Community Health Action Plan 2016

County: Randolph
Period Covered: 2016-2019
Partnership/Health Steering Committee, if applicable: Healthy Randolph Steering Committee

Community Health Priority identified in the most recent CHA: Mental Health

Local Community Objective: (*Working description/name of community objective*): X **New** __**Ongoing** (*addressed in previous Action Plan*)

- **Baseline Data:** *(State measure/numerical value. Include date and source of current information)*:
- **For continuing objective provide the updated information:** *(State measure/numerical value. Include date and source of current information)*:
- ***Healthy NC 2020 Objective*** that most closely aligns with focus area chosen below: Decrease the average number of poor mental health days among adults in the past 30 days; Reduce the rate of mental health-related visits to the emergency department.

Population(s)

I. Describe the local target population that will be impacted by this community objective:

A. Total number of persons in the target population specific to this action plan: _____

B. Total number of persons in the target population to be reached by this action plan: _____

C. Calculate the impact of this action plan:

(Total # in B divided by total # in A) X 100% =_____ of the target population reached by the action plan.)

***Healthy North Carolina 2020* Focus Area Addressed:** Each of the two CHA priorities selected for submission must have a corresponding *Healthy NC 2020* focus area that aligns with your local community objectives.

- **Check below the applicable Healthy NC 2020 focus area(s) for this action plan.**
  For more detailed information and explanation of each focus area, please visit the following websites:
  http://publichealth.nc.gov/hnc2020/foesummary.htm **AND** http://publichealth.nc.gov/hnc2020/

☐ Tobacco Use	☐ Maternal & Infant Health	☐ Social Determinants of Health
☐ Physical Activity & Nutrition	☐ Substance Abuse	☐ Environmental Health
☐ Injury	☒ Mental Health	☐ Chronic Disease
☐ Sexually Transmitted Diseases/Unintended Pregnancy	☐ Infectious Disease/Foodborne Illness	☐ Cross-cutting
	☐ Oral Health	

Selection of Strategy/Intervention Table

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

Strategy/Intervention(s)	Strategy/Intervention Goal(s)	Implementation Venue(s)	Resources Utilized/Needed for Implementation
Name of Intervention: Community Conversations about Mental Health Community Strengths/Assets: Currently established community groups (Health Randolph and Randolph Community Collaborative).	S.M.A.R.T Goals: By September 2019, incorporate 3 behavioral forums/expos/fairs into schools and within the community.	Target Population(s): Students and community members Venue: Schools, community agencies (TBD)	Resources Needed: Toolkit provided by SAMHSA (Substance Abuse Mental Health Services Administration)
Name of Intervention: Collaborative Care Model Community Strengths/Assets: Grant to allow for this service to be provided.	S.M.A.R.T Goals: By September 2019, approximately 6,300 patients will be served through the behavioral health-primary integration project.	Target Population(s): Individuals seeking behavioral health services Venue: Primary care offices	Resources Needed:

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

INTERVENTIONS: SETTING, & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: Community Conversations about Mental Health ☒ **New** ☐ **Ongoing** ☐ **Completed** **Setting:** Community **Target population:** Individuals interested in learning about mental health. **New Target Population:** ☒Y ☐N **Start Date – End Date (mm/yy):** 10/16-9/19 **Targets health disparities:** ☒Y ☐ N	☒**Individual/Interpersonal Behavior** ☐**Organizational/Policy** ☐**Environmental Change**	**Lead Agency:** Healthy Randolph Tenet I **Role:** Coordinate forums, expos and health fairs; Disperse education materials to previously mentioned events; Providing educational packets. ☐**New partner** ☒**Established partner** **Target population representative:** Co-Chairs of Healthy Randolph Tenet I **Role:** Assist with the coordination of forums, expos and health fairs; Assist with disseminating education materials to previously mentioned events; Assist with providing educational packets. ☐**New partner** ☒**Established partner** **Partners:** Behavioral health providers **Role:** Promote events among colleagues and clients. ☐**New partner** ☒**Established partner**	**Expected outcomes***:* Decrease the average number of poor mental health days and reduce the rate of mental health related visits to the emergency department. **Anticipated barriers:** Any potential barriers? ☒Y ☐N If yes, explain how intervention will be adapted: Myths and stigma surrounding mental health. **List anticipated intervention team members:** Healthy Randolph Tenet I, Randolph Community Collaborative, local providers **Do intervention team members need additional training?** ☐Y ☒N If yes, list training plan: **Quantify what you will do:** Create 3 behavioral forums/expos/fairs into schools and within the community. **List how agency will monitor intervention activities and feedback from participants/stakeholders:** A communication system will be in place among intervention team members in order to identify potential opportunities to hold educational events. **Evaluation:** **Please provide plan for evaluating intervention:** Surveys will be collected from event participants. Attendance at all events will be recorded.

