2019 Haywood County e-CHIP

The 2018 Community Health Assessment (CHA) priority areas are:

1) Substance Use & Mental health

2) Perinatal & Early Child Health

3) Chronic Disease Prevention

Haywood County Local Priority Overview Video

Clear Impact Scorecard™ is a strategy and performance management software that is accessible through a web browser and designed to support collaboration both inside and outside organizations. WNC Healthy Impact is using Clear Impact Scorecard™ to support the development of electronic community health improvement plans (eCHIP), State of the County Health Reports and Hospital Implementation Strategy scorecards in communities across the region. The 2019 Haywood County Community Health Improvement Plan (eCHIP) was submitted on Monday, September 9, 2019.

Scorecard helps communities organize their community health improvement efforts by:

- Developing and communicating shared vision
- Defining clear measures of progress
- Sharing data internally or with partners
- Simplifying the way you collect, monitor and report data on your results

The following resources were used/reviewed in order to complete the CHA, submitted March 4, 2019:

- American Heart Association
- Center for Youth Wellness
- Centers for Disease Control and Prevention- CDC Community Health Improvement Navigator
- Centers for Disease Control & Prevention (2019). Calculate What Diabetes Costs your Business.
- County Health Rankings (CHR)- Haywood County, North Carolina
- CHR- Health Factors
- Eat Smart Move More NC
- Haywood Community College, Enrollment and FTEs - Continuing Education
- Haywood County Health and Human Services Agency
- Haywood Regional Medical Center
- MountainWise
- NC State Center for Health Statistics (SCHS)- Data Book
- NC SCHS- Selected Vital Statistics
- NC Department of Health and Human Services (DHHS)- Early Childhood Action Plan
- NC DHHS- NC Medicaid Eligibility and Program Expenditures
- NC DHHS- Newly Diagnosed Chlamydia Annual Rates
- NC Department of Public Instruction (DPI)- High School Dropout Counts and Rates
- NC DPI- 4-Year Cohort Graduate Rate Report
- NC State Bureau of Investigation
- US Census Bureau
- US Environmental Protection Agency

- US Department of Health & Human Services Office of Disease Prevention and Health Promotion
- University of North Carolina-Chapel Hill University Library
- WNC Health Network

An additional resource related to the CHIP is the CHA tools located at: https://publichealth.nc.gov/lhd/

Key:

R Result

I Indicator

P Program/Strategy

PM Performance Measure

Substance Use and Mental Health - Long-Term CHIP

R SU 1) Advancing health and resilience by advocating for prevention, treatment, harm reduction and recovery.

Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

Why It Matters?

Substance use continues to be identified as a top health priority in our community. Many individuals impacted by substance use disorders also struggle with mental health disorders, leading these health priorities to be combined. Over 95% of key informants ranked substance use and over 66% ranked mental health as critical to address (2018 Haywood County Community Health Assessment). Key informants included community or business leaders, physicians, other health providers, public health representatives, and social service providers. Alcohol, tobacco and other drugs negatively impact all ages and ethnic groups in our community.

Risk factors associated with substance use include several biological, social, environmental, psychological, and genetic factors; and, these factors can include gender, race and ethnicity, age, income level, educational attainment, and sexual orientation (Healthy People 2020). In 2016, the rate of smoking among pregnant women in Haywood County was 17.7 per 100,000 (State Center for Health Statistics). Individuals with mental health disorders also smoke at a higher rate than the general population (NAMI). Health indicators in our County show the following trends: .

- In 2018, unintentional medication and other drug overdoses comprised 44% of all cases seen at the emergency department. This is a slight decline from the 47% of cases in 2017 (NC DETECT, 2017-18*).
- In 2018, over 17% of adults reported being current smokers. This was a decrease from 2015, which showed a figure of over 24% (WNC Health Network-WNCHN, 2018).
- Binge drinking was reported by six percent of survey respondents. This was a dramatic improvement from 2015, in which 12.7% of adults reported binge drinking (WNC Health Network-WNCHN, 2018). Binge drinking is defined as five or more drinks for a man and four or more for a woman on one occasion in the past month.
- Over 17% of survey respondents experienced more than seven days of poor mental health in the past month. This was an uptick from the 16% who reported this in 2015 (WNC Health Network-WNCHN, 2018).
- Over 3500 mental-health related visits were made to the emergency department by Haywood County residents (NC DETECT, 2018*). This was a decrease from the previous year, which showed over 3800 visits.
    - *NC DETECT is a statewide public health syndromic surveillance system, funded by the NC Division of Public Health (NC DPH) Federal Public Health Emergency Preparedness Grant and managed through collaboration between NC DPH and UNC-CH Department of Emergency Medicine's Carolina Center for Health Informatics. The NC DETECT Data Oversight Committee does not take responsibility for the scientific validity or accuracy of methodology, results, statistical analyses, or conclusions presented.
- Over nine percent of adults did not get needed mental health care or counseling in the last year, an increase from seven percent in 2015 (WNCHN-WNC Healthy Impact, 2018).

Alignment

Substance use and mental health and the related result ''advancing health and resilience by advocating for prevention, treatment, harm reduction and recovery'' are aligned with the following Healthy NC 2020 Focus Areas/Objectives:

Substance Abuse and Mental Health

- Reduce the percentage of high school students who had alcohol on one or more of the past 30 days.
- Reduce the percentage of individuals aged 12 years and older reporting any illicit drug use in the past 30 days

- Reduce the percentage of individuals aged 12 years and older reporting any illicit drug use in the past 30 days.
- Reduce the rate of mental health-related visits to emergency departments (per 10,000 population).
- Decrease the average number of poor mental health days among adults in the past 30 days.

Experience and Importance

How would we experience ''advancing health and resilience by advocating for prevention, treatment, harm reduction and recovery'' in our community?

Following the completion of the 2018 Haywood County Community Health Assessment (CHA), the Substance Use Prevention Alliance completed ''Getting to Strategies.'' This is a road map for health priority work groups. The SUPA provided answers to the following questions:

- What are the overall quality of life conditions (results) we want for the people who live in our community?
- What would these conditions (results) look like if we could see them?
- How can we measure these conditions?
- How are we doing on the most important of these measures?
- Who are the partners with a role to play?
- What works to do better?
- What do we propose to do?

Quality of Life Conditions (results):

- A more caring, engaging and loving community
- Everyone meets their full potential
- Institutions and the community are trauma-informed
- We are more empathetic and informed about addiction and mental health
- Substance use is less romanticized among youth
- There is more understanding, less stigma and increased community awareness
- There is increased cultural diversity and awareness
- We are more focused on wellness and less on sickness

Health Behaviors:

- Reduced substance use and overdose
- Less pressure to make poor choices
- Reduced medication use
- Better stress management
- All individuals have Naloxone at home and in their possession at all times. Provide Naloxone to people.
- More physical activity
- Modeling healthy behaviors in order to help others (cooking/exercise/self care)
- Expanded messaging and campaigns about prevention, including more substance use education and prevention among youth and funding for school programs
- Invest in prevention staff

Clinical Factors:

- Expanded Medicaid/access to more affordable health insurance
- Available mental health and substance use treatment centers
- More hiring and reduced attrition among service providers
- Increased awareness of services and engagement in treatment and the continuum of care
- Better services

Social and Economic Factors:

- Livable wages and more economic opportunity
- Individuals have work that is more fulfilling and supportive employers.
- Students have better grades and are more successful (more educational attainment)
- More community involvement and an increase in relationships across community
- A willingness to engage at all levels, with an increase in understanding and kinder people
- Be hands and feet in the community with an increased commitment to helping/serving. Be more open to change and be part of it.
- Reduced isolation, including more gatherings (block parties) and conversations
- Non-judgmental language; use person-first language with no labels. Do not attach stigma to behavioral health issues. Have the ability to openly discuss mental health and substance use concerns.
- More educational events and opportunities exist and more people taking advantage of opportunities (e.g. poverty simulation)
- A community that embraces harm reduction
- An increased awareness of reality with no blinders
- Increased inclusivity, including caring for each other, being open, valuing all and seeing the whole person
- Recognize successes and areas to improve. Have a commitment to improve.
- Have more self-compassion with healthy boundaries and social support for self.
- Provide increased support for parents (to enable them to better care for kids); fewer individuals are reporting Adverse Childhood Experiences.
- Provide adequate support to address intergenerational poverty; no more denial of needs.
- Improved targeting of law enforcement strategies; fewer arrests for unmet behavioral health needs.
- Reduced trafficking of substances
- Invest in post-high school youth programs
- Increased awareness of supportive services, programs and agencies available. Promote use of these resources for people who need them.

Physical Environment:

- Increased affordable housing with a reduction in or absence of homelessness
- Fulfilled housing and other needs
- Increased hiring and housing of people with behavioral health concerns

Health Outcomes:

- Improved physical and mental health, with fewer people reporting poor mental health days and physical/emotional problems
- A reduced demand for services, including fewer overdoses and mental health crises
- Increased resilience and less stress
- Healthy youth and families
- Improved perception regarding the current climate
- Improved efficiency and funding with greater connectedness
- People are less busy, but more engaged in important things. We establish healthy boundaries.
- We experienced improved education and understanding about the issues. This includes adopting healthy norms and standards.

