Community Health Action Plan 2011

Designed to address Community Health Assessment priorities and to meet Healthy Carolinians Re/Certification requirements

County: Mecklenburg **Partnership, if applicable: Mecklenburg Healthy Carolinians** **Period Covered: 2011-2013**

LOCAL PRIORITY ISSUE

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

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

- By (year):
- Objective (specific, measurable, achievable, realistic, time-lined change in health status of population): Provide health care to all Mecklenburg County residents regardless of ability to pay.
- Original Baseline: 17.0% of adults (18 and older) in Mecklenburg County reported that there was a time in the past 12 months that they needed to see a doctor but did not because of the cost.
- Date and source of original baseline data: BRFSS, 2007
- Updated information (For continuing objective only): 20.8% of adults (18 and older) in Mecklenburg County reported that there was a time in the past 12 months that they needed to see a doctor but did not because of the cost.
- Date and source of updated information: BRFSS, 2009

POPULATION(S)

- Describe the local population(s) experiencing disparities related to this local community objective: Uninsured adults (18-65) in Mecklenburg County
- Total number of persons in the local disparity population(s): 16.5% of population, ~150,180
- Number you plan to reach with the interventions in this action plan: 150,180

HEALTHY NC 2020 FOCUS AREA ADDRESSED

Check **one** Healthy NC 2020 focus area: (Which objective below most closely aligns with your local community objective?)

__ 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)

HEALTHY NC 2020 Objective(s) that most closely match your local community objective include:

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

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
Currently researching evidence-based programs that address this objective		

(Insert rows as needed)

WHAT INTERVENTIONS ARE ALREADY ADDRESSING THIS ISSUE IN YOUR COMMUNITY?

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

Intervention	Lead Agency	Progress to Date

(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
MedLink of Mecklenburg	Network of safety net providers	They provide free or low-cost health care services
Mecklenburg Area Partnership for Primary Care Research (MAPPR)	Mike Dulin, MD, Elizabeth Family Medicine	Collaborative effort to assess the healthcare needs of the growing Latino community.
Dickson Institute	Carolinas Medical Center, Mike Dulin, MD	Conduct research on utilization of healthcare services

(Insert rows as needed)

INTERVENTIONS: SETTING, & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATEEFFECTIVENESS
INTERVENTIONS SPECIFICALLY TARGETING HEALTH DISPARITIES		
Intervention: Web portal for Hispanic community Intervention: X new __ ongoing __ completed Setting: Start Date – End Date (mm/yy):*unsure* Level of Intervention - change in: X Individuals __ Policy &/or Environment	Lead Agency: Mecklenburg Area Partnership for Primary Care Research (MAPPR) MAPPR works to assess the healthcare needs of Charlotte's growing Latino population and mobilizes healthcare professionals, community members and researchers to improve healthcare services and access to Latino and other underserved communities in the Charlotte area MAPPR consists of over 30 members, including local clinics and other health and human services agencies, as well as schools, universities, and County agencies. MAPPR provides extensive outreach to the community in the form of community meetings, focus groups, newsletters, a website and listserv, outreach to local agencies and participation in groups such as MedLink.	1. **Quantify what you will do** MAPPR is working to develop a web portal targeted towards the healthcare and human services needs of the Latino community. The coalition is developing a web portal that will provide up-to-date information on a variety of resources, as well as the functionality to filter resources based on needs such as language, location, cultural competency, etc…The initial phase of this project will result in a web portal designed for use by community agencies in providing appropriate referral information for their Latino clients. 2. **Expected outcomes:Explain how this will help reach the local community objective (what evidence do you have that this intervention will get you there?)**MAPPR's research has found that one of the barriers to accessing care the Latino population in Charlotte faces is information on the available resources. This work, funded by the Robert Wood Johnson