		How you market the intervention: Print, televised and social media.	

Intervention: Collaborative Care Model ☒ **New** ☐ **Ongoing** ☐ **Completed** **Setting:** Primary care offices **Target population:** Individuals seeking behavioral health services **New Target Population:** ☒Y ☐N **Start Date – End Date (mm/yy):** 10/16 – 09/19 **Targets health disparities:** ☒Y ☐ N	☒**Individual/Interpersonal Behavior** ☒**Organizational/Policy** ☐**Environmental Change**	**Lead Agency:** Piedmont Integrated Health **Role:** • Establish a steering committee to guide implementation • Develop and implement protocols and screening tools for depression, anxiety and substance abuse • Integrate behavioral health and psychiatric interventions into primary care settings throughout the Piedmont Integrated Network • Hire licensed clinical social workers and assign primary care settings for them to work in. • Create an outcomes and key measures dashboard to utilize to track the progress of outcome measures over time. ☒**New partner** ☐**Established partner** **Target population representative:** Piedmont Integrated Health **Role:** Create integrated behavioral health screenings and interventions into the primary care setting	**Expected outcomes***:* 1. At 12 months following screenings and interventions, 40% of intervention patients will experience a 50% or greater reduction in behavioral health symptoms from baseline. 2. At 12 months following screening and interventions, 80% of intervention patients will report greater satisfaction with their health care experience and treatment. 3. The number of Emergency Department visits for behavioral health issues will decrease by 20% over a three year period for patients who are in the Piedmont Integrated health network. 4. Due to its incidence in Randolph County and the prevalence of depression in patients with diabetes, 75% of newly diagnosed diabetic patients will be screened for depression at diagnosis and at three, six and 12 months after diagnosis at practices that have an embedded Licensed Clinical Social Worker. 5. 2,100 patients will be served annually through the behavioral health-primary care integration project. **Anticipated barriers:** Any potential barriers? ☐Y ☒N If yes, explain how intervention will be adapted: **List anticipated intervention team members:** Piedmont Integrated Health, Randolph Hospital, Daymark Recovery Services, Therapeutic Alternatives and Sandhills LME. **Do intervention team members need additional training?** ☐Y ☒N If yes, list training plan: **Quantify what you will do:** Hire at least three licensed clinical social workers that will be imbedded in primary care settings impacting at least 2,100 patients improving patient outcomes related to depression, anxiety, substance abuse as well as chronic physical illnesses such as hypertension, diabetes and emphysema.

		☒**New partner** ☒**Established partner** **Partners:** Randolph Hospital **Role:** Assist with integrating behavioral health screenings and interventions into the primary care setting; work with various media resources to educate definded publics regarding these services ☐**New partner** ☒**Established partner** **How you market the intervention:** Utilize local media outlets to educate community on the addition of these services. Educate manufacturing companies through CHC BetterCare about these services and how to access them. Educate local medical community about these added services and how their patients can access them.	**List how agency will monitor intervention activities and feedback from participants/stakeholders:** Create an outcomes and key measures dashboard to utilize to track the progress of outcome measures over time. **Evaluation:** **Please provide plan for evaluating intervention:** Create an outcomes and key measures dashboard to utilize to track the progress of outcome measures over time.