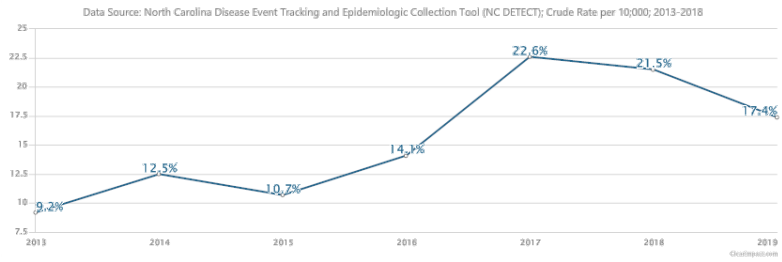
During both the 2018 CHA prioritization process and SUPA discussions, we discussed how we're doing on the most important of health measures:

- Substance use data from the emergency department (alcohol toxicity, all opioid overdose, heroin overdose, meth use, underage alcohol use)

- Adult tobacco use
- Naloxone reversals
- Available prevention staff
- Uninsured adults
- Adults who have ongoing medical care
- The average weekly wage (lower than the state average)
- Educational attainment, including the high school graduate and drop-out rates
- Adults who think Haywood County is a poor or fair place to live
- Adults who always or usually get the support they need
- Adults who have an Adverse Childhood Experiences score of four or more
- The percentage of residents spending more than 30% on rent
- Adults reporting poor or fair health
- Adults limited in activities (primarily due to back/neck problems and mental health/depression)
- Adults who report being negatively affected by theirs or someone else's substance use

---

I SU Emergency department visits for unintentional medication or drug overdoses



2019	17.4%	–	↘ 2	89% ↑
2018	21.5%	–	↘ 1	134% ↑
2017	22.6%	–	↗ 2	146% ↑
2016	14.1%	–	↗ 1	53% ↑
2015	10.7%	–	↘ 1	16% ↑
2014	12.5%	–	↗ 1	36% ↑
2013	9.2%	–	→ 0	0% →

Story Behind the Indicator

The "Story Behind the Curve" helps us understand why the data on unintentional medication and drug overdose is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? *These are the positive forces are work in our community and beyond that influence this issue in our community*

- Five law enforcement agencies carry Naloxone, a reversal medication for opioid overdoses. This project is overseen by Haywood County EMS. Many lay citizens have also been trained to use this medication. The North Carolina Harm Reduction Coalition (NCHRC) conducts monthly training sessions at the local health department.
- NCHRC and the Waynesville Police Department partner to offer the Law Enforcement Assisted Diversion program (LEAD). This program directs people with low-level offenses to treatment and other resources instead of jail. An example of this offense includes possessing a small amount of an illegal substance.
- NCHRC distributes supplies such as Fentanyl test strips, sterile syringes and antibiotic ointment to help reduce the harm associated with injection drug use.
- Haywood Regional Medical Center hosts training sessions for health care providers about safer prescribing practices.
- With NCDHHS grant funding, HHSA contracted with NCHRC to fund a post-overdose outreach specialist. This peer not only provided post-overdose follow-up, but connected participants with syringe exchange services.

What's Hurting? *These are the negative forces are work in our community and beyond that influence this issue in our community.*

- Fentanyl is often found in Heroin and increases the likelihood of an overdose.
- Local data about youth substance use is lacking, which hinders the community's ability to apply for federal funding.
- Stigma still exists surrounding drug use and Medication-Assisted Treatment (MAT), such as Suboxone.

- Many residents lack adequate housing, living-wage employment, and Medicaid access, making it difficult to achieve and sustain recovery from substance use and mental health disorders.
- During the first two quarters of 2019, the most recent data available, 1,736,000 opioid pills were prescribed to Haywood County residents (NC Opioid Dashboard, 2019).

Partners With A Role To Play

Partners in our Community Health Improvement Process:

- Substance Use Prevention Alliance
- Haywood Regional Medical Center

Partners With a Role in Helping Our Community Do Better on This Issue:

- Appalachian Community Services of Western North Carolina
- Blue Ridge Community Health Services
- Concerned Citizens
- Down Home North Carolina
- Drugs in Our Midst
- Groups Recover Together
- Haywood County Health and Human Services Agency
- Haywood Community College
- Hazelwood Healthcare
- Haywood County Schools
- Haywood County Sheriff's Office
- Haywood Pathways Center
- Haywood Regional Medical Center
- Meridian Behavioral Health Services
- Mountain Projects
- MountainWise
- NC Harm Reduction Coalition
- Healthy Haywood- Substance Use Prevention Alliance
- Perinatal Substance Use Collaborative
- Vaya Health
- Waynesville Police Department
- WNC AIDS Project

Strategies Considered & Process

The following actions have been identified by our Substance Use Prevention Alliance and community members as ideas for what can work for our community to make a difference on unintentional medication and drug overdose.

Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on unintentional medication and drug overdose.*

- Adverse Childhood Experiences/Trauma- Developing a Community Resilience Plan.
- Conduct community education about overdose prevention and reversal.
- Provide harm reduction services, including fentanyl testing and post-overdose response.

- Coordinate presentations by first responders and harm reduction staff for the Substance Use Prevention Alliance. Presentations will include post-overdose response protocol and information about harm reduction interventions.

What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on unintentional medication or other drug overdose.*

- Education about safer prescribing practices
- Law Enforcement Assisted Diversion (LEAD) was implemented in Haywood County in 2017. LEAD has a full-time case manager who has served 15 participants and connected five participants with Medication-Assisted Treatment. One participant has entered a year-long residential treatment program (NC Harm Reduction Coalition, 2019).
- Medication-Assisted Treatment- MAT is an evidence-based method for treating substance use disorders. Haywood County has six agencies that provide MAT. A clinic also exists in a neighboring county.

Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on unintentional medication and drug overdose.*

Name of Strategy Reviewed	Level of Intervention
Drug-Free Communities Grant	Organizational, Community
Syringe Exchange Program	Individual, Community, Policy
Medication-Assisted Treatment	Individual, Policy, Organizational

What Community Members Most Affected by Unintentional Medication and Drug Overdose Say *These are the actions and approaches recommended by members of our community who are most affected by unintentional medication and drug overdose.*

- Implement the Pride survey to obtain youth substance use data
- Hold community listening sessions to determine barriers receiving substance use treatment
- Offer community education about overdose signs and symptoms, as well as how to reverse an overdose
- Organize presentations by first responders about post-overdose response protocol

Process for Selecting Priority Strategies

The Substance Use Prevention Alliance (SUPA) discussed the data indicators they felt could be impacted within the three-year Community Health Assessment (CHA) cycle. From this discussion, the coalition formed work groups to address the data indicators of greatest concern. Within each work group, programs were reviewed and chosen based on resource availability, community acknowledgement of need and programs' merits to positively influence indicator outcomes. A timeline was developed for each work group and its chosen data point. Programs were selected that could be realistically implemented within a three-year period. The programs align with the vision statement for the SUPA and support the top health priority identified by the CHA. Specific actions were determined that could be achieved for each data indicator. Specific programs were identified that will be implemented to reduce negative outcomes for each data indicator. Each program/project addresses some of the more well-known and researched root causes of overdose. For instance, an Adverse Childhood Experiences score of 4+ increases the likelihood that a person will experience later health problems, such as substance use. Efforts that include education and building a Community Resilience Plan will better equip individuals to address trauma. The Law Enforcement Assisted Diversion (LEAD) program has been shown to reduce re-arrests by 58% (LEAD Bureau, 2020). Harm reduction practices have been shown to lower overdose rates and connect people to substance treatment programs (NC Harm Reduction Coalition, 2020).

Data Holes

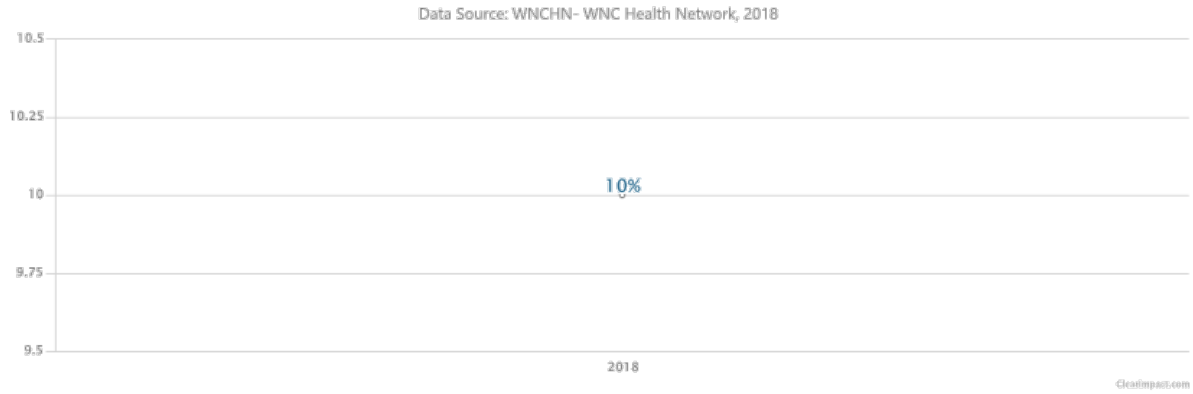
We are keeping an eye on medication and other drug overdoses as a way of telling how we are doing as a community in addressing substance use. We also strive to build a community where we ''advance health and resilience by advocating for prevention, treatment, harm reduction and recovery.'' We have identified other data that is not currently available, but that we would like to develop to help us monitor progress on this result:

- Youth tobacco use
- Youth alcohol use
- Youth drug use

These data points can be collected from youth by conducting the Pride survey in local schools. Pride collects data such as perceptions surrounding drug use, past 30-day drug use and the locations where drugs are used.

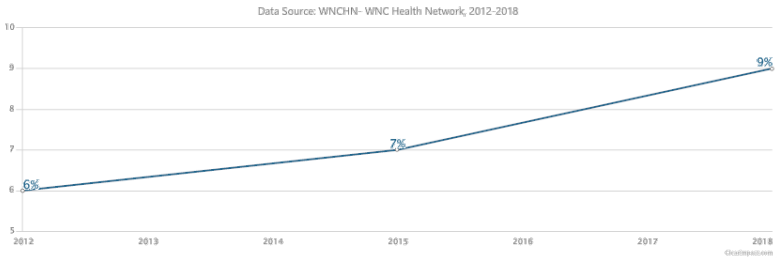
I SU Adverse Childhood Experience Scores Among Adults (score of 4 or more)

2018	10%	–	→ 0	0% →



I SU Did not get mental health care or counseling needed in the last year

2018	9%	–	↗ 2	50% ↑
2015	7%	–	↗ 1	17% ↑
2012	6%	–	→ 0	0% →



P SU Implement the Pride survey in Haywood County Schools to gather youth substance use data.

Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

What Is It?

The Pride survey is a trusted method of obtaining substance use data from youth. A thorough data collection will prepare Haywood County to apply for the Drug-Free Communities Grant. DFC provides $125,000 per year for five years and allows the opportunity to hire a full-time coordinator. Communities who receive DFC funding experience a reduction in past 30-day use of alcohol, tobacco, marijuana and illicit prescription drug use among youth. DFC-funded communities have experienced long-term reduction in youth substance use (Community Anti-Drug Coalitions of America, 2002-2018).