		Foundation, will provide community agencies with the information required to make culturally and linguistically appropriate referrals.
INDIVIDUAL CHANGE INTERVENTIONS		
Intervention: _____ Intervention: __ new __ ongoing __ completed Setting: Start Date – End Date (mm/yy):	The lead agency is _____ and it will _____ List other agencies and what they plan to do: Include how you're marketing the intervention	**1. Quantify what you will do** (# classes, # participants, etc.) **2. Expected outcomes:Explain how this will help reach the local community objective (what evidence do you have that this intervention will get you there?)**
POLICY OR ENVIRONMENTAL CHANGE INTERVENTIONS		
Intervention: MedLink Community Communication Committee Intervention: X new ___ ongoing ___ completed Setting: Start Date – End Date (mm/yy): 4/2011-4/2014	The lead agency is Care Ring, which will facilitate meetings with other members of this MedLink subcommittee. The work of the subcommittee will involve all members of MedLink, as the committee will bring ideas and suggestions for improving awareness of the local health care safety net, the role of access to healthcare and the challenges the uninsured face to the full committee for approval and implementation. Our work will also include qualitative research on community understanding of the problem of access to care and the level of awareness both from the client and potential supporter perspectives.	**1. Quantify what you will do** The purpose of this committee is to develop a concise, simple message regarding access to care in Mecklenburg County. The issue is often complicated and MedLink identified a need for a simplified message so that members can more effectively advocate for policy change, funding, and awareness. The purpose is to create common definition, use common, simplified data to explain the problem, and deliver a more unified, concise message to as to raise the issue of access to care to one that demands urgent attention (like that of education and homelessness). **2. Expected outcomes:** Clear, concise simplified messages / information regarding access to care will help attract attention to the issue, strengthen funding proposals, and allow for improved communication with city and county officials. With improved awareness service providers will be better able to serve those in need and individuals will be better able to access the care they need.
Intervention: Offer financial screenings to determine service eligibility Intervention: ___ new X ongoing ___ completed Setting: Start Date – End Date (mm/yy): ongoing	This is an effort that involves all members of MedLink that conduct financial screenings, including NC MedAssist, Care Ring, Charlotte Community Health Clinic, CW Williams, Matthews Health Clinic, Lake Norman Free Clinic and others.	**1. Quantify what you will do** Given that we know there are some children and adults in our community that are eligible for, but not enrolled in, Medicaid, our financial screenings and partnerships through MedLink, identify and link potentially-eligible children and adults with the Department of Social Services (in

	MedLink includes representatives from the Department of Social Services, and have recently conducted in-service trainings on Medicaid eligibility. All agencies work diligently to ensure that clients who are identified through a financial screening as possibly eligible for Medicaid are provided the necessary information and guidance to apply for Medicaid.	some cases through having eligibility screening on-site at local clinics). **2. Expected outcomes:** MedLink and its member agencies will continue to stay abreast of changes to the Medicaid program, particularly as implementation of the Medicaid expansion through the Affordable Care Act draws closer. MedLink members will work closely to support our local Department of Social Services and provide patient navigation support in order to minimize the number of individuals eligible for, but not enrolled in, Medicaid.
Intervention: Assess gaps in health care services Intervention: ___ new X ongoing ___ completed Setting: Start Date – End Date (mm/yy): ongoing	This is a collaborative effort of MedLink of Mecklenburg County Assessing the gaps in healthcare services is one of the key drivers of MedLink's collaboration. Sharing up-to-date information on what services are available, as well as client demographic data and availability remain a key priority for the MedLink group.	**1. Quantify what you will do** MedLink will continue to evaluate the evolving needs of the community's uninsured population. **2. Expected outcomes:** Continuous evaluation of the needs of our community's uninsured population and the barriers that exist to accessing care will result in data-driven collaborative efforts to meet the needs of the uninsured. For example, recognition that individuals from 200-400% of the federal poverty level who make too much money to qualify for the free clinics or other programs for low-income uninsured, led to the development of a new low overhead, primary care clinic in Charlotte designed to meet the needs of this population. Our safety net has identified several gaps in our community, including access to specialty care for the undocumented and access to specialty care for those with moderate ability to pay but who are priced out of the private insurance market. Other gaps that challenge our community include access to dental care for uninsured adults and access to pre-natal care for the uninsured.
Intervention: Streamline eligibility and referral processes within MedLink and other human services agencies Intervention: Xnew ___ ongoing ___ completed Setting: Local safety net clinics Start Date – End Date (mm/yy):	This is a collaborative effort of MedLink of Mecklenburg. Agencies involved include, but are not limited to, Care Ring, NC MedAssist, Lake Norman Free Clinic, Ada Jenkins Center, Charlotte Community Health Clinic,and Matthews Free Clinic. To date this intervention continues to be in the planning stages, although there is interest at the County level in developing shared data systems that streamline eligibility and referral processes, minimize duplication of efforts, and improve customer service.	**1. Quantify what you will do:** MedLink is investigating the possibility of streamlining eligibility and referral processes for the safety-net health care and other human services agencies in Mecklenburg County. These efforts draw upon a strategic framework of creating centralized screening and a single portal of entry into the healthcare safety net (although at multiple locations) that was developed in August 2008. Preliminary efforts to this end include eligibility screeners from our county's Project Access program (Physicians Reach Out, a program of Care Ring) providing screening for their program to free clinic patients at their clinic location once a month.

		2. Expected Outcomes: Streamlined eligibility and referral processes will improve customer service and eliminate the time and resources that local clinics spend conducting financial screening for patients. Shared eligibility and screening is also intended to more effectively refer patients to the most appropriate healthcare access point.

(Insert rows as needed)