment Rate of Workforce

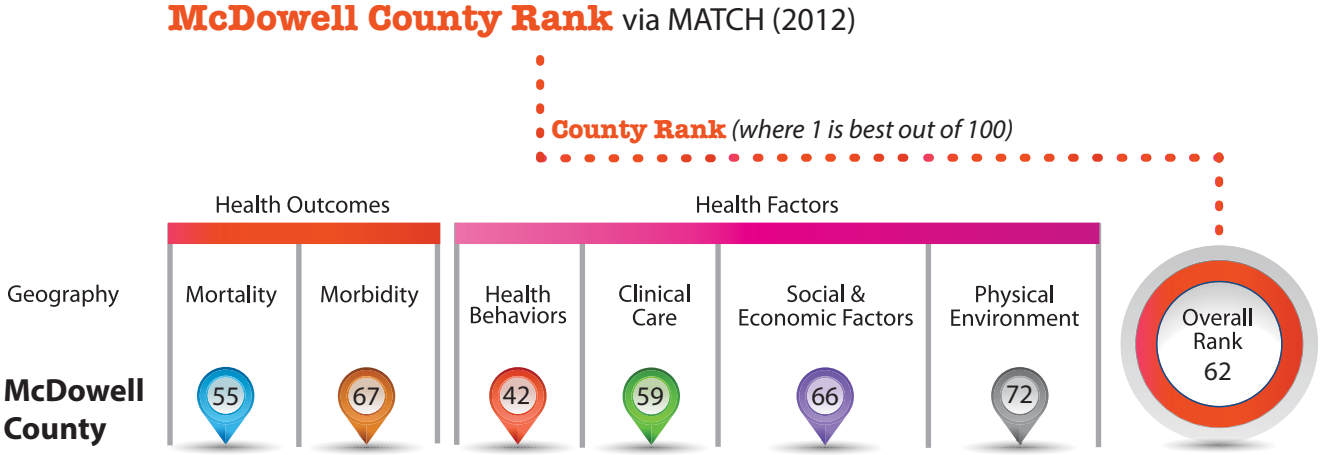
Annual Average Geography	2007	2008	2009	2010	2011
McDowell County	5.6	8.2	15.5	13.6	13.0
Regional Arithmetic Mean	4.9	6.8	11.8	11.8	11.5
State Total	4.8	6.3	10.5	10.9	10.5

NOTABLE CHANGES SINCE 2004

- 57.7% growth in Latino population since 2004
- 2,085 more unemployed adults than in 2004
- 4.5% decrease in obese 2-4 year olds since 2004
- 3,247 more adults receiving Medicaid benefits than 2004
- Non-Profit Organizations collaborating to meet community needs

County Health Rankings

The table below presents the health outcome and health factor rankings for McDowell County.



Sources:

County Health Rankings and Roadmaps, 2012. Available at www.countyhealthrankings.org/app/northcarolina/2012/rankings/outcomes/overall

The estimated prevalence of diagnosed obesity among adults in McDowell County from 2005 to 2009 increased by 24.9%.

Adult Obesity

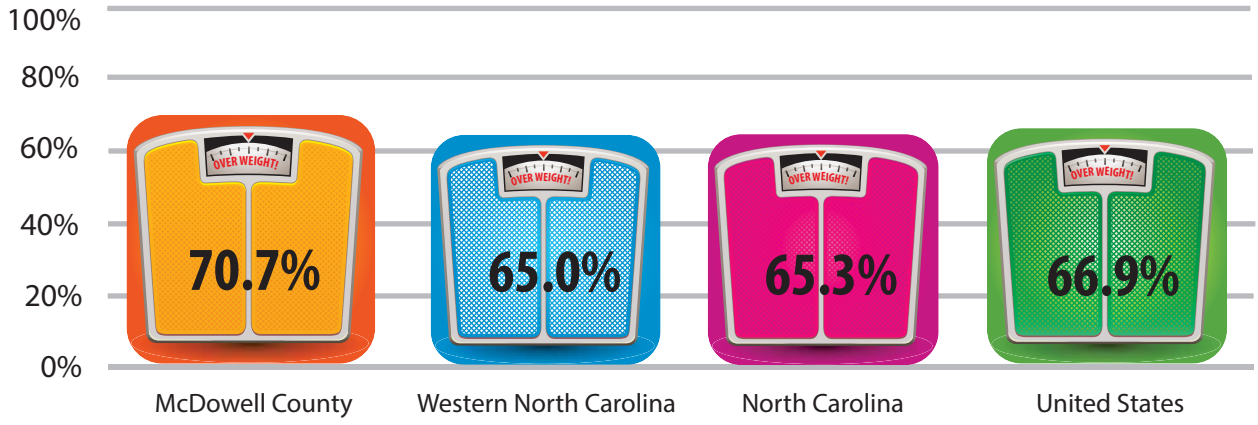
Obesity among adults in McDowell County rose most years between 2005 and 2009;
the increase from 2005 to 2009 was 24.9%.

Estimate of Diagnosed Obesity Among Adults 20 and older (2005 - 2009)

	2005		2006		2007		2008		2009	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
McDowell County	8,757	26.9	10,440	31.9	10,640	32.4	11,160	33.8	11,132	33.6
Regional Total	128,908	--	136,661	--	139,114	--	143,681	--	148,403	--
Regional Arithmetic Means	8,057	25.2	8,541	26.4	8,695	26.7	8,980	27.4	9,275	28.0

Total Overweight Adults

Based on self-reported heights and weights



Childhood Obesity

Currently, McDowell County does not have statistically reliable data on childhood obesity specific to our county population. Perceptions among those working with children feel that the rates in McDowell would exceed the rates in the chart for WNC.

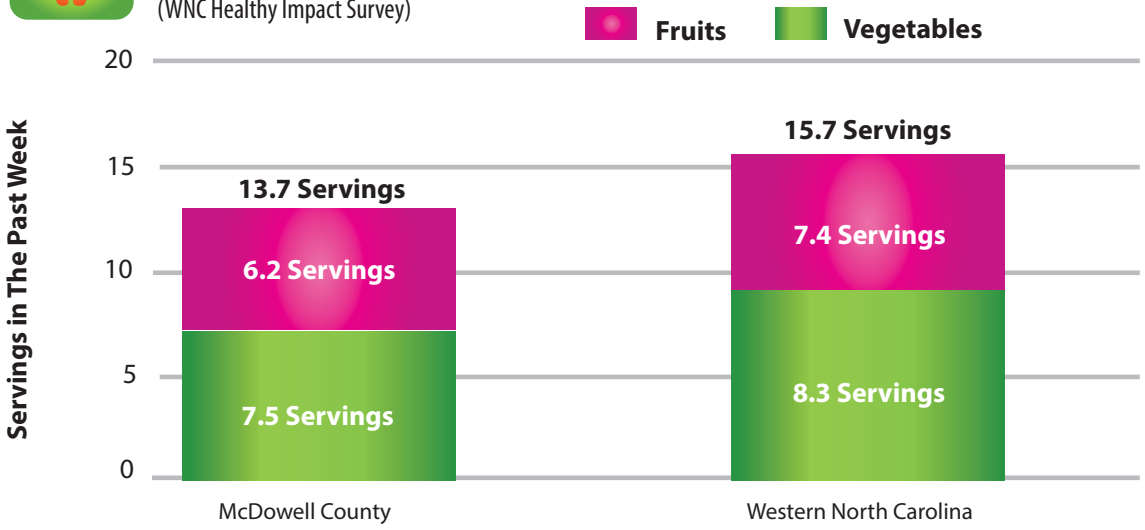
Prevalence of Overweight and Obesity Children 12 to 18 years

North Carolina Nutrition and Physical Activity Surveillance System (NC-NPASS) Data, 2009

Children 12 to18 years	Total	Overweight %	Obese %
Western North Carolina (Regional) Arithmetic Mean	84	19.0%	23.8%
State	6854	18.1%	28.0%

Average Servings of Fruits/Vegetables in the Past Week

(WNC Healthy Impact Survey)



Sources:

- *2012 PRC Community Health Survey, Professional Research Consultants, Inc.*

Notes:

- *Asked of all respondents.*
- *For this issue, respondents were asked to recall their food intake during the previous week.*
- *Reflects 35 or more 1-cup servings of fruits and/or vegetables in the past week, excluding lettuce salad and potatoes.*

Diabetes was the sixth leading cause of death in McDowell County in the 2006-2010 aggregate period.