The Pride survey was identified by the Substance Use Prevention Alliance as an action that, when combined with other actions in our community, has a strong potential to make a difference in Haywood County. This is a new program in our community.

The survey should be conducted yearly in Haywood County's eight middle and high schools. Students surveyed will be in 7th, 9th and 11th grades. This process will continue for as long as possible.

The priority population for the Pride Survey includes Haywood County Schools (HCS) students and staff, and the Pride survey aims to make a difference at the organization level. Implementation of the survey will take place in HCS. Survey results will be anonymous and therefore not connected to a particular student. Results will only be shared with HCS administrators, grant funders, and other approved individuals.

This strategy addresses health disparities by identifying differences among the grade levels surveyed. By obtaining quality data, the community will be better positioned to implement evidence-based interventions that will best serve each school. Interventions selected will be ones recommended by DFC, a nationally-recognized grant program.

2019 Update:

At this time, the Pride Survey has not been conducted. The survey's length makes it difficult to administer during limited instructional time. Haywood County Schools (HCS) gave approval for a brief survey about alcohol and vaping. The survey was conducted January 2020 with all ninth-grade students enrolled in HCS. To date, over 100 completed surveys have been returned (Mountain Projects, 2020). Data analysis has begun and will be finalized upon receiving the remaining surveys. Funding for the survey came from the Partnership for Success grant awarded to Mountain Projects.

Partners

The partners for the Pride survey include:

Agency	Person	Role
Haywood County Schools	Jill Barker	Lead
Mountain Projects	Patti Tiberi	Collaborate
Substance Use Prevention Alliance (Youth Substance Use Prevention Work Group)	Coalition Members	Support

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Obtain final approval from Haywood County Schools	Written approval	Haywood County Schools/ Assistant Superintendent Jill Barker/School Board	November 2019
Pay for survey forms and evaluation services	Funding	Mountain Projects/Patti Tiberi	December 2019
Notify school administrators and parents/guardians of survey	Notification letter	Haywood County Schools/Superintendent Bill Nolte and Assistant Superintendent Jill Barker	December 2019
Conduct survey with all 7th, 9th and 11th grade students	Written approval	Haywood County Schools/ Assistant Superintendent Jill Barker	January 2020
Review survey results as provided by Pride Surveys	Survey report	Substance Use Prevention Alliance Members (Youth Substance Use Prevention Work Group)	May 2020
Share survey results with Haywood County Schools administration	Survey report	Mountain Projects/Patti Tiberi	July 2020

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of the Pride survey through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

Sustainability Plan:

The following is our sustainability plan for conducting the Pride Survey:

1. Performing Pride survey, resulting in data that equips the community to apply for Drug-Free Communities (DFC) funding.
2. Repeat the Pride survey annually to demonstrate need for prevention programming in the schools and community.
3. DFC funding will be used for evidence-based interventions that result in long-term changes, such as policy and environmental changes.
4. **Performance measures**- We will gather data on the number of students who participate and the percentage who participate. Data gathered will include alcohol, tobacco, marijuana and illicit prescription drug use, key measures that have improved in DFC-funded communities (Community Anti-Drug Coalitions of America, 2002-2018). If the community receives DFC funding, changes in youth substance use will be assessed and communicated to funders.

5. **Key stakeholders**- Stakeholders include Haywood County (HCS) Schools administrators and staff, the School Health Advisory Committee, Haywood County Health and Human Services Agency (HHSA) staff and members of the Substance Use Prevention Alliance (SUPA). SUPA members include treatment providers, harm reduction advocates, medical providers, public health specialists, prevention providers and directly impacted community members.
6. **Program champions**- These individuals include the SUPA chair and HHSA staff.
7. **Financial support**- Support for the Pride survey comes from grant funding obtained by Mountain Projects. Following the survey, our community will apply for DFC funding. This grant will finance the survey during the five years of funding. When the grant has ended, we will request ongoing funding through the HCS foundation and Haywood Healthcare Foundation.
8. **Communication**- A decision will be made in partnership with HCS about beneficial ways to use the data. We will also decide together on how to best educate the community about youth substance use. Communication may include education about social norms.
9. **Program value**- This will be communicated by explaining the impact of collecting data (funding) and the impact on youth substance use as a result of receiving funding. Successes will also be communicated to community leaders, such as the HHSA board and the Board of County Commissioners.
10. **Staff capacity**- Existing school staff, including teachers and administrators, will distribute surveys to students and collect them. Mountain Projects will collect the surveys from Haywood County Schools and submit them to the Pride survey company for evaluation.

	Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
PM SU Number of students who complete the survey	2020	111	–	→ 0	0% →

P SU Conduct youth-focused prevention activities to enhance protective factors.

What Is It?

Conducting youth-focused prevention activities was identified by the Substance Use Prevention Alliance as an action that, when combined with other actions in our community, has a reasonable chance of making a difference in youth alcohol, tobacco and drug use in our community. This is an ongoing program in our community, with implementation of several new components.

This program will continue or initiate the following:

- Provide six hours of school-based prevention education to eighth grade students (continuing program)
- Conduct focus groups with youth to further inform prevention efforts (new program)
- Create a youth-focused community calendar, enhancing the protective factor of ''strong neighborhood attachment'' (new program); National Institute on Drug Abuse, 2003.

The priority population/customers for youth-focused prevention are adolescents in Haywood County, and youth-focused prevention aims to make a difference at the individual and environmental levels. Implementation will take place in school and community settings.

This program addresses the health disparities related to youth substance use. Individuals who begin using substances at a young age are more likely to develop a substance use disorder as adults (Center on Addiction, 2017). Poverty is also a risk factor for substance use (National Institute on Drug Abuse, 2003).

2019 Update:

- Drug prevention education was provided to 507 eighth-grade students at Bethel, Canton, and Waynesville Middle Schools. Topics included vaping, alcohol and underage drinking, the effects of substance use on the brain, drugs found in Haywood County and how this is being addressed, and what happens when someone is charged for drugs. Students also heard a personal story from someone in long-term recovery, who discussed wrong choices and consequences (Drugs in Our Midst, 2019). Lesson plans for each topic were provided to the Superintendent of Haywood County Schools (HCS). Partners are: HCS, Mountain Projects, Addiction Professionals of NC, Waynesville Police Department, Haywood County Sheriff's Office, Mothers Against Drunk Driving, and MountainWise.
- Focus groups with youth have not been conducted at this time. The Substance Use Prevention Alliance (SUPA) continues to build capacity in preparation for recruiting and engaging students.
- A youth-focused community calendar has not been created at this time, as SUPA requires additional time to build capacity.
- A full-time coordinator was hired to lead the Partnership for Success grant efforts in October 2019. The grant focuses on underage alcohol consumption and vaping.

Partners

The partners for youth-focused prevention activities include:

Agency	Person	Role
Addiction Professionals of NC	Richie Tannerhill	Collaborate
Drugs in Our Midst	Jean Parris	Support
Haywood County Schools	Jill Barker	Support
Mountain Projects	Patti Tiberi and Libby Ray	Collaborate
MountainWise	Tobin Lee	Collaborate
Substance Use Prevention Alliance (Youth Substance Use Prevention Work Group)	Work Group Members	Lead

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Schedule school presentations	School staff	Drugs in Our Midst/Jean Parris	November 2019
Conduct school presentations	Presenters and educational materials	Drugs in Our Midst/Jean Parris	April 2020
Evaluate school presentations	Staff time; student feedback	Drugs in Our Midst/Jean Parris	June 2020
Schedule youth focus groups	Staff time; school permission, if needed	Substance Use Prevention Alliance (Youth Substance Use Prevention Work Group)	September 2020
Recruit youth and hold focus groups	Staff time; youth participants; meeting space	Substance Use Prevention Alliance (Youth Substance Use Prevention Work Group)	October 2020
Evaluate feedback from youth focus groups	Staff time; youth feedback	Substance Use Prevention Alliance (Youth Substance Use Prevention Work Group)	January 2021
Select format for youth community calendar	Staff time; samples of calendar formats, including phone/web apps; youth feedback	Substance Use Prevention Alliance (Youth Substance Use Prevention Work Group)	March 2020
Choose items for youth community calendar	Staff time; local school and event calendars; youth feedback	Substance Use Prevention Alliance (Youth Alcohol, Tobacco and Drug Use Work Group)	June 2020
Develop draft of community calendar	Funding; staff time; youth feedback	Substance Use Prevention Alliance (Youth Alcohol, Tobacco and Drug Use Work Group)	October 2020
Finalize and publish community calendar	Funding; staff time; youth feedback	Substance Use Prevention Alliance (Youth Alcohol, Tobacco and Drug Use Work Group)	January 2021
Evaluate community calendar	Staff time; youth feedback	Substance Use Prevention Alliance (Youth Alcohol, Tobacco and Drug Use Work Group)	June 2021

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of youth-focused prevention activities through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above. Performance measures include the number of eighth-grade students who receive substance use prevention education, who participate in focus groups to inform prevention efforts, and who are reached through the youth-focused community calendar.

Sustainability Plan:

The following is our sustainability plan for youth-focused prevention activities:

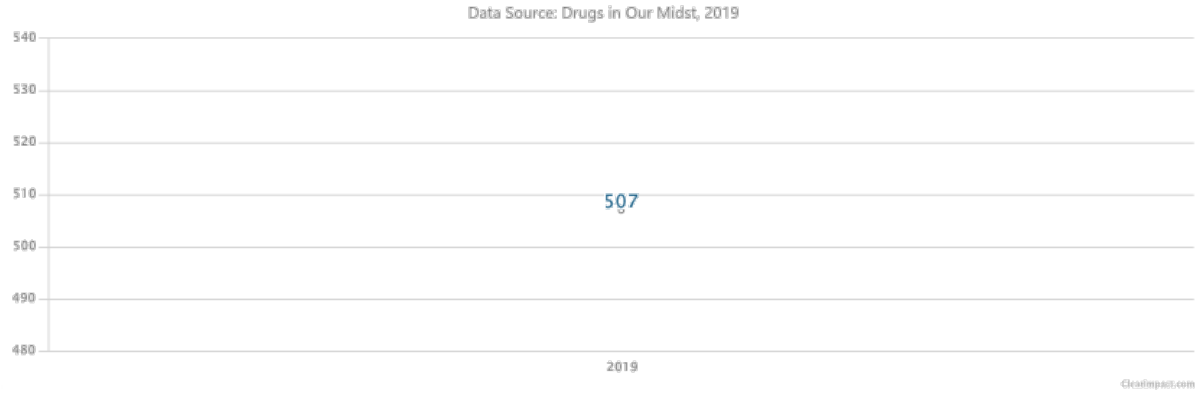
- Sustainability Components:
  - Identify a champion for the program
    - Program champion will obtain buy-in from school staff and students, allowing the project to continue over multiple years

years

- Ensure champion is included in communication of program objectives to stakeholders and ensure awareness amongst community members
- Use data from youth focus groups to guide decisions about youth prevention programs
  - Communicate focus groups' decisions to stakeholders
- Obtain program evaluation from students and staff about program performance and effectiveness
  - Address areas with less than positive performance and effectiveness early on
  - Ensure students are involved with actions to increase program performance and effectiveness

- Focus group efforts can be easily sustained, as the only expense is staff time.
- Youth feedback will help ensure that calendar content is relevant and beneficial.

