Wake County Community Action Plan

BUILD Health Challenge 2.0

Wake County Medical Society Community Health Foundation

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LOI Form

Project Name*

Wake County Community Action Plan

BUILD Health Implementation Award - Round 1

City*

Please provide the name of the city where the proposed project will take place.

Raleigh

State*

Please provide the two letter postal code.

NC

BUILD Health Challenge Eligibility*

In addition to the 8 national BUILD Health Challenge Awards for U.S. cities, 10 BUILD Health Challenge Awards will be given in specific regions. (For more information about regional awards, population thresholds, and/or topic requirements, please refer to page 3 of the Call for Applications, available at www.buildhealthchallenge.org/application.)

Below are the areas that are eligible for BUILD Health Challenge Awards. Select all that apply to your project:

North Carolina

Local or County Public Health Department Partner*

Please provide the organization name.

Wake County Human Services

Local Hospital or Health System Partner*

Please provide the organization name.

WakeMed, Duke Raleigh, UNC/Rex

Additional Partners

If you have additional partners in this project, please list them below.

Alliance Medical Ministry

Proposal Overview*

In 100 words or less, describe the work you are proposing to carry out with the support of BUILD Health Challenge funding.

The Wake County Medical Society Community Health Foundation's Steering Committee has developed an organized, collective impact initiative that will better link clinical and social service organizations together in a coordinated effort to better serve low-income residents in Wake County. This initiative will allow Wake County residents to receive the resources they need to address their social determinants of health and allow them to achieve their highest level of health and functioning as community members.

Community Profile*

Describe the community or neighborhood at the focal point of this implementation plan, as well as the specific health disparities being addressed by this proposal. What methods or data were used to identify these priorities? Include relevant demographic and health disparity data,highlighting the specific social determinant(s) of health that contribute to this issue.

Wake County is North Carolina's second-most populated county with a total of 1,024,198 people as of July 1, 2015. It is the 9th fastest-growing county in the United States, with the town of Cary and the city of Raleigh being the 8th and 15th fastest-growing cities, respectively. Of all Wake County residents, 11.1% live in poverty ($24,300 annually for a family of four according to the U.S. Health and Human Services data released in January, 2016) while the median household income is $67,309 annually.

Partnership Profile*

Describe the organizations that are partnering to address this challenge, as well as the history of collaboration between the partnering entities. How are the complementary resources, expertise, and capacities of each organization being aligned to address the specific health priorities of focus in this community?

The Wake County Medical Society Community Health Foundation (WCMSCHF) is uniquely suited to meet the requirements of this grant because of its service programs and collaboration within Wake County. WCMSCHF was established as a 501(c)3 in 2000. The Vision of WCMSCHF is a healthy, productive, empowered and engaged community. The Mission is to improve the value of healthcare for our community by advancing high quality, patient-centered and coordinated care. Its two main service programs are Community Care of Wake and Johnston Counties and the CapitalCare Collaborative, both of which administer a network of primary care providers and relationships with community resources. Wake County Human Services (WCHS), in partnership with the community, offers full access to high quality and effective health and human services for Wake County residents. (US Census Bureau, 2015) North Carolina (NC) has a federally mandated, State-supervised, and County-administered social services system. The single administrative agency in NC is the Department of Health and Human Services (DHHS). Regional Service Centers ensure that the citizens within each region of the County have access to a broad range of County services. Regional sites include the Northern Regional Center (Wake Forest, NC), Southern Regional Center (Fuquay Varina, NC), Eastern Regional Center (Zebulon, NC) and the Millbrook Human Services Center (Raleigh, NC). WCHS is responsible for delivering a wide array of services and programs, including Adult and Child Welfare Services, Health Clinics, Children and Family Services, Economic Services (Medicaid, Food and Nutrition Services, Child Care Subsidy, Work First, Child Support Enforcement), Housing, Health Promotion, Guardianship, and Employment Services. Urban Ministries now has four programs, each named for the intended outcome: health, nutrition, a pathway home, and a place where volunteers offer their hands in service and their hearts and voices in education and advocacy. Alliance Medical Ministry is a non-profit organization that provides

comprehensive primary medical care to working uninsured adults in Wake County. Patients self-refer and are referred from area emergency departments, the Health Department and social service organizations. For a small fee based on a sliding scale, patients receive time with physicians, lab work, medications, health and nutrition education, chronic disease management, access to specialty care, access to a community garden and wellness programs, bilingual services, counseling and 24-hour coordination of services. WCMSCHF's Steering Committee has been convening for 10 years to identify and address gaps to improve the lives of individuals within the community and continues to improve the collaboration and communication among agencies to provide better coordinated care and resources. Steering Committee members include key community stakeholders from the area hospitals, Community Health Centers and safety net providers, behavioral health providers, Wake and Johnston Counties Public Health, Social Services, and Emergency Medical Services, Home and Hospice Care, and other vital community providers and partners. Most of the members are involved with the uninsured, underserved populations. In 2016, more than 30 community leaders from the Steering Committee formed a Community Wide Action Planning Team (CAPT) to develop an Action Plan for creating a formalized approach to addressing social determinants of health. The CAPT met between May - October 2016 to develop a Community Action Plan (CAP) that includes a shared mission and common agenda, vision, values, priority areas, objectives, a shared measurement system, and a budget to focus their collective efforts. The CAP was approved by the full Steering Committee on Nov. 3, 2016. The goal for 2017 is to develop implementation teams, identify funding necessary to achieve the plan's objectives and outcomes, and begin implementation of the CAP.