Diabetes

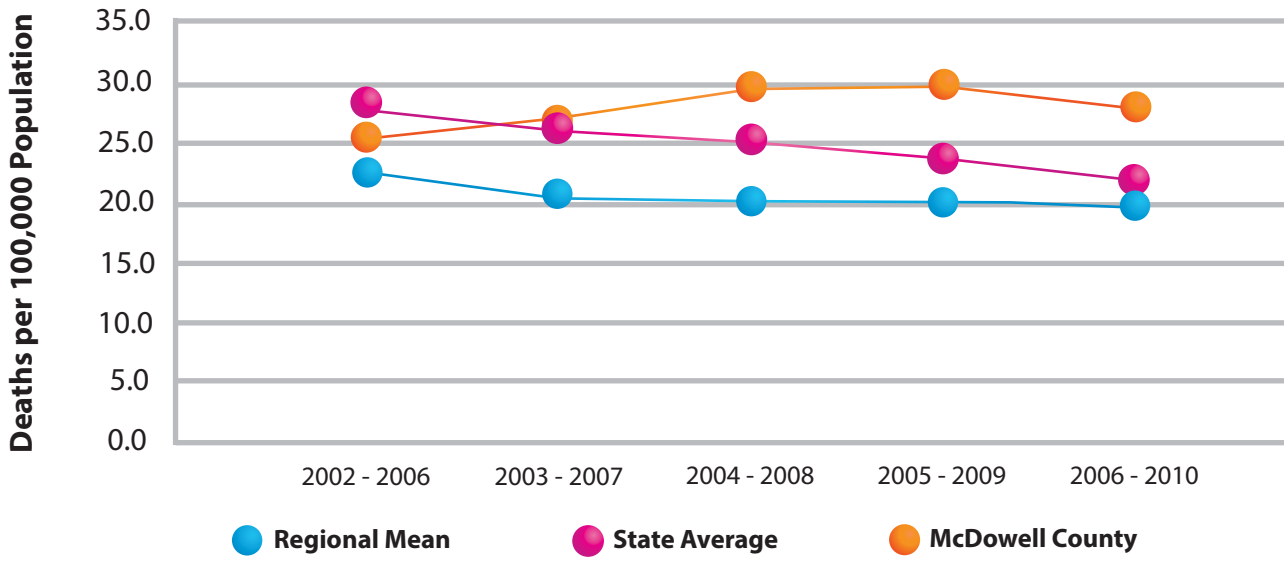
Diabetes is a disease in which the body's blood glucose levels are too high. Over time, having too much glucose in the blood can damage the eyes, kidneys, and nerves. Diabetes can also lead to heart disease, stroke and more (US National Library of Medicine).

Gender Disparities in Diabetes Mellitus Mortality, McDowell County

Diabetes mortality rates stratified by gender in McDowell County are plotted in graph below. From this data it appears that men in the county have experienced a growing disparity in diabetes mortality. In the beginning of the period cited, the diabetes mortality rate for women in the county (25.1) was 6.8% higher than the comparable rate for men (23.5). The diabetes mortality rate for women fluctuated over the entire period cited but changed little in the net (from 25.1 to 24.4). However, by the end of the period cited, the rate for men had risen to 34.9%, an increase of 48.5%, and this rate for men was 43.3% higher than the comparable rate for women.

Diabetes Mellitus Mortality Rate

Death per 100,000 Population
(Five-Year Aggregates 2002 - 2006 through 2006 - 2010)



Notes:

- *There is some instability in the regional mean rates because each includes one or more unstable county rate.*

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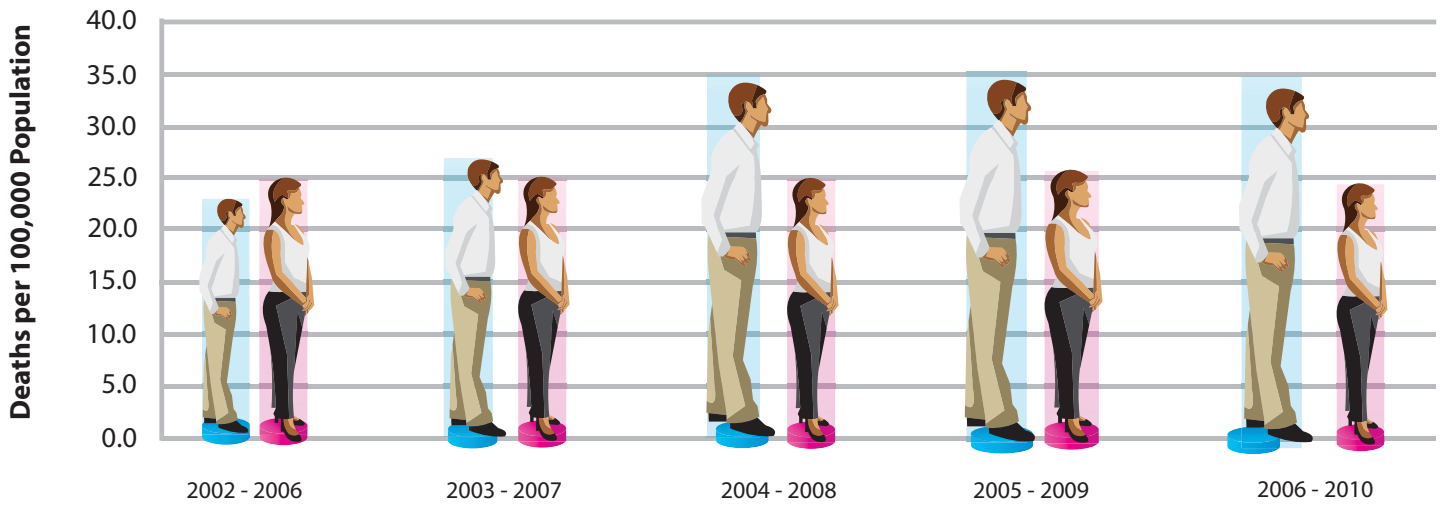
(Five-Year Aggregates 2002 - 2006 through 2006 - 2010)

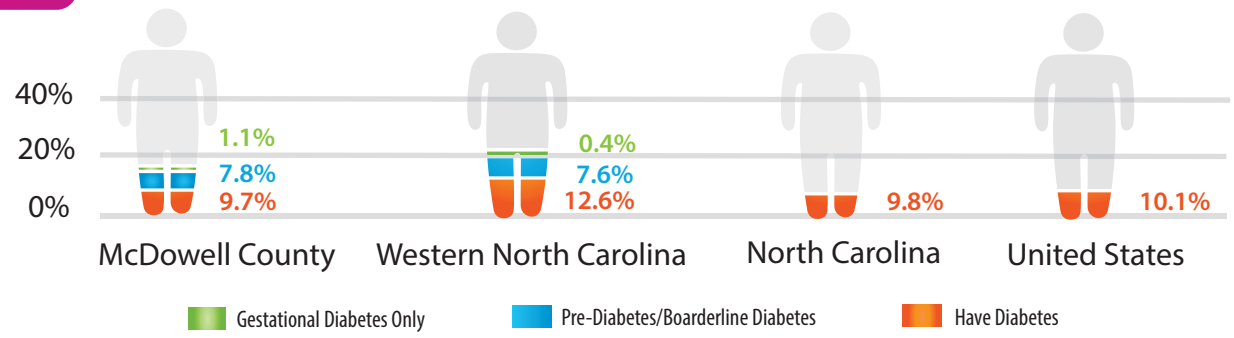


Note:

There is some instability in the regional mean rates because each includes one or more unstable county rate.