PM SU	Number of eighth-grade students who receive six hours of drug education	2019	507	–	→ 0	0% →



PM SU	Number of youth participating in focus groups to inform prevention efforts	–	–	–	–	–
PM SU	Number of individuals reached through youth-focused community calendar	–	–	–	–	–

		Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
P SU	Implement the Catch My Breath curriculum for students who are found using tobacco on campus.					

What Is It?

Catch My Breath, a youth e-cigarette prevention program, was identified by the Substance Use Prevention Allliance as an action that, when combined with other actions in our community, has a reasonable chance of making a difference in youth substance use in our community. CATCH is a coordinated school health program, of which e-cigarette prevention is one component. CATCH is part of the ''Whole School, Whole Community, Whole Child Model'' developed by the Centers for Disease Control and Prevention. This is a new program in our community.

The priority population/customers for Catch My Breath are students caught using or possessing tobacco on campus, and Catch My Breath aims to make a difference at the individual and organizational levels. Implementation will take place in schools.

Catch My Breath addresses health disparities by addressing the sub-population of students who use tobacco and who may potentially experience its health effects.

2019 Update:

Administrators from Tuscola High School (THS) have expressed concerns about the impact of vaping on their student body. As a result, staff from Mountain Projects, MountainWise and Haywood County Health and Human Services Agency met with THS staff in December 2019 to discuss concerns and provide resources. The regional tobacco prevention manager was part of this discussion and continues to promote Catch My Breath in Haywood County. While no students completed the program in 2019, the Catch My Breath vaping education program was approved in early 2020 by THS administrators (The Mountaineer, 2020).

Partners

The partners for this Catch My Breath include:

Agency	Person	Role
MountainWise	Tobin Lee	Collaborate
Haywood County Schools	Jill Barker	Lead
School Health Advisory Committee	Chelsea Williams/Brandi Stephenson	Support
Substance Use Prevention Alliance	Youth Substance Use Prevention Work Group Members	Support

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Present program to Assistant Superintendent	Visual presentation and printed materials	MountainWise/Tobin Lee	January 2020
Present program to principals	Visual presentation and printed materials	MountainWise/Tobin Lee	March 2020
Implement program at schools	Principal approval	Haywood County Schools/School Principals	October 2020
Evaluate program using selected performance measures	Numbers of students and schools participating	Haywood County Schools (School Health Advisory Committee).	May 2021

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of Catch My Breath through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

Sustainability Plan:

The following is our sustainability plan for Catch My Breath:

1. Catch My Breath is available for free.
2. Performance measures will be reported to Haywood County Schools administrators and school board members.
3. Anecdotal evaluation will be obtained from staff members to determine successes, challenges and lessons learned.

PM	SU	Number of students who complete the Catch My Breath curriculum.	–	–	–	–	–		
PM	SU	Number of schools that implement the Catch My Breath curriculum.	–	–	–	–	–		

P SU Offer Medication-Assisted Treatment (MAT) to women upon release from the Haywood County Detention Center.

Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

What Is It?

Medication-Assisted Treatment (MAT) was identified by the Substance Use Prevention Alliance as an action that, when combined with other actions in our community, has a reasonable chance of making a difference in overdose rates in our community. This is an ongoing program in our community, with Haywood County Health and Human Services Agency (HHSA) being a new provider of MAT.

Current MAT interventions are effective and MAT is the standard of care for treating opioid use disorders. In Haywood County, seven organizations offer MAT, including HHSA. The HHSA provider prescribes Suboxone to eligible individuals.

The priority population/customers for the HHSA MAT program are women being released from the Haywood County Detention Center. MAT aims to make a difference at the individual and organizational levels. Implementation will take place in the HHSA public health services clinic.

This strategy addresses health disparities by serving individuals who are at increased risk of suffering from communicable diseases, dying prematurely, and who lack insurance coverage to receive substance use treatment.

2019 Update:

In November 2019, a $40,000 grant award was received from the Haywood Healthcare Foundation, allowing HHSA to offer MAT. Additional funding was pursued from the Pisgah Health Trust in December 2019 and HHSA is awaiting a decision. HHSA developed an agreement with with Meridian Behavioral Health Services, who will offer follow-up counseling to all HHSA MAT patients. MAT services began at the HHSA in January 2020.

Partners

The partners for MAT include:

Agency	Person	Role
Haywood Healthcare Foundation	Marge Stiles	Support
Haywood County Health and Human Services Agency (HHSA)	Dana Ashe	Lead
Haywood County Sheriff's Office	Jeff Haynes	Support
NC Harm Reduction Coalition	Jesse-lee Dunlap and Gariann Yochym	Support, Represent Target Population
Meridian Behavioral Health Services	Trevor Hermann	Collaborate

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Secure funding to implement Mediation-Assisted Treatment	Staff time	Patrick Johnson/HHSA	November 2019
Make arrangements for follow-up counseling through a local treatment provider.	Staff time	Patrick Johnson/HHSA	January 2020
Acquire Naloxone for distribution to MAT patients	Staff time, medication	Emily Jenkins/HHSA	January 2020
Begin serving MAT patients	Staff time, funding	Emily Jenkins/HHSA	January 2020
Evaluate MAT program	Staff time	Patrick Johnson and Emily Jenkins/HHSA	Ongoing

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of Medication-Assisted Treatment (MAT) through the use of Results-Based AccountabilityTM to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

Sustainability Plan:

The following is our sustainability plan for MAT:

- Sustainability Components:
  - We will monitor program performance by tracking the number of women who receive MAT. This will demonstrate both program success and need to funders.
  - On a monthly basis, program need will be demonstrated by tracking the number of emergency department visits due to opioid overdoses.

		Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
PM SU	Number of women who receive Medication-Assisted Treatment	2020	2	–	→ 0	0% →
P SU	Educate the community about trauma and Adverse Childhood Experiences (ACES).					

What Is It?

Educating the community about trauma and Adverse Childhood Experiences (ACES) was identified by the Substance Use Prevention Alliance (SUPA) as an action that, when combined with other actions in our community, has a reasonable chance of making a difference in substance use and mental health in our community. Our focus on trauma and ACES will include forming a Building Resilient Communities (BRC) group, helping organizations adopt a Community Resilience Plan and helping school staff to be trained about ACES. ''BRC addresses upstream toxic effects of ACES and promotes an integrated, multi-pronged approach focusing on de-fragmenting childhealthcare delivery systems to build strong healthcare-community partnerships that develop common goals and shared work plans.'' This is a new program in our community.

The priority population/customers for education about trauma and ACES are school staff. The communication efforts include stakeholders. Stakeholders include local government officials and community members. This community education program aims to make a difference at both individual and organizational levels. Implementation will take place in schools and community organizations, such as faith communities and other non-profit agencies.

This strategy addresses health disparities by increasing awareness of the impact of ACES. Individuals with an ACES score of 4 or more are more likely to experience physical and mental health problems, including a substance use disorder.

2019 Update:

Three organizations hosted a screening and discussion of the Resilience film (Haywood County Health and Human Services Agency, 2019). An ACES collaborative group formed in October 2019 and continues to expand its membership. The group is comprised of professionals from public health, prevention, justice, education, and treatment sectors. The group's goal is to build a more trauma-informed and resilient community. Multiple partners in Haywood county participated in a two-day Resources for Resilience training. One of the SUPA leaders received training through the Adverse Childhood Experiences Southeastern Summit in fall 2019.

Partners

The partners for education about trauma and ACES include:

Agency	Person	Role
Adverse Childhood Experiences Collaborative	Group members	Lead
Haywood County Schools	Brandi Stephenson	Collaborate

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Discuss the program and conduct education with the Adverse Childhood Experiences (ACES) Collaborative.	Building Resilient Communities (BRC) toolkit	ACES Collaborative	February 2020
Speak with the School Health Advisory Committee about trauma-informed care.	BRC toolkit	ACES Collaborative	May 2020
Form a Building Resilient Communities (BRC) core group.	BRC toolkit	ACES Collaborative	September 2020
Develop a plan to show the Resilence movie throughout Haywood County and offer screening events.	Copy of film, facilities to host screening events	ACES Collaborative	September 2020
Form a BRC community team.	BRC toolkit, facility to host meetings	ACES Collaborative	January 2021
Develop the Community Resilience Plan.	BRC toolkit	ACES Collaborative	February 2021
Encourage community organizations to adopt the Community Resilience Plan.	BRC toolkit, Community Reslilience Plan	ACES Collaborative	March 2021
Begin conducting evaluation of work plan tasks.	ACES Collaborative members and community organization leaders	ACES Collaborative	August 2021

Evaluation & Sustainability

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of trauma and Adverse Childhood Experiences (ACES) education through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Performance measures are: the number of community members and stakeholders attending screening events; number of community members who participate in a Building Resilient Communities (BRC) group, number of organizations who adopt the Community Resilience Plan and the number of school staff who complete ACES training sessions. Our 2018 Community Health Assessment phone survey collected ACES data from adults in Haywood County. We will communicate with partners at the WNC Health Network to express the importance of this data and our desire to see follow-up data in 2021.