The Implementation Plan*

Provide a brief narrative description of the bold, upstream,integrated, local, data-driven strategies you are proposing to address in this health challenge. How will the BUILD Health Challenge opportunity enable you to implement these strategies? Why do you believe your proposed strategies will be effective?

Wake County has many resources that address social determinants of health; however, there are significant improvements that can be made in the identification, coordination, and use of them. The CAP focuses on addressing this through specific strategies in its Priority Area, Increase Access and Reduce Barriers to Health and Social Services. The BUILD Health Challenge will enable Wake County community partners to implement these strategies by funding a central position (CAP Coordinator) to manage, coordinate, and facilitate the community partners involved and to implement the plan. The funding will also provide technical support for data collection through a shared measurement system and program evaluation. The proposed strategies will be effective because of the strong community partner engagement and commitment already in place to implement this plan. While this initiative already has coordination and communication among its partners and implementation has already started, additional funding as described is necessary to enhance the momentum of implementation and to assist with carrying out and achieving the outcomes of this plan.

Objective 1: Starting October 1, 2016, the WCMSCHF Steering Committee's participation in the Wake Network of Care, a resource hub developed and maintained by Wake County Human Services and Alliance Behavioral Health that contains current resources for food, employment, housing, legal, safety, and other social services will be further integrated and expanded. In collaboration with Wake County Human Services and Alliance Behavioral Health, the CAP Coordinator will develop a dissemination plan of who will receive information and training on the Wake Network of Care resource hub. The Coordinator will collect hub utilization data that will be reviewed with the Steering Committee in regular intervals and help determine effectiveness of the dissemination plan and next steps of hub integration and expansion.

Objective 2: By March 31, 2017, a minimum of 5 standard screening questions to measure social service needs for high risk patients to be used by providers and social service organizations in Wake County will be developed through collecting and assessing social service needs screening questions that partners are currently using. The findings from the collection of screening questions will formally presented to the Steering Committee.

Objective 3: By October 31, 2017, the CAP Coordinator will identify clinical sites to participate in a purposeful referral process to link clinical and social services across Wake County. The CAP Coordinator will track the number of safety net and social service providers using the screening questions.

Objective 4: By December 30, 2017, a purposeful referral process to link clinical and social services across Wake County will be implemented. The CAP Coordinator will compile an inventory of partners' current referral processes and identify best and promising practices to the Steering Committee. One to two pilots will be developed and implemented, facilitated by the Coordinator.

Objective 5: By June 30, 2018, these screenings and referrals will be collected, tracked, and reported through collaboration with identified Electronic Health Records, the Health Information Exchange, and Epic vendors in Wake County.

Objective 6: By July 1, 2018, health outcomes and quality of life measures that will evaluate the effectiveness of the resources that address social determinants of health will be determined from an implementation team that is facilitated by the CAP Coordinator. An inventory of measures and validated tools currently used by partner organizations will be compiled and an implementation team developed.

The Impact*

Describe the anticipated short-term and long-term impacts on your community, recognizing that the long-term impacts may be realized beyond the term of a two-year award period. What new learning may result from the implementation of this work that may be of value to other communities tackling similar challenges?

The CAP has specific objectives associated with each of the action steps listed in the implementation plan, with short and long-term impacts. Short-term impacts of the CAP include facilitation of and communication among community partners for work being done to address social determinants of health, identification and maximization of the resources that are available through consistent screening and referral processes among community partners, and improved identification of individuals who need assistance and utilization of community resources that address social determinants of health. Long-term impacts of the CAP include data that will help determine which social determinant of health resources have the greater impact on health outcomes and quality of life for Wake County residents, better access to resources to address social determinants of health, and improved health outcomes and quality of life for Wake County residents.

New learning that may result from the implementation of this work that may be of value to other communities tackling similar challenges is strategies to keep a large group of community partners together and over a long period of time, focused on the five conditions of collective success - a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations. An additional learning will be maintaining and enhancing a shared measurement system, including data collection from many different organizations within a community. Data and communication among community partners that address health and social services is powerful and if done effectively, can impact a community in many positive ways.

File Attachment Summary

Applicant File Uploads

No files were uploaded