Prevalence of Diabetes (Ever Diagnosed)

(WNC Healthy Impact Survey)



Sources:

- *2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 78]*
- *2011 PRC National Health Survey, Professional Research Consultants, Inc.*
- *Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 North Carolina data.*

Notes:

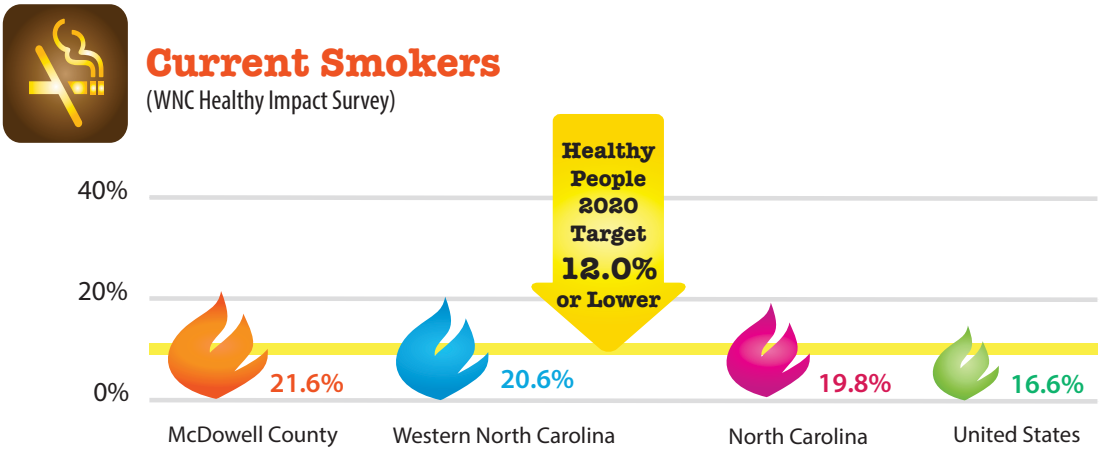
- *Asked of all respondents.*
- *Local and national data exclude gestation diabetes (occurring only during pregnancy*

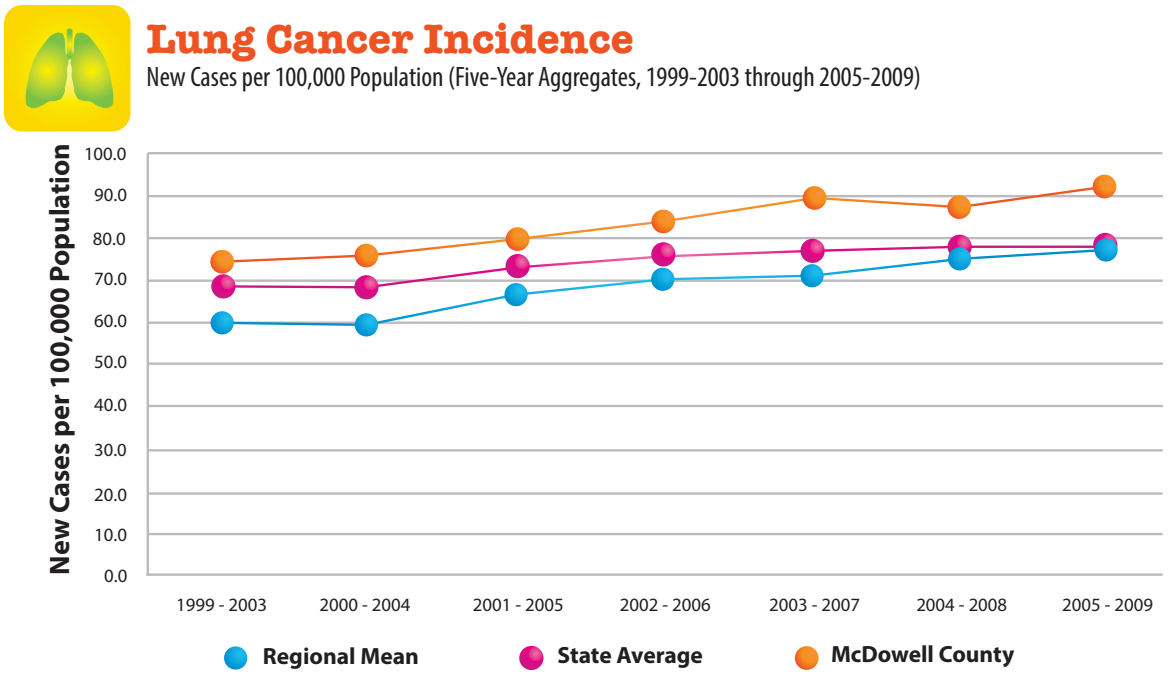
Tobacco

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco related illness.

Since lung cancer is a significant cause of mortality in McDowell County, it is instructive to examine the trend of development of new lung cancer cases over time. The graph below depicts the seven-year trend of lung cancer incidence.

From this data it appears that lung cancer incidence in McDowell County, which was higher than both the mean WNC and NC rates throughout the period cited, increased 21.9% (from 76.2 to 92.9) between 1999-2003 and 2005-2009. Region-wide, the mean lung cancer incidence rate has been creeping upward over the past several years, from a point well below the comparable state rate to a point barely below it. The lung cancer incidence rate in WNC increased 25.0% from the 1999-2003 aggregate period (60.3) to the 2005-2009 aggregate period (75.4), while the statewide lung cancer incidence rate increased by 9.5% (from 69.3 to 75.9) over the same time frame. Since lung cancer mortality is already on the rise in the region, the increase in the incidence rate may portend additional lung cancer mortality in the future.



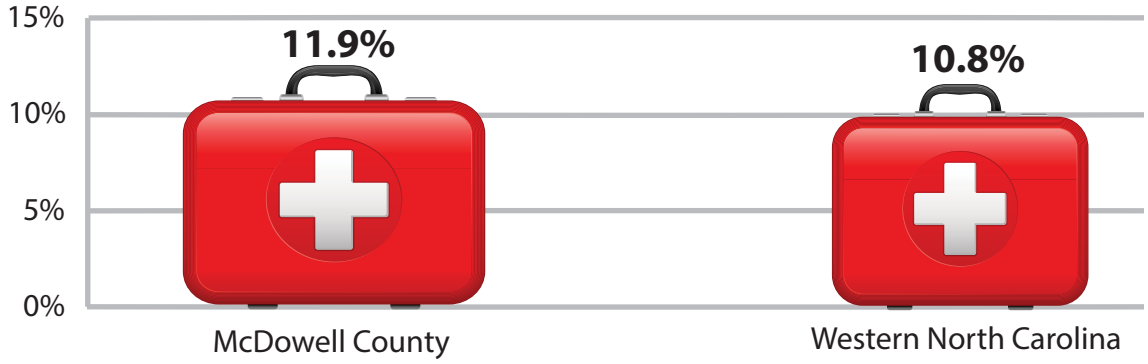


Medical Care Access

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Was Unable to Get Needed Medical Care at Some Point in the Past Year

(WNC Healthy Impact Survey)



Uninsured Population

The table below presents data on the proportion of the non-elderly population (ages 19-64) without health insurance of any kind. From 2006-2007 to 2009-2010 there was an 8.7% increase in uninsured adults in McDowell County.