Sustainability Plan:

The following is our sustainability plan for trauma and ACES education:

- Sustainability Component:
  - Several resources, such as the Resilience film and BRC toolkit, are available to our community at no cost. This will assist our community in offering education on a long-term basis.
  - Training school staff will help Haywood County Schools achieve the goal of becoming a trauma-informed school district.
  - Sustainability will be achieved by organizations adopting the Community Resilience Plan, as this will become part of organizational procedure.
  - By assessing program performance measures, we will be able to determine the efficacy and successes of the program. This will allow us to communicate with stakeholders and continue to build community support.

PM	SU	Number of Resilience Film screening events held in the community	2019	3	–	→ 0	0% →
PM	SU	Number of members who participate in the ACES Collaborative group	2020	17	–	↗ 1	42% ↑
PM	SU	Number of community organizations who adopt the Community Resilience Plan	–	–	–	–	–
PM	SU	Number of school staff who complete training sessions about ACEs	2019	30	–	→ 0	0% →
P	SU	Determine barriers to receiving mental health and substance use treatment.	Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

What Is It?

Determining the barriers to receiving mental health treatment was identified by the Substance Use Prevention Alliance as an action that, when combined with other actions in our community, has a reasonable chance of making a difference in the number of individuals not receiving mental health care in our community. This is a new program in our community.

The priority population/customers for determining mental health treatment barriers are individuals or family members who've had trouble accessing treatment. Determining treatment barriers aims to make a difference at the individual and organizational levels. Implementation will take place in community settings, such treatment centers, soup kitchens, churches and the local homeless shelter.

This strategy addresses disparities by identifying gaps in receiving mental health and substance use treatment.

2019 Update:

The Substance Use Prevention Alliance includes an active work group that addresses barriers to treatment and recovery. At this time, focus groups have not been scheduled. The group has approached treatment partners and community organizations with a request to conduct focus groups at their agencies. Group members have accomplished the following:

- The North Carolina Harm Reduction Coalition shared survey results from their program participants. The results have provided the work group with valuable insight into barriers that individuals face.
- Meridian Behavioral Health Services committed to further examining their agency's intake process. They will inquire if their current questions about barriers can be expanded.
- Vaya Health committed to sharing quarterly data highlighting services received and locations and providers where individuals present for care.

Partners

The partners for this determining substance use and mental health treatment barriers include:

Agency	Person	Role
Substance Use Prevention Alliance (Barriers to Care Work Group)	Work Group Members	Lead
NC Harm Reduction Coalition	Gariann Yochym	Collaborate
Appalachian Community Services of Western North Carolina	Tabatha Brafford	Collaborate
Haywood Pathways Center	Mandy Haithcox	Collaborate
The Open Door Ministries	Bill Guy	Collaborate
Vaya Health	Shelly Foreman	Collaborate

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Provide the existing list of local treatment resources	Copies of treatment sheet	Haywood Health and Human Services Agency/Lauren Wood	January 2020
Host focus groups to receive feedback about barriers to care.	Organizations willing to host, supplies for note taking during groups	Sustance Use Prevention Alliance/Barriers to Care work group members	April 2020
Evaluate feedback provided by focus groups	Feedback from focus groups	Sustance Use Prevention Alliance/Barriers to Care work group members	June 2020
Speak with partners who provide treatment to determine next steps	Meetings with treatment providers; feedback from focus groups.	Sustance Use Prevention Alliance/Barriers to Care work group members	October 2020

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of determining barriers to care through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

Sustainability Plan:

The following is our sustainability plan for determining barriers to receiving mental health and substance use treatment:

- Sustainability Component:
  - Lessons learned from focus groups will be shared with local treatment providers and other community-based organizations. This will assist them in addressing barriers to receiving treatment.

			Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
PM	SU	Number of individuals participating in barriers-to-treatment focus groups	–	–	–	–	–
PM	SU	Number of barriers-to-treatment focus groups held	–	–	–	–	–
P	SU	Conduct community education about overdose prevention, symptoms and reversal.					

What Is It?

Conducting community education about overdose was identified by the Substance Use Prevention Alliance as an action that, when combined with other actions in our community, has a reasonable chance of making a difference in unintentional medication and drug overdose in our community. This is a new program in our community.

The priority population/customers for conducting community education about overdose are individuals at risk of overdose and their loved ones, and community education about overdose aims to make a difference at the individual level. Implementation will take place through treatment providers, the homeless shelters and soup kitchens, family support groups and mass media.

This strategy addresses health disparities by educating individuals who are more likely to experience or witness an overdose.

2019 Update:

North Carolina Harm Reduction Coalition (NCHRC) staff conducted overdose prevention training at Haywood County Health and Human Services Agency and the Haywood County Detention Center (HCDC). As of October 2019, one NCHRC staff member is housed at the HCDC 10 hours per week. A 2017 study conducted at the HCDC showed that 79% of inmates have a substance use disorder (Raggio, Kopak, and Hoffman, 2017). Upon release from HCDC custody, each individual receives a Naloxone kit and educational materials (NCHRC). Those who resume substance use upon release are more likely to overdose due to decreased tolerance, demonstrating the importance of this intervention. An NC DHHS grant received in December 2019 will hire a full-time Linkages-to-Care Navigator (LTC) and a part-time Post-Overdose/Resource Coordinator (PO/RC). The LTC navigator will be based at the HCDC to connect individuals at risk of overdose to services upon release. The PO/RC will provide overdose follow-up and syringe exchange program services.

Partners

The partners for conducting overdose education include:

Agency	Person	Role
Substance Use Prevention Alliance (Overdose Prevention and Harm Reduction Work Group)	Overdose Prevention and Harm Reduction Work Group Members	Lead
NC Harm Reduction Coalition	Gariann Yochym and Jesse-lee Dunlap	Collaborate
Open Door Soup Kitchen	Bill Guy	Collaborate
The Community Kitchen	Allison Jennings	Collaborate
Haywood Pathways Center	Mandy Haithcox	Collaborate
Drugs in Our Midst (Family Support Groups)	Jean Parris	Partner
Appalachian Community Services	Tabatha Brafford	Collaborate
Behavioral Health Group	Jim Casey	Collaborate
Groups Recover Together	Joel Misler/Aubrey Masters	Collaborate
Meridian Behavioral Health Services	Amy Wilson	Collaborate
Hazelwood Healthcare	Matt Holmes	Collaborate

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Obtain overdose prevention training packet	Permission to use training packet, an electronic version of the packet and partners able to print copies.	NC Harm Reduction Coalition	October 2019
Contact community partners to discuss opportunity	Staff time	Substance Use Prevention Alliance (Harm Reduction and Overdose Prevention Work Group)	December 2019
Schedule educational sessions and provide training packets to those conducting education	Staff time; partners able to print copies	Substance Use Prevention Alliance (Harm Reduction and Overdose Prevention Work Group)	January 2019
Begin conducting educational sessions	Staff time; meeting space	Substance Use Prevention Alliance (Harm Reduction and Overdose Prevention Work Group)	March 2019
Begin evaluating performance measures	Staff time, performance measure data	Substance Use Prevention Alliance (Harm Reduction and Overdose Prevention Work Group)	May 2020

Evaluation & Sustainability

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of conducting community overdose education through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

Sustainability Plan:

The following is our sustainability plan for community overdose education:

- Sustainability Components:
  - This is a low-cost program, as the training packet has no cost. Minimal costs will be incurred when printing copies.
  - Tracking performance measures will demonstrate program value to potential funders.
  - The Substance Use Prevention Alliance is comprised of champions who are dedicated to promoting and providing overdose education.

PM	SU	Number of individuals receiving overdose prevention training	2019	217	–	↘ 1	-17% ↓
PM	SU	Number of overdose prevention training sessions held	2019	20	–	↗ 1	18% ↑

P SU Coordinate presentations by first responders and harm reduction staff for the Substance Use Prevention Alliance.

Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

What Is It?

Conducting presentations by first responders and harm reduction staff was identified by the Substance Use Prevention Alliance (SUPA) as an action that, when combined with other actions in our community, has a reasonable chance of making a difference in unintentional medication and drug overdose in our community. This is a new program in our community.

2019 Update:

Formal presentations were not conducted in 2019, as the overdose prevention and harm reduction work group continued to finalize its action plan and build capacity. In early 2020, the NC Harm Reduction Coalition provided a presentation to SUPA members. The presentation focused on the comprehensive, solution-focused response to concerns about syringe litter.

Partners

The partners for the educational presentations include:

Agency	Person	Role
Haywood County Sheriff's Office	Lindsay Regner	Partner
Haywood County Emergency Medical Services	Greg Shuping	Partner
Substance Use Prevention Alliance (Overdose Prevention and Harm Reduction Work Group)	Overdose Prevention Work Group Members	Lead
NC Harm Reduction Coalition	Gariann Yochym	Partner

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Contact Haywood County Sheriff's Office (HCSO) to schedule date	Potential dates; meeting space	Lindsay Regner	October 2019
Host presentation by HCSO	Meeting space; staff time	Overdose Prevention and Harm Reduction Work Group Members	January 2020
Evaluate presentation by HCSO	Meeting space; staff time; evaluation forms	SUPA members	January 2020
Contact NC Harm Reduction Coalition (NCHRC) to schedule date	Potential dates; meeting space	Gariann Yochym	October 2019
		Overdose Prevention and Harm	

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Hold presentation by NCHRC	Meeting space; staff time	Overdose Prevention and Harm Reduction Work Group Members	March 2020
Evaluate presentation by NCHRC	Meeting space; staff time; evaluation forms	SUPA members	March 2020
Collect numbers for performance measures and determine next steps	Meeting space; staff time	SUPA members	June 2020

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of harm reduction and first responder presentations through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above. We will track the number of individuals who receive education. The impact of this education will also be assessed following written evaluations after each presentation.

Sustainability Plan:

The following is our sustainability plan for presentations by harm reduction staff and first responders:

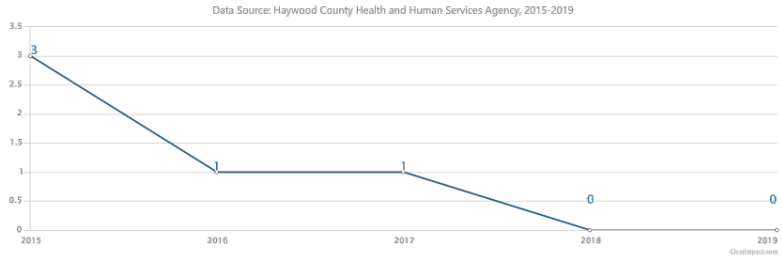
- Sustainability Component:
  - The NC Harm Reduction Coalition (NCHRC) is a long-time partner that provides statewide assistance.
  - Harm Reduction practices, such as Naloxone administration and syringe disposal boxes, are used by first responders as an ongoing practice.
  - NCHRC and Haywood County Health and Human Services both continue to pursue ongoing funding to support harm reduction practices. Existing funding includes a grant focused on post-overdose support and hepatitis testing and treatment.
  - The NCHRC has a strong working relationship with the Haywood Regional Medical Center emergency department, allowing post-overdose referrals to be received.
  - NCHRC has spoken on numerous occasions to the Board of County Commissioners, who has expressed support for the work being done.

PM SU	Number of community partners who receive education about harm reduction practices	2020	18	–	→ 0	0% →
PM SU	Number of community partners who received education about post-overdose response	–	–	–	–	–

Perinatal and Early Child Health - Plan in Development

R Perinatal/ECH 2) Perinatal and Early Child Health

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
I	Number of child deaths related to unsafe sleep conditions.	2019	0	–	→ 1	-67% ↓
		2018	0	–	↘ 1	-67% ↓
		2017	1	–	→ 1	-67% ↓
		2016	1	–	↘ 1	-67% ↓
		2015	3	–	→ 0	0% →



		Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
P	Promote safe sleep in home and child care.					

What Is It?

Promoting safe sleep for young children was identified by Great by Eight as an action that, when combined with other actions in our community, has a reasonable chance of making a difference in the number of infant deaths in our community. This is an ongoing program in our community.

Currently, Haywood County Health and Human Services Agency (HHSA) provides pack and plays to families who cannot afford a safe sleep space for infants. Sleep sacks are also provided.

The priority population/customers for safe sleep are families with young children, and promoting safe sleep aims to make a difference at the individual and community levels. Implementation will take place in clinical settings, thereby impacting safety in homes and child care facilities.

This strategy addresses health disparities by reducing the likelihood of infant death in families with limited resources.

2019 Update:

Public health and social work staff from Haywood County Health and Human Services Agency (HHSA) continued providing safe sleep materials to families with an identified need. Local pediatricians have been informed of these resources and are able to refer families to the HHSA. This program began in late 2016.

Partners

The partners for promoting safe sleep include:

Agency	Person	Role
Haywood Regional Medical Center	Rod Harkleroad	Collaborate
Haywood Pediatrics	Kasey Valentine	Collaborate
Mountain Pediatric Group	Garret Nieswonger	Collaborate
Haywood Healthcare Foundation	Marge Stiles	Support
Kiwanis Club of Waynesville	Kiwanis Club Officers	Support
Haywood County Health and Human Services Agency	Patrick Johnson	Lead
Great by Eight Early Childhood Group	Murat Yazan	Support

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Track annual distribution of pack and plays	Staff time	Haywood County Health and Human Services Agency/Patrick Johnson	January 2020 and 2021
Monitor supplies and pursue ongoing funding	Staff time	HHSA/Patrick Johnson	Ongoing

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of promoting safe sleep through the use of Results-Based AccountabilityTM to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

Sustainability Plan:

The following is our sustainability plan for promoting safe sleep in home and child care:

- Sustainability Components:
  - The number of pack and plays provided to families will tracked and used to demonstrate need to funders and other stakeholders.
  - The number of child deaths related to unsafe sleep will be tracked and used to demonstrate need to funders and stakeholders.

PM	Number of pack and plays provided to families	2019	27	–	↗ 3	575% ↑

P Pursue a best practices clinic for pregnant women with Substance Use Disorder.

Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

What Is It?

A best practices clinic for pregnant women with Substance Use Disorder (SUD) was identified by the Perinatal Substance Use Collaborative as an action, that when combined with other actions in our community, has a reasonable chance of making a difference in perinatal substance use in our community. This is a new program in our community.

The priority population/customers for the best practices clinic are pregant women with SUD, and the clinic aims to make a difference at the individual and environmental levels. Implementation will take place in a clinical setting.

2019 Update:

The Perinatal Substance Use Collaborative began discussing the possibility of bringing a Project CARA satellite clinic to Haywood County. Project CARA serves pregnant women with SUD in the westernmost counties. The clinic will be a satellite location to serve Haywood County residents. The Project CARA site is 30 minutes away, which is challenging for women without adequate transportation.

Partners

The partners for the best practices clinic for women with Substance Use Disorder include:

Agency	Person	Role
Perinatal Substance Exposure Collaborative	Collaborative Members	Collaborate; Represent Target Population
Project CARA	MAHEC Maternal-Fetal Medicine Specialists	Lead

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of best practices clinic for pregnant women with Substance Use Disorder (SUD) through the use of Results-Based AccountabilityTM to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. [The Performance Accountability Worksheet is a guide to program performance monitoring and improvement efforts. It will help you in clarifying program customers, developing performance measures, and identifying "headline" measures.] Our evaluation activities will be tracked in the Work Plan table, above. [Guidance: If you do not use the activity tracking table in the Work Plan section, you will need to add a written description of your plan to collect, monitor and respond to changes in your performance measures in this section.]

Sustainability Plan:

The following is our sustainability plan for a best practices clinic for women with SUD:

- Sustainability Component [insert number if applicable, e.g. 1, 2, 3]:
  - [Briefly describe how you will plan to achieve this component of your sustainability plan.]

[Guidance: Examples of sustainability plan include: using program performance measures to ensure ongoing effectiveness and demonstrate successes to funders and other key stakeholders, communicating and engaging diverse community leaders and organizations, identifying champions who strongly support the program, establishing a consistent financial base for the program, providing adequate staffing, increasing community awareness on the issue and demonstrating the value of the program to the public, etc.]

PM	Number of pregnant women served by the best practices clinic	–	–	–	–	–

P Promote NC-211 as a resource list for families.

Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

What Is It?

Promoting 2-1-1 as a resource list for families was identified by the Great by Eight early childhood group as an action that, when combined with other actions in our community, has a reasonable chance of making a difference in perinatal and early child health in our community. This is an ongoing program in our community that requires additional promotion in order to fully assist Haywood County residents. 2-1-1 is an effective program that assisted callers over 2400 times from 2015-2019.

The priority population/customers for the 2-1-1 resource list are individuals in need of resources, and the 2-1-1 resource list aims to make a difference at the individual level. Implementation will take place through a free telephone and online assistance service.

This strategy addresses health disparities by serving individuals who experience resource gaps, including physical health needs and social determinants of health.

2019 Update:

Great by Eight team members decided to better utilize and promote NC 2-1-1 instead of developing a new list.

Partners

The partners for promoting the 2-1-1 resource list include:

Agency	Person	Role
Great by Eight Early Childhood Group	Group Members	Collaborate
2-1-1 Asheville Call Center	Amanda Bauman	Lead

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of the 2-1-1 resource list through the use of Results-Based AccountabilityTM to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures.

Sustainability Plan:

The following is our sustainability plan for promoting the 2-1-1 resource list:

- Sustainability Components:
  - NC 2-1-1 is a free resource and promotion of it will have little or no cost.
  - The number of calls from Haywood County residents are continuously tracked by United Way. Haywood County Health and Human Services Agency will request numbers from United Way in order to demonstrate program need to stakeholders.

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
PM	Number of NC 2-1-1 calls received	2019	650	–	↗ 3	46% ↑

Chronic Disease Prevention- Long-Term CHIP

R CD 3) Helping Haywood residents live well and live long by promoting physical activity, healthy eating, and quality healthcare.

Why It Matters?

Why It Matters?

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of early death, coronary heart disease, stroke, high blood pressure, type 2 diabetes, breast and colon cancer, falls, and depression. Among children and adolescents, physical activity can improve bone health, improve cardio-respiratory and muscular fitness, decrease levels of body fat, and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Factors **positively** associated with adult physical activity include post-secondary education, higher income, enjoyment of exercise, expectation of benefits, belief in ability to exercise (self-efficacy), history of activity in adulthood, social support from peers, family, or spouse, access to and satisfaction with facilities, enjoyable scenery, and safe neighborhoods. Factors **negatively** associated with adult physical activity include advancing age, low income, lack of time, low motivation, rural residency, perception of great effort needed for exercise, overweight or obesity, perception of poor health, and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs (DHHS, 2010)

In addition, strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including overweight and obesity, malnutrition, iron-deficiency anemia, heart disease, high blood pressure, dyslipidemia (poor lipid profiles), type 2 diabetes, osteoporosis, oral disease, constipation, diverticular disease, and some cancers. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, work-sites, healthcare organizations, and communities.

Social factors thought to influence diet include knowledge and attitudes, skills, social support, societal and cultural norms, food and agricultural policies, food assistance program, and economic price systems. The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home. Marketing also influences people's—particularly children's—food choices (DHHS, 2010).

Over one-half of key informants (community or business leaders, physicians, other health providers, public health representatives and social service providers) ranked nutrition, physical activity and weight as a major issue. They also shared comments such as: ''We have populations that are not able to afford fresh produce and barely make enough to cover their food costs for the month. Need to work on properly educating the public on malnutrition and ensuring they know how to access, afford, and utilize healthy foods.'' Specific populations as risk include African American and Hispanic individuals, as well as individuals experiencing poverty (WNC Health Network-WNCHN, 2018).

Health indicators in our County show the following trend:

- Only 30% of respondents reported obtaining leisure-time physical activity in the past month. This was an increase from 24% in 2015 (WNC Health Network-WNCHN, 2018).
- Nearly 13% of adults reported receiving a diagnosis of pre-diabetes, a slight increase from 2015 (WNC Health Network-WNCHN, 2018).
- Fewer adults reported taking action to control high blood pressure: 93.3% in 2015 vs 92% in 2018 (WNC Health Network-WNCHN, 2018).

Alignment

Chronic disease prevention and the related result ''helping Haywood residents live well and live long by promoting physical activity, healthy eating and quality healthcare'' are aligned with the following Healthy NC 2020 Focus Areas/ Objectives.