Estimated Percent Uninsured Adults Ages 19 -64

Biennial Periods (2006 - 2010)

Geography			
McDowell County	**20.7%**	**20.0%**	**22.5%**
Regional Arithmetic Mean	**23.4%**	**22.3%**	**22.0%**
State Total	**19.5%**	**23.2%**	**23.6%**
	(2006 - 2007)	(2008 - 2009)	(2009 - 2010)

Teen Pregnancy Prevention

Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children.

While North Carolina has made strong progress is decreasing the number of teen pregnancies, cutting its rate in half since it peaked in 1991, the state still has the 14th highest teen pregnancy rate in the United States, with underserved rural counties typically having higher rates than urban counties. The Healthy People 2020 target is 36.2 while the 2010 teen pregnancy rate was 59.2 in McDowell County, 46.3 in WNC, and 49.7 in NC.

In 2010, there were 77 babies born to teen mothers in McDowell County (up from 67 in 2009), consequently ranking our county 30th in the state for teen pregnancy. An Action Team to address teen pregnancy is organized through the McDowell Health Coalition.

Substance Abuse and Behavioral Health

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. The listening sessions we did highlighted the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders. Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems (DHHS, 2010). An Action Team to address Substance Abuse and Behavioral Health is organized through the McDowell Health Coalition.

Emergency Department Utilization

According to the 2012 CHA, the highest frequency of emergency department visits in McDowell County in 2010 were psychiatric disorders (13.98% of all ED visits), followed by chest pain/ischemic heart disease (12.87%) and diabetes (9.51%).

Summarized Action Plan

Our 2013 socio-ecological model envisions a McDowell County where more people are eating fresh fruits and

vegetables, playing outdoors, getting good, affordable medical care and prevention services and enjoying smoke-free environments.

In an effort to reduce diabetes, McDowell County's approach is comprehensive. Our action plan includes environmental strategies such as greenways enhancement and EBT systems at the farmer's markets. Our plan includes raising awareness and providing education, prevention and case-management at the community and individual level.

To address tobacco, our CHIP includes new smoke-free policies in institutions and health promoting interventions in medical and community settings such as schools and worksites.

Focusing efforts on understanding and improving social determinants of health is evidenced in our approach to include vulnerable populations who may have lower wealth, less education and other health risk factors.

Monitoring and Accountability

The Rutherford Polk McDowell Health District works closely with the McDowell Health Coalition. The Coalition is, in turn, guided by a strong cross section of community leaders. Action Teams and partners of the McDowell Health Coalition will help Rutherford Polk McDowell District Health Department to monitor and evaluate the work described in this CHIP.

Action Teams reflect a diverse cross sector of community members working together to achieve shared measures. Monthly Board meetings serve to monitor activities and provide accountability toward meeting objectives.

Community members are encouraged to contact one of the leaders below to get involved.

- Healthy Living Action Team: Meghan Merritt, Corpening Memorial YMCA
- Access to Care Action Team: Director of Department of Social Services
- Teen Pregnancy Action Team: Jimmy Hines, Health Director Rutherford Polk McDowell District Health Department
- Social Determinants of Health Action Team: Caroline Rodier, Partnership for Children of the Foothills
- Tobacco Action Team: Mary Smith, Community Transformation Program
- Substance Abuse Prevention Action Team: Ricky T. Buchanan, Chief Deputy

Healthy Places Initiative

In May of 2012, the Kate B. Reynolds Charitable Trust [the Trust], which promotes health and wellness statewide announced a long-term commitment to improve community-wide health in McDowell County through the Healthy Places NC initiative. Healthy Places NC is a new rural place-based strategy aimed at enhancing the health and overall quality of life for people in select Tier 1 counties. McDowell, Halifax and Beaufort are the three initial counties invited to participate in this initiative. In each county, Healthy Places work and projects will be driven by the community's concerns, as well as by where the Trust thinks there's an opportunity for sustainable, long-term change.

Healthy Places builds on the existing strengths and assets in McDowell County and supports the use of mutually reinforcing strategies and programs to try to improve the health of the community. Some of these strategies include bringing resources to the community, capacity building to strengthen individual leadership skills and the infrastructure of organizations, connecting groups doing complimentary work, and some grant making.

For example, the community identified a need for more places for physical activity so the Trust recently funded eight local elementary schools to enhance recreational facilities including playground equipment, basketball courts and walking trails to promote both activity during the school day and community use of the facilities when school is not in session.

For the past year, WNC Non-Profit Pathways, a capacity building intermediary, has been engaging local nonprofit boards and staff in trainings in McDowell to increase their organizational effectiveness and build their leadership capacities. The County Health Rankings and Roadmap team has been offering support and technical assistance to the McDowell County Health Coalition. KABOOM!, a national playground builder that uses a model of community engagement, has been working with the community and will build two playgrounds in McDowell County in the Fall of 2013 to also enhance opportunities for physical 15 activity in parts of the community that lack adequate play spaces.

Other recent investments support shared efforts to prevent and manage diabetes, to increase low income participation in farmer's markets, to implement a community care paramedic program, to provide matching funds for the Catawba River Greenway expansion, and to advance the work of volunteer driven health organizations, such as the McDowell County Health Coalition.

Healthy Places NC provides opportunities for the Trust and the people and organizations of McDowell County to work deeply together to address persistent health issues. The goal is to have real impact on major health challenges for the long term.

Community Transformation Grant Program

The Centers for Disease Control and Prevention (CDC) continues its long-standing dedication to improving the health and wellness of all Americans through the Community Transformation Grant (CTG) Program.

CTG will design and implement community-level programs that prevent chronic diseases such as cancer, diabetes, and heart disease. In McDowell, the CTGP commits to increasing signage for farmer's markets and offering support for smoke-free policies.

Chapter 1

WHAT IS A COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)?

A Community Health Improvement Plan, or CHIP, is an action-oriented strategic plan outlining the priority health issues for a defined community, and how these issues will be addressed, including strategies and measures, to ultimately improve the health of the community. CHIPs are created through a community-wide, collaborative action planning process that engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.

This CHIP is intended to help focus and solidify each of our key partner agency's commitment to improving the health of the community in specific areas. The goal is that through sustained, focused effort on this overarching framework, a wide range of public health partners and stakeholders engaged in assessment, planning, and action will be able to document measured improvement on these key health issues over the coming years.

The next phase will involve broad implementation of the action plan details included in this CHIP, and monitoring/evaluation of the CHIP's short-term and long-term outcomes and indicators.

This 2013 CHIP is focused on creating plans within a six month to three year timeline. The community health improvement process is iterative and involves continuous monitoring; we plan to release an annual update of this document in December 2013, and again in December 2014. The next community health assessment will be conducted in 2015.

HOW TO USE THIS CHIP

This CHIP is designed to be a broad, strategic framework for community health, and will be a "living" document that will be modified and adjusted as conditions, resources, and external environmental factors change. It has been developed and written in a way that engages multiple voices and multiple perspectives. We are working towards creating a unified effort that helps improve the health and quality of life for all people who live, work, and play in our county.