Physical Activity and Nutrition/Chronic Disease

- Increase the percentage of high school students who are neither overweight nor obese.
- Increase the percentage of adults who report they consume fruits and vegetables five or more times per day.
- Increase the percentage of adults getting the recommended amount of physical activity.
- Reduce the cardiovascular disease mortality rate.
- Decrease the percentage of adults with diabetes.

Experience and Importance

How would we experience ''helping Haywood residents live well and live long by promoting physical activity, healthy eating and quality healthcare'' in our community?

Following the completion of the 2018 Haywood County Community Health Assessment (CHA), the Wellness Action Group (WAG) completed ''Getting to Strategies.'' This is a road map for health priority work groups. The WAG discussed answers to the following questions:

- What are the overall quality of life conditions (results) we want for the people who live in our community?
- What would these conditions (results) look like if we could see them?
- How can we measure these conditions?
- How are we doing on the most important of these measures?
- Who are the partners with a role to play?
- What works to do better?
- What do we propose to do?

Quality of Life Conditions (results):

- Healthy, active, engaged and happy people who are thriving and working to build better lives and a better community
- We embrace the vibrant potential of this area
- Inclusivity and accessibility for working community members, which helps the whole
- Programs are available with no strings attached
- Awareness of a healthy diet and sharing information with all
- People are more empowered to live to be healthy; a greater ability to maintain a healthy diet
- Awareness of available opportunities
- Healthier food environment: healthier restaurants and less fast food
- Improved accessibility for healthy diet and food security
- A safe community
- Everyone can access good health

Clinical Factors

- Medicaid expansion and health care for all
- Focus on prevention of heart disease and diabetes
- More clinical lifestyle change programs, such as Walk with a Doc, including better promotion and referrals

Health Behaviors

- More accessible and free fitness programs: e.g. Girls on the Run (scholarships available), Active Routes to School and gyms; evening and weekend options available. These programs may include a revised Healthy Haywood Fitness Challenge and community walking groups.
- Improved promotion and marketing of existing opportunities and resources
- Improved education about healthy habits: offer nutrition education through social media and educate others about nutrition literacy (reading labels and understanding ingredients)
- People take advantage of programs like Double Up Food Bucks and MANNA produce distribution.
- Culturally appropriate recipe modifications and Meatless Mondays
- Improved education and awareness of nutritious foods, including how to shop and eat cheaply
- Heart disease prevention programs
- Fewer cases of illness and death from preventable chronic disease
- Lower obesity rates, including among children

- Lower obesity rates, including among children

Social and Economic Factors

- Improved food security; Fruit and veggie access without restriction
  - Existing programs include: Double Up Food Bucks, Haywood Gleaners, SNAP, WIC, Cooperative Extension
- Improved partnering and delivery of food
- Cooking education is available
- Potential pickup and delivery/distribution of restaurant food
- Programs raising funds to support other programs
- Healthier workplaces
- More intergenerational interaction and community support, such as seniors engaged in youth programs
- Less crime
- Better paying and living wage jobs

Physical Environment

- Improved access to recreation and physical activity, including group fitness opportunities
- Plenty of sidewalks and other walkable spaces
- Story walk expansion (involves family, physical activity, literacy).
- Gardens at all schools and pre-kindergarten; more church gardens
- Safe, adequate, affordable housing
- Adequate, available, more convenient public transportation

Health Outcomes

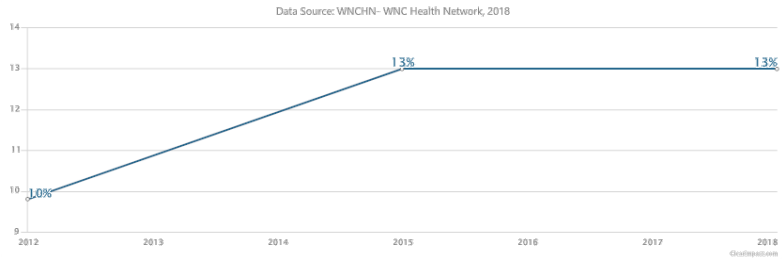
- Less preventable chronic disease
- Less death from preventable chronic disease
- Lower obesity rates/childhood obesity

What information led to the selection of this health issue and related result?

In addition to the above focus areas, the WAG discussed how Haywood County is doing on the most important of these health measures. This information was also reviewed as part of the prioritization process during the CHA. The group discussed the percentages of individuals who:

- Are uninsured (adults)
- Have access to ongoing care (adults)
- Meet recommended physical activity levels (adults)
- Have not had any leisure-time activity in the past month (adults)
- Are limited in activities (primarily due to back/neck or mental health/depression problems) (adults)
- Who eat the recommended amounts of fruits and vegetables (adults)
- Use tobacco (cigarettes, smokeless and vaping) (adults)
- Are food insecure (adults)
- Receive free and reduced lunch (children)
- Usually get the support they need (adults)
- Also discussed was the average gross weekly wage, which is far below the state average

CD Percentage of adults diagnosed with pre-diabetes



2018	13%	–	→ 1	33%	↑
2015	13%	–	↗ 1	33%	↑
2012	10%	–	→ 0	0%	→

Story Behind the Indicator

The "Story Behind the Curve" helps us understand why the data on the adult pre-diabetes rate is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? *These are the positive forces at work in our community and beyond that influence this issue in our community*.

- Health care providers refer individuals to nutrition counseling and Diabetes Prevention Program (DPP) classes.
  - Nutrition services are available at Blue Ridge Health and Haywood Regional Medical Center.
- Grant funding to Haywood County HHSA administered by NC State University provides free DPP classes.
- Physical activity is supported by free use of school tracks and playgrounds when activities are not scheduled.

What's Hurting? *These are the negative forces at work in our community and beyond that influence this issue in our community*.

- Fewer than four percent of adults consume at least five servings of fruits or vegetables per day (WNC Health Network-WNCHN,2018).
- Transportation is a barrier for many residents. While public transportation exists and is making great strides, it is only available during the day and not on weekends.
- Fewer than 1/5 of adults meet the recommendations for daily physical activity (WNC Health Network-WNCHN, 2018).
- Only 34% of adults report having a healthy weight (WNC Health Network-WNCHN, 2018).

Partners With A Role To Play

The partners for the National Diabetes Prevention Program include:

Agency	Person	Role
Haywood County Health and Human Services Agency	Lauren Wood, Megan Hauser	Lead
Blue Ridge Health	Health Care Providers	Support
Haywood Regional Medical Center	Health Care Providers	Support
Midway Medical Center	Health Care Providers	Support
NC State University	Corinne Goudreau	Grant administration
MountainWise Public Health Partnership	Shaina Clark	Support

Strategies Considered & Process

The following actions have been identified by our Wellness Action Group and community members as ideas for what can work for our community to make a difference on pre-diabetes.

Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on pre-diabetes.*

- Expansion of the Diabetes Prevention Program (DPP) through grant funding

- Additional referrals to the DPP from health care providers
- Community gardens

What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on pre-diabetes.*

- Referrals from health care providers to the DPP
- Double Up Food Bucks, a bonus dollars program for Supplemental Nutrition Assistance Program (SNAP) recipients.
- A greenway system that spans nearly five miles
- A healthcare foundation that funds initiatives to address unmet health needs in the county.

Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on pre-diabetes.*

Name of Strategy Reviewed	Level of Intervention
National Diabetes Prevention Program	Individual, Organizational
Medical Nutrition Therapy	Individual, Organizational
Interventions Engaging Community Health Workers	Individual, Organizational

What Community Members Most Affected by pre-diabetes Say *These are the actions and approaches recommended by members of our community who are most affected by pre-diabetes*

- More free and low-cost fitness opportunities
- Support and promote food security initiatives
- Support Medicaid expansion

The following actions have been identified by our Haywood County Health and Human Services Agency (HHSA) as ideas for what can work for this performance measure to make a difference on the percentage of adults with pre-diabetes.

Actions and Approaches Identified by the HHSA *These are actions and approaches that we think can make a difference for this performance measure.*

- Expansion of the DPP through grant funding
- Becoming a Medicare DPP supplier.
- Health care provider referrals
- Community gardens

No-cost and Low-cost Ideas Identified by the HHSA *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure*.

- Health care provider referrals to the DPP
- Improved promotion of existing resources and opportunities
- Promote active transportation through policy change and by providing resources through the Healthy Communities program

What communities served/customers think would work to do better *These are actions and approaches that our communities served/customers think can make a difference for this performance measure*.

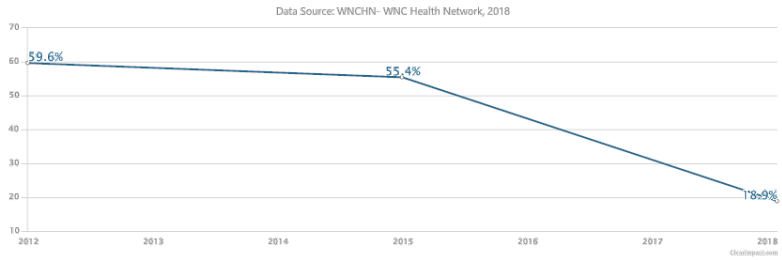
- Expanded public transportation
- Improved delivery and accessibility for food resources- assistance available during evenings and weekends
- Improved education about nutrition and other healthy habits using formats like social media

Process for Selecting Priority Strategies

The Wellness Action Group (WAG) discussed the data indicators they felt could be impacted within the three-year Community Health Assessment cycle. From this, the group discussed programs to address the data indicators of greatest concern. Programs were reviewed and chosen based on resource availability, community acknowledgement of needs and programs' merits to positively influence indicator outcomes. Programs were selected that could be realistically implemented within a three-year period. The programs align with the mission statement for the WAG and support the third health priority identified by the CHA. Specific actions were determined that could be achieved for each data indicator. Specific programs were identified that will be implemented to reduce negative outcomes for each data indicator. Each program addresses some of the more well-known and researched root causes of Type 2 Diabetes. For instance, the 5-7% weight loss encouraged by the DPP is enough to prevent or delay Type 2 Diabetes. A community fitness challenge will assist residents in reaching 150 minutes of moderate activity weekly, the current federal guideline.