We encourage you to review the priorities and goals, reflect on the suggested intervention strategies, and consider how you can join this call to action: individually, within your organizations, and collectively as a community. To get involved or for questions about the purpose of this document, please contact Jimmy Hines at jhines@rpmhd.org or Marjorie Vestal at mvestal@rpmhd.org.

CONNECTION TO THE 2012 COMMUNITY HEALTH ASSESSMENT (CHA)

Community health assessment (CHA) is the foundation for improving and promoting the health of a community. Community health assessment, as a process and product, is a key step in the continuous community health improvement process. The role of CHA is to identify factors that affect the health of a population and determine the availability of resources within the county to adequately address these factors.

The 2012 McDowell County CHA process and products were designed to provide a rich set of data for our county and its partners to use in identifying major health concerns and issues. The information collected through this process, and the priorities identified, were considered in setting the priorities for our county, which are included in this CHIP[1].

WNCHEALTHYIMPACT

WNC Healthy Impact is a partnership between hospitals and health departments, and their partners, in western North Carolina to improve community health. As part of a larger, and continuous, community health improvement process, these partners are collaborating to conduct community health (needs) assessments across western North Carolina. See www.WNCHealthyImpact.com for more details about the purpose and participants of this regional effort. The regional work of WNC Healthy Impact is supported by a steering committee, workgroups, local agency representatives, and a public health/data consulting team.

1 In some guidance documents, including National Public Health Accreditation standards, the CHIP includes details on the priority setting process. However, in the state of North Carolina, Local Health Department Community Health Assessment process and product includes the priority setting process, and the CHIP here is intended to document efforts involved in action planning that follow the collaborative setting of priorities in each county.

CHAPTER 2

COMMUNITY HEALTH ASSESSMENT PROCESS

Purpose of Community Health Assessment (CHA)

Community health assessment (CHA) is the foundation for improving and promoting the health of county residents. CHA is a key step in the continuous community health improvement process. The role of CHA is to identify factors that affect the health of a population and determine the availability of resources within the county to adequately address these factors.

A CHA, which refers both to a process and a document, investigates and describes the current health status of

the community, what has changed since a recent past assessment, and what still needs to change to improve the health of the community. The *process* involves the collection and analysis of a large range of secondary data, including demographic, socioeconomic and health statistics, environmental data, as well as primary data such as personal self-reports and public opinion collected by survey, listening sessions, or other methods. The *document* is a summary of all the available evidence and serves as a resource until the next assessment. Together they provide a basis for prioritizing the community's health needs, and for planning to meet those needs.

Because it is good evidence-based public health practice, local health departments (LHDs) across North Carolina (NC) are required to conduct a comprehensive CHA at least every four years. It is required of public health departments in the consolidated agreement between the NC Division of Public Health and local public health departments. Furthermore, it is required for local public health department accreditation through the NC Local Health Department Accreditation Board (G.S. § 130A-34.1). As part of the Affordable Care Act, nonprofit hospitals are also now required to conduct a community health (needs) assessment at least every three years.

The local health department usually conducts the CHA as part (and usually the leader) of a team composed of representatives from a broad range of health and human service and other organizations within the community. Community partners and residents are part of this process as well.

Please see the RPMHD website under Health Promotions to access the full CHA. www.rpmhd.org/index.php/health-promotion.

DATA COLLECTION PROCESS

As part of WNC Healthy Impact, a regional data workgroup of public health and hospital representatives and regional partners, with support from the consulting team, made recommendations on the data approach and content of the CHA and this CHIP.

CRITERIA FOR SELECTING "HIGHLIGHTS"

The body of assessment data supporting this document is wide-ranging and complex. In order to develop a summary of major findings, the consultant team applied three key criteria to nominate data for inclusion in this report. The data described in this report was selected because: County statistics deviate in significant ways from WNC regional data or NC statistics; County trend data show significant change—positive or negative—over time; or County data demonstrate noteworthy age, gender, or racial disparities.

ADDITIONAL LOCAL DATA

The Rutherford Polk McDowell District Health Department used an online Survey Monkey Tool to receive additional feedback from residents in the three counties we serve.

COMMUNITY ENGAGEMENT

In the random-sample survey that was administered in our county as part of this CHA, 200 community members completed a questionnaire regarding their health status, health behaviors, interactions with clinical care services, support for certain health-related policies, and factors that impact their quality of life.

Chapter 3

PRIORITY ONE: REDUCING DIABETES THROUGH PHYSICAL ACTIVITY & NUTRITION

Situational Analysis

In 2012, community members were involved in many listening sessions conducted by the McDowell Health Coalition with assistance from the Corpening Memorial YMCA and the Rutherford Polk McDowell District Health Department. Together, these partners conducted at least seven listening sessions with the following local groups:

- McDowell County Health Department Patients
- McDowell Senior Center
- Centro Unido Latino Americano
- Addie's Chapel
- McDowell County Department of Social Services Clientele
- The Good Samaritan Clinic
- McDowell County NPO & Human Service Agency Directors

Quotes from the listening sessions can be seen below.

Chronic disease, cancer, mental illness, and substance abuse emerged as being the serious health problems most often sited by the 67 participants.

Specifically, diabetes and obesity surfaced as the most commonly identified chronic diseases in all groups. Our Healthy Eating & Active Living Action Team agreed

that a common agenda to reduce diabetes would produce strategies that would also reduce obesity and other major health risks while providing a shared method to measure our improvements.

The McDowell Health Coalition is leading a strong movement with many proven strategies to increase physical activity and improve nutrition throughout the county. Collective community efforts are designed to reduce the burden of chronic disease especially diabetes.

The collective impact from all community efforts will result in more children and adults enjoying a healthy weight status and will reduce risk for chronic diseases.

"I was born here and I know McDowell community well. What keeps people from being healthy is lack ofeducation about balanced foods, and tradition."

"Our children start out with the disadvantage of poor health."

"Many children in McDowell are being diagnosed with chronic diseases such as obesity and high blood pressure."

"It is very sad when people cannot afford good food and health care."

"There needs to be a shift in the perceptions of this community. Disparities occur because someone is being ignored, meaningfully or not. Education and communication is the key to solving our health (and social) problems".

Listening Session Participants 2012

WISEWOMAN™

Well-integrated Screening and Evaluation for Women Across the Nation

Spotlight on Success - WISEWOMAN

In April 2013, 12 Latina women attended "The Heart of a WISEWOMAN" Conference at the McDowell Health Department. For most of these local women, it was the first time they had attended a health-related event with their peers. They danced, ate, and enjoyed learning to Eat Smart and Move More together in their primary language – Spanish.

The "Heart of a WISEWOMAN" Conference helps to motivate women to make healthy changes and provides useful tools for preventing chronic disease. Organized by Public Health Nurse and Program Coordinator, Alma Bartlett, another Conference is planned for October - in English.

"We are seeing a good trend toward reducing chronic disease among local McDowell women" says Alma.

The WISEWOMAN program provides low-income, under-insured or uninsured women with chronic disease risk factor screening, lifestyle intervention, and referral services in an effort to prevent cardiovascular disease. The priority age group is women aged 40–64 years.

"Through the McDowell Health Department's BCCCP and WISEWOMAN Programs we provided screening and referral to over 260 low-income underinsured women in 2012-2013. This target population includes a higher than average number of minority women and others at increased risk of disease. We plan to improve those outcomes in subsequent years" explains Alma.