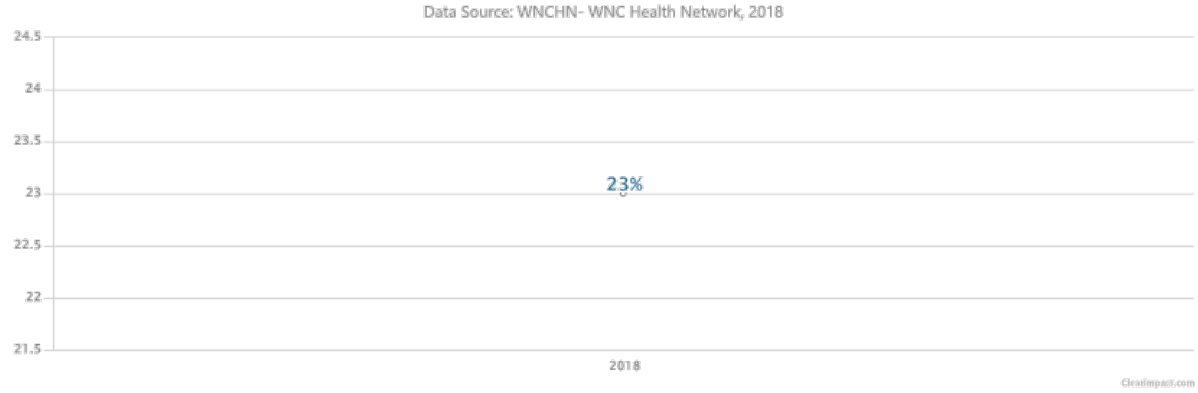
I CD Percentage of adults meeting physical activity recommendations in Haywood County

2018	18.9%	–	↘ 2	-68% ↓
2015	55.4%	–	↘ 1	-7% ↓
2012	59.6%	–	→ 0	0% →



I CD Percentage of adults experiencing food insecurity

2018	23%	–	→ 0	0% →



P CD Implement a community wellness challenge, Haywood 4 Good.

Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

What Is It?

Organizing a community wellness challenge was identified by the Wellness Action Group (WAG) as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in adult physical activity rates in our community. The program has been piloted in neighboring counties, including Swain County, whose program has received Institutional Review Board approval. This is a new program in our community.

The priority population/customers for the community wellness challenge are physically inactive adults in Haywood County, and the wellness challenge aims to make a difference at the individual level. Implementation will take place in wellness-related settings such as parks, trails, neighborhoods, homes, and at community events and organizations.

2019 Update:

WAG membership unanimously approved providing a comprehensive wellness program to the community. This initiative was collaboratively named Haywood 4 Good. Haywood County Health and Human Services Agency, in partnership with MountainWise, began preparing a logo, marketing materials, program guide, and calendar of activities. MountainWise presented to the WAG about the program and its implementation in neighboring counties. A meeting was held with the Haywood Regional Medical Center (HRMC) CEO, who expressed support for the initiative. In early 2020, an application for sponsorship was submitted to HRMC and a financial committment was made by Blue Cross and Blue Shield of North Carolina. MountainWise has committed to providing staff time and funds for the wellness challenge. The program will be implemented in spring 2020.

Partners

The partners for the community wellness challenge include:

Agency	Person	Role
Haywood County Health and Human Services Agency	Lauren Wood/Megan Hauser	Lead
Wellness Action Group	Team Members	Lead, Support
Town of Canton	Recreation Department	Support
Town of Clyde	Joy Garland	Support
Town of Maggie Valley	Town Staff	Support
Waynesville Parks and Recreation	Rhett Langston	Support

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Coordinate presentation to the Wellness Action Group by the WNC Get Fit Challenge	Guest speaker	Haywood Health and Human Services/Megan Hauser	September 2019
Develop implementation plan for the wellness challenge	Information from partners who have implemented the program; information about available funds; staff time	Wellness Action Group/Team Members	March 2020
Create marketing materials	Graphic designer; funding; staff time	Formation Public Resources/Derek Stipe	July 2020
Create website	Web designer; funding; staff time	Haywood Health and Human Services/Public Health Education Specialist	July 2020
Distribute marketing materials	Staff time; print copies; digital images	Wellness Action Group/Team Members	August 2020
Enroll participants	Funding; Challenge Runner account	Haywood Health and Human Services/Public Health Education Specialist	September 2020
Hold structured events (walk/hike) during the challenge	Staff and volunteers to coordinate and lead	Wellness Action Group/Team Members	September/October 2020
Secure and distribute prizes	Prizes, funding	Wellness Action Group/Team Members	November 2020
Evaluate challenge numbers and participant feedback	Survey Monkey	Wellness Action Group/Team Members	December 2020

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of the community wellness challenge through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

Sustainability Plan:

The following is our sustainability plan for the community wellness challenge:

- Sustainability Components
  - Participant numbers, health improvements, and feedback will be evaluated. This information will be used to determine the future of the program and justify necessary funding to stakeholders.
  - The challenge is not a typical nutrition or weight loss program, but will instead have a comprehensive focus of physical, spiritual, emotional, and community wellness. Unlike previous programs, the wellness challenge will not focus on gym membership or have a cost, increasing the likelihood that participants will continue healthy habits over time. These features will allow us to engage a more diverse group of community members.
  - Haywood County Health and Human Services Agency (HHSA) has a history of conducting a community fitness challenge and has strong support from community partners. The HHSA is committed to providing staff time for this program.

PM CD Number of registered participants in the community wellness program

Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
–	–	–	–	–

P CD Develop a comprehensive food resource guide for Haywood County.

What Is It?

Developing a comprehensive food resource guide was identified by the Wellness Action Group (WAG) as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in food insecurity in our community. This is a new program in our community.

The priority population/customers for the food resource guide are individuals experiencing food insecurity and the community programs that serve them, and the food resource guide aims to make a difference at the individual level. Implementation, which focuses on distribution of this guide, will take place in food pantry, public health, medical and non-profit settings.

This strategy addresses health disparities by offering a tool to the nearly 1/5 of adults in Haywood County experiencing food insecurity (WNC Health Network-WNCHN, 2018).

2019 Update:

A food resource guide and flyer were developed. The guide was designed to help organizations direct clients to community resources. The flyer, brief and colorful, is ideal for sharing with the greater community. These items were launched at a MANNA food bank pop-up market and food resource fair in November 2019. The food agencies featured on the guide held a food resource fair in conjunction with the food distribution event. WAG members have actively shared this information and continue to do so.

Partners

The partners for developing a comprehensive food resource guide include:

Agency	Person	Role
Haywood County Health and Human Services Agency	Lauren Wood	Lead
Mountain Projects	Vicky Gribble	Lead
Wellness Action Group	Group Members	Collaborate

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Develop draft of guide	Information about local food resources, staff time	Mountain Projects/Vicky Gribble	August 2019
Review guide at a Wellness Action Group meeting	Team members	Wellness Action Group team members	September 2019
Finalize guide	Team members	Mountain Projects/Vicky Gribble	October 2019
Select budget-friendly nutrition literature to support guide	Team members; nutrition resources	Wellness Action Group team members	January 2020
Distribute guides to individuals and community organizations	Team members; printed copies	Wellness Action Group team members	December 2020

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Maintain performance measure data (count of the number programs included in guide)	Team members	Wellness Action Group team members	December 2020

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of the comprehensive food resource guide through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above. We will maintain a count of the number of resource guides distributed.

Sustainability Plan:

The following is our sustainability plan for the comprehensive food resource guide:

- Sustainability Component:
  - Following program implementation, the Wellness Action Group will continue to revise and distribute this guide. This group includes strong champions who oversee the maintenance of this guide.
  - This is a low-cost program, which involves minimal printing costs. As appropriate, additional funding will be sought to assist with the continuation of this program.
  - We will continue to track food insecurity data in our county to demonstrate the need for this intervention.
  - The guide is suited for distribution to a diverse group of partners, including food pantries, soup kitchens, medical providers and social services providers.

PM CD Number of community programs included in guide — Jan 2020 | 31 | – | → 0 | 0% →

P CD Offer National Diabetes Prevention Program classes.

Time Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change

What Is It?

The National Diabetes Prevention Program (DPP) was identified as an action that, when combined with other actions in our community, has a reasonable chance of making a difference in the adult pre-diabetes rate our community. This is an ongoing program in our community, which began in the spring of 2016. Thanks to a grant administered by NC State University, this one-year program is now offered at no cost and provides fitness and nutrition-related incentives. The program also provides gas cards and child care if participants identify these as barriers.

The audience for the DPP are individuals in Haywood County at risk for developing type 2 diabetes with a priority placed on vulnerable populations, such as African Americans, American Indians, and the less educated and lower-income generating populations. The program aims to make a difference at the individual/interpersonal behavior level. This CDC-developed lifestyle change program has been proven effective in preventing or delaying the onset of type 2 diabetes. Implementation will continue to take place at the local health department.

This strategy addresses health disparities. According to Healthy North Carolina 2020*,

- African Americans are nearly twice as likely to have diabetes, compared with whites (15.6% versus 8.4% in 2009).
- Compared with whites, American Indians are more likely to have diabetes (11.7% versus 8.4% in 2009).
- Individuals with less education and with lower incomes are also more likely to have diabetes (2009).

* Source: North Carolina Institute of Medicine. *Healthy North Carolina 2020: A Better State of Health.* Morrisville, NC: North Carolina Institute of Medicine; 2011.

2019 Update:

In February 2019, Haywood County Health and Human Services Agency (HHSA) began a DPP class with that concluded in February 2020 and had a 50% retention rate. In May 2019, HHSA graduated a class with a retention rate of 85%. In September 2019, HHSA began a class supported through grant funds, which has a retention rate of 60% (HHSA, 2019-2020). Data from the May 2019 class helped the HHSA to obtain full CDC recognition for DPP. HHSA is now eligible to pursue billing Medicare for the program.

Partners

The partners for the National Diabetes Prevention Program include:

Agency	Person	Role
Haywood County Health and Human Services Agency	Lauren Wood, Megan Hauser	Lead
Blue Ridge Health	Health Care Providers	Support
Haywood Regional Medical Center	Health Care Providers	Support
Midway Medical Center	Health Care Providers	Support
NC State University	Corinne Goudreau	Grant administration
MountainWise Public Health Partnership	Shaina Clark	Support

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Promotion to