WISEWOMAN programs provide standard preventive services including blood pressure and cholesterol testing. WISEWOMAN programs also offer testing for diabetes. Women are not just tested and referred, but can also take advantage of local lifestyle programs that target poor nutrition and physical inactivity, such as healthy cooking classes, walking trails, or lifestyle counseling. Women who smoke are encouraged to quit and are referred to proactive quit lines or quitsmoking classes. The interventions vary from program to program, but all are designed to promote lasting, healthy lifestyle changes.

Alma Bartlett says "I love this Program! I have seen this program help to prevent heart disease and diabetes, time and time again."

Partners

Addressing chronic disease is complex and will require the collaborative planning, action, and coordination of multiple partners in our community. The following partner agencies and organizations are engaged in efforts to reduce chronic disease through healthy eating and active life styles in our community.

Partners		
Organizations	**Primary Focus or Function**	**Contact Information/Website**
Rutherford Polk McDowell District Health Department	WIC Nutrition education, WISEWOMAN, BCCPP, Nurse Family Partnership	www.rpmhd.og
Corpening Memorial YMCA	Diabetes Education, Diabetes Prevention, Physical Activity Classes and coaching	www.ymcawnc.org 828-659-9622
McDowell Hospital	Diabetes Case Management, Education, Nutrition Education, Smoking Cessation	828-659-5000
McDowell Trails Association	Develop and maintain trails and Greenways	www.mcdowelltrails.com
Good Samaritan Clinic	Provides care for the uninsured and low income	828-559-2055
McDowell Sheriff's Department, Ricky Buchanan	Law Enforcement and Community Engagement in Substance Abuse	rbuchanan@mcdowellsheriff.org
Appalachian Sustainable Agriculture Project	Technical Assistance for Farmers and Farm Markets	www.asapconnections.org
Partnership for Children of the Foothills, Caroline Rodier	Team Leader for Social Determinants Of Health Action Team	828-659-0460 caroline@pfcfoothills.org
Centro Unido Latino Americano	Migrant Farm Worker Health Program, Interpretation and Translation Services	Annette Catala www.culawnc.org
Coalitions / Groups		
McDowell Health Coalition	Organizes Action Teams to address Health Priorities	Facebook: Healthy McDowell
McDowell County Senior Center	Meals on Wheels, exercise programs, luncheons, prescription medication counseling for senior citizens	www.mcdowellseniorcenter.org
Community Transformation Grant, Mary Smith	Planning for Health and Wellness, Increase access to physical activity	ctcbrpm@gmail.com
Historic Marion Tailgate Market, Freddie Killough	Farmers Market	Marion Business Association 828-652-2215 info@hometownmarion.org
McDowell County DSS	Determines eligibility for Medicaid, food and nutrition services, childcare, transport and more	www.mcdowellcountyncdss.org
Nurse Family Partnerships and Child Service Coordination Program	Nurses visit low-income women to improve pregnancy, child health and more	www.rpmhd.org

PRIORITY ONE: REDUCE DIABETES THROUGH A COMPREHENSIVE APPROACH

SITUATIONAL ANALYSIS

Our data shows our community suffers from heart disease, lung diseases, obesity and overweight, poor eating habits and high rates of smoking. Clearly, McDowell residents can benefit from lifestyle changes. While we have chosen to focus on diabetes reduction, we see that our strategies will also result in a reduction in obesity, heart disease, lung cancer and more.

Our plan improves the built environment to increase places for people to be active and make positive changes. We intend to increase consumption of fresh local fruits and vegetables while enhancing opportunities for a vibrant local farm economy.

With policy level work, we will increase smoke-free community college campuses. Connecting people to needed resources for health improvements is a key to our success.

Building on the success of the Diabetes Prevention Program at the Corpening YMCA, this year we move forward into working with folks who already have diabetes in a partnership program between McDowell Mission Hospital and the YMCA. Because diabetes lowers life expectancy by up to 15 years, increases the risk of heart disease by 2 to 4 times, and is the leading cause of kidney failure, lower limb amputations and adult-onset blindness, we are committed to reducing diabetes in McDowell.

Our CHIP addresses diabetes in medical settings as well as community settings such as the YMCA. A variety of settings for health interventions will allow us to achieve a collective impact in reaching our goals. We see the benefit of working with individuals, groups, families and institutions to reach our goal.

Reduce Diabetes Through a Comprehensive Approach Action Plan	**Vision of Impact** **Make the healthy choice the easy choice by improving access to physical activity and healthy food where we live, learn, work, and play.**
Community Objectives **Decrease the risk of chronic illness among adults and children by increasing awareness and opportunities to make healthy choices in food and activity.**	**Baseline/Indicator Source**
1 Decrease the percentage of adults with diabetes by .5% per year for three years. From 9.7% to 8.2% by December 2015.	*WNC Healthy Impact Survey 9.7% 2012 (self-report)*
Related Healthy NC 2020 Objective: Decrease the percentage of adults with diabetes	*BRFSS – 8.6% by 2020*
Related Healthy People 2020 Objective: Decrease the percentage of adults with diabetes	*8.2% by 2020*
2. By December 2015, increase percentage of adults consuming recommended daily servings of fruits and vegetables from 8% to 15%	*WNC Healthy Impact Survey – Baseline = 8% Target for 2015 = 15%*
Related Healthy NC 2020 Objective: Increase the percentage of adults who report they consume fruits and vegetables five or more times per day [2020 Target: 17.4% for Tier 1 Counties.]	*BRFSS – 2020 target = 17.4*

Strategy 1 – Increase physical activity opportunities in the built environment

STRATEGY BACKGROUND

Sources:

Greenways http://www.greenways.com/srts_marion.html
http://www.thecommunityguide.org/diabetes/index.html

Families Eating Smart and Moving More

http://www.eatsmartmovemorenc.com/FamiliesESMM/FamiliesESMM.html

Evidence Base:

Environmental and Policy Approaches to Increase Physical Activity: Creation of or Enhanced Access to Places for Physical Activity Combined with Informational Outreach Activitieswww.thecommunityguide.org/pa/environmentalpolicy/ improvingaccess.html, http://www.greenways.com/srts_marion.html

Type of Change:

Community level change to the built environment

PARTNER AGENCIES

Lead:

City of Marion & McDowell Trails Association

Collaborating:

YMCA, City of Marion Planning Department, McDowell Health Coalition, Community Transformation Program

Supporting:

Rutherford Polk McDowell Health District

STRATEGY OBJECTIVE 1:

The Phase II Greenway Project will add a 2,800 linear foot paved extension to the Historic Joseph P. McDowell Catawba River Greenway ("Greenway"), as well as new recreational facilities including a canoe launch, eight fitness stations, and outdoor amphitheater.

INDICATOR:

Additional feet of Greenway, new facilities in place.

Action Plan

Activity (what is being done?)	**Resources Needed** (who? how much?)	**Anticipated Result** (what will happen?)	**Result Verification** (how will you know?)	**Target Date** (by when?)
Complete design plans	Engineer staff time	Input is given and design completed	Design presented, final approval is given	By December 2013
Gain permits	Staff time	Project will be permitted	Permits	By May 2014
Bids for construction	Staff time	Bids are reviewed	Contractor chosen	By June 2014
Construction	Contractor's time &	Project completed	New facilities	By May 15, 2015

Goal:

Reduce diabetes through increasing opportunities to be physically active

Strategy 2 – Install Market Manager and EBT system at Marion Tailgate Market.

STRATEGY BACKGROUND

Source:
State Indicator Report on Fruits and Vegetables 2009, www.fruitsandveggiesmatter.gov/indicatorreport and http://www.healthyfoodaccess.org/

Evidence Base:
2013 no McDowell Farmers Market accepts EBT – increase by 1

Type of Change:
Policy, Environmental

PARTNER AGENCIES:

Lead:
Marion Business Association Tailgate Market Manager

Collaborating:
ASAP, Kate B. Reynolds Healthy Places, CTG

Supporting:
McDowell Health Coalition, Local branch of NC Cooperative Extension

STRATEGY OBJECTIVE 1:
Increase visitors to tailgate market

INDICATOR:
Number of visitors to market

Action Plan Objective 1

Activity (what is being done?)	**Resources Needed** (who? how much?)	**Anticipated Result** (what will happen?)	**Result Verification** (how will you know?)	**Target Date** (by when?)
Add space to county farmer's market	Table, chairs, floor space	More vendors will offer more foods, more sales, more consumption	Verify number of vendors	August 2013
Hold special events	McDowell Cooperative Extension	More sales, more consumption	Sales records	November 2013
Provide tools/ resources to expand markets	CTG will provide r esources and TA	Expansion, more vendors, more sales	Vendors records	November 2013
Awareness Campaign on Healthy Food Access	CTG will develop targeted messages and distribute	Increased awareness of benefits fresh produce	Measure exposure of media	December 2015
Promote Farmers Market	CTG and Cooperative Extension, social marketing sites, flyers	More sales, more consumption	Sales records	November 2013

Goal:
Reduce and prevent diabetes among low-income by increasing consumption of fresh produce through use of EBT at Farmers market.

Strategy 2 Continued – Install Market Manager and EBT system at Marion Tailgate Market

STRATEGY OBJECTIVE 2:

Increase sales of produce at tailgate market especially EBT card sales

INDICATOR:

Sales records for fresh produce and EBT card sales records

Action Plan - Objective 2

Activity (what is being done?)	**Resources Needed** (who? how much?)	**Anticipated Result** (what will happen?)	**Result Verification** (how will you know?)	**Target Date** (by when?)
Awareness Campaign for EBT use for food	Staff time, partners, flyers	More people will know they can use EBT at Market	Records of promotions, media exposure	July 2014
Purchase EBT machine	Staff time	EBT in place at market	Verify	May 2014
Educate vendors	Staff time	Vendors promote/use EBT	Verify with vendors	May 2014

Goal:

Reduce and prevent diabetes among low-income by increasing consumption of fresh produce through use of EBT at Farmers market.

Strategy 3 - Implement "Taking Control of Type Two" Diabetes Management Program

STRATEGY BACKGROUND

Source:
McDowell Mission Accredited Diabetes Program, Centers for Disease Control and Prevention http://www.cdc.gov/communitytransformation

Evidence Base:
Guide to Community Prevention Services http://www.thecommunityguide.org/diabetes/selfmgmteducation.html Corpening YMCA's Diabetes Prevention Program Outcomes

Type of Change:
Individual

PARTNER AGENCIES

Lead:
The McDowell Hospital

Collaborating:
Corpening YMCA

Supporting:
McDowell Health Coalition and partnering organizations.

STRATEGY OBJECTIVE 1:

Enroll clients in program to stabilize or reduce glucose levels in participants

INDICATOR:

Individual glucose levels of participants

Action Plan - Objective 1

Activity (what is being done?)	**Resources Needed** (who? how much?)	**Anticipated Result** (what will happen?)	**Result Verification** (how will you know?)	**Target Date** (by when?)
Enroll Participants	Staff time, referral network	120 participants enrolled	Enrollment records	June 2014
Education	Staff time	Gain knowledge, resources	Pre and post testing	June 2014
Increase Physical Activity	Staff time, membership to YMCA	Participants increase P.A. to recommended amounts	Self-report activity logs, attendance records	June 2014
Biometric measurement	Staff time, hospital staff time, medical personnel	Improved blood sugar levels	Biometrics	June 2014

Goal:

Reduce diabetes through case management and education

Strategy 3 Continued - Implement "Taking Control of Type Two" Diabetes Management Program

STRATEGY OBJECTIVE 2

Enrollment and participant in YMCA's diabetes prevention program

INDICATORS:

Individual glucose levels of participants

Action Plan – Objective 2

Activity (what is being done?)	**Resources Needed** (who? how much?)	**Anticipated Result** (what will happen?)	**Result Verification** (how will you know?)	**Target Date** (by when?)
Enroll participants	Staff time, referral network	N=150 per year	Enrollment records	May 2014
Weigh loss program	Staff time, classroom	Reduce body weigh by 7%	Biometrics recorded	May 2014

Goal:

Reduce diabetes through case management and education

Chapter 4

PRIORITY TWO: INCREASE ACCESS TO CARE

Situational Analysis

Many of the uninsured make too much money to qualify for Medicaid or they make too little to afford private health insurance. The population ages 19 to 65 years has no publicly funded health care coverage. Their health care insurance is dependent on their employment status or financial well-being. Of this population, Hispanic/Latinos have the highest uninsured rate.

Unemployed or part-time workers and families that no longer qualify for welfare support also lack health insurance. People who live in rural areas often experience a shortage of health care providers or lack of facilities to provide health care. Other barriers to access are unemployment, under-employment, or part-time work; no college education; being poor; lack of transportation; un-affordability of insurance plans; and language barriers.

Access to health care is critical to eliminating disparities in health status among North Carolinians. To fully realize the potential of prevention, each resident must have access to clinical preventive care, primary care, emergency services, dental services, medicines, long-term care, and rehabilitative services.

Public Health Programs such as the NC WISEWOMAN Program reach populations with health disparities and provide needed screenings and education to prevent and reduce chronic disease.

Increase Access to Care Action Plan	**Vision of Impact** **The McDowell community shares a common agenda to increase the number of residents who have access to affordable health care for themselves and their families. We will actively promote new health insurance options to help folks enroll in public and private coverage.**
Community Objectives	**Baseline/Indicator Source**
1. Reduce the number of uninsured adults between 18 and 64 years of age by 1% per year for three years.	*22.9% (2011) Target by 12/15: 19.0%*
Related Healthy NC 2020 Objective: Reduce the number of uninsured adults between 18 and 64 years of age.	*8% by 2020*

Strategy 1 -Simplify the Eligibility and enrollment process for Public Insurance Program

STRATEGY BACKGROUND

Source:
Patient Protection and Affordable Care Act Pub L No. 111-148

Evidence Base:
NC IOM, Healthy NC 2020: A Better State of Health

Type of Change:
Community, individual, family

PARTNER AGENCIES

Lead:
Department of Social Services

Collaborating:
The McDowell Hospital Health Plus Rural Health Clinic

Supporting:
Good Samaritan Clinic, RPMHD

STRATEGY OBJECTIVE 1:
By December 2015 inform additional people about the availability of public and private insurance programs.

INDICATOR:
Number of people with insurance coverage.

Action Plan - Objective 1

Activity (what is being done?)	**Resources Needed** (who? how much?)	**Anticipated Result** (what will happen?)	**Result Verification** (how will you know?)	**Target Date** (by when?)
Identify uninsured people and assist with health insurance enrollment	DSS staff time	Increase enrollment in insurance programs	Number enrolled	December 2015
Actively promote new health insurance	DSS staff time, resoure navigator at hospital staff time, GSC staff time	Increased awareness of insurance programs	Number of contacts	December 2014
Support people enroll	DSS staff time, resource navigator and hospital staff time, GSC staff time	Inform clients about ways to enroll in permanent insurance programs	Number of clients informed	December 2015

Goal:
Reduce the number of uninsured adults between 18 and 64 years of age.

Strategy 2 -Increase Access to Care, Disease Prevention Programs, Services and Screenings Especially Among High Risk and Low-wealth People.

STRATEGY BACKGROUND

Source:

Patient Protection and Affordable Care Act Pub L No. 111-148

Evidence Base:

NC IOM, Healthy NC 2020: A Better State of Health

Type of Change: Individual

PARTNER AGENCIES

Lead:

The McDowell Hospital, Resource Navigation Program

Collaborating:

Centro Unido Latino Americano, Rutherford Polk McDowell Health District, Community Care of WNC

Supporting:

McDowell Health Coalition, Good Samaritan Clinic

STRATEGY OBJECTIVE 1

Increase access to Primary Care Homes for uninsured people

INDICATOR:

Number of people enrolled and assisted with enrollment – goal is to increase by 1% per year

Action Plan - Objective 1

Activity (what is being done?)	**Resources Needed** (who? how much?)	**Anticipated Result** (what will happen?)	**Result Verification** (how will you know?)	**Target Date** (by when?)
Gain referrals	Staff time, partners	Get patients enrolled in navigation program	Increased enrollment in navigation program	December 2013 - 2015
Enroll eligible clients	Staff time	More enrollment	Enrollment records	December 2013 - 2015
Increase awareness of eligible benefits	Staff time	Clients will gain beneftis if eligible	Verify eligibility	December 2013 - 2015
Assist with applying for permanent health insurance	Staff time	Eligible clients receive information about applying for permanent health insurance	Verification of staff time spent in informing clients	December 2013 - 2015

Goal:

Increase access to care for the uninsured and low-income.

Strategy 2 Continued-Increase Access to Care, Disease Prevention Programs, Services and Screenings Especially Among High Risk and Low-

STRATEGY OBJECTIVE 2:

By December 2015, increase participation in Migrant Farm Workers Health Program. Increase nutrition education among program participants

INDICATOR:

Number enrolled in Program. Number receiving nutrition education.

Action Plan - Objective 2

Activity (what is being done?)	**Resources Needed** (who? how much?)	**Anticipated Result** (what will happen?)	**Result Verification** (how will you know?)	**Target Date** (by when?)
Increase awareness of health programs at local worksites	Centro Unido staff time	More awareness among eligible families	Number of people enrolled will reach goal of 150 enrolled. Tracking system FHASES shows increase	December 2013
Increase nutrition education - prevention focused	Training for Centro Unido staff time	Patients will increase knowledge of nutrition. Improved diet choices	Record hours of training for staff. Record hours of education delivered to clients	December 2015

Goal:

Increase access to care for the uninsured and low-income.

Strategy 2 Continued-Increase Access to Care, Disease Prevention Programs, Services and Screenings Especially Among High Risk and Low-wealth People.

STRATEGY OBJECTIVE 3:

By December 2013 increase disease prevention programs, services and screenings especially among high risk and lowwealth people.

INDICATOR:

Number of RPM Health District clients enrolled in BCCCP and WISEWOMAN programs

Action Plan - Objective 3

Activity (what is being done?)	**Resources Needed** (who? how much?)	**Anticipated Result** (what will happen?)	**Result Verification** (how will you know?)	**Target Date** (by when?)
Increase awareness of BCCCP and WISEWOMAN programs	Staff time	More awareness among eligible woman, increased awareness among medical providers for referrals	Number of people enrolled. Number of medical system partners contracted	December 2013
Host annual Wise Woman conferences for Spanish and English (separately)	Staff time, NC health interventionist time, partners time	Clients attend and gain knowledge, participate in heart healthy activities to improve health	Attendance records, evaluation of conference	April 2013 - Latinas October 2013 - All April 2014 - Latinas October 2014 - All
Increase health education - prevention focused	New leaf curriculum staff time, tracking system	Patients will increase lifestyles intervention strategies to improve heart health	Number of clients in tracking system	December 2015

Goal:

Increase access to care for the uninsured and low-income.

Chapter 5 – Next Steps

We will continue to work with a wide range of community partners to modify this Community Health Improvement Plan (CHIP) in the months and years ahead in Rutherford County. This CHIP will be used by partner organizations to complete agency specific reporting of roles and responsibilities (e.g., our health department and local hospitals), as well as informing agency strategic plans across the county where appropriate.

This CHIP will be widely disseminated electronically to partner organizations and used as a community roadmap to monitor and evaluate our collective efforts.

Dissemination of this CHIP will also include making it publicly available on the Rutherford Polk McDowell District Health Department website (www.rpmhd.org), the WNC Healthy Impact website (www.WNCHealthyImpact.com) and in local libraries.

Moving forward, the CHIP report will be updated to provide the framework for the annual State of the County's Health Report, which will be submitted and made publicly available in December 2013.

REFERENCES

NACCHO's CHA/CHIP Resource Center *http://www.naccho.org/topics/infrastructure/CHAIP/index.cfm*

Wisconsin Association of Local Health Departments and Boards *http://www.walhdab.org/NewCHIPPResources.htm*

NC Division of Public Health Community Health Assessment Resource Site *http://publichealth.nc.gov/lhd/cha/resources.htm*

Template Implementation Plan v 1.0; 6/2012. Wisconsin CHIPP Infrastructure Improvement Project *Revised 7/2012 for NACCHO CHA/CHIP Project

NC DPH Community Health Assessment Guide Book *http://publichealth.nc.gov/lhd/cha/docs/guidebook/CHA-GuideBookUpdatedDecember15-2011.pdf*

Connecticut DPH Guide and Template for Comprehensive Health Improvement Planning http:*//www.ct.gov/dph/lib/dph/state_health_planning/planning_guide_v2-1_2009.pdf*

Bexar County CHIP h*ttp://www.bcchip.org/#!home/mainPageSedgwick County CHIPhttp://www.sedgwickcounty.org/healthdept/communityhealthpriorities_2010.pdf*

Kane County CHIP Executive Summary *http://kanehealth.com/chip.htm*

Kane County full CHIP *http://kanehealth.com/chip.htm*

[Counties: insert additional details used in determining EBIs, researching the issues, etc.]

Glossary of Terms

Vision of Impact	Describe the impact that the work of the CHIP will have in the identified health priorities in your county at the end of three years. In other words, what does success look like in 2016?
Community Objective	Description of what the collaborative action team wants to accomplish by addressing the specific health priority.
Strategy	Also known as interventions or approaches which will address priority health issues.
Goal	The impact of the work you anticipate for a specific strategy
Strategy Objectives	Description of what is to be achieved or the specific change expected to occur within a specific time frame. Objectives should be SMART (Specific, Measurable, Achievable, Realistic, & Time Specific). Can have more than one objective for each strategy and related goal.
Indicators	Measurements used to determine whether the objectives were met. They answer the question: how will I know if the objective was accomplished?
Activities	Key components of the strategy needed to achieve the objective for the strategy.
Resources Needed	Description of what your community will need (staff time, materials, resources, etc.) to implement the specific activity.
Results	Also 'impacts, outputs, and outcomes'. It's what happens as a result of the completion of specific activities.
Result Verification	How you will know that results have been achieved for specific activities.
Target Date	The date results will be verified.
Lead	An organization in this role commits to seeing that the issue is addressed. It would take responsibility for developing the resources needed to advance the issue such as a detailed plan. It would focus on the day-to-day and long-range tasks of moving the goal forward. Organizations in a lead role would ask others to assist with specific tasks.
Collaborating	An organization in this role commits to significant help in advancing the issue. For example, it might assist with planning, assembling data, or developing policy options. It would participate regularly in developing strategy to advance the goal.
Supporting	An organization in this role commits to help with specific circumscribed tasks when asked. These tasks might include attending meetings or writing letters of support to move the goal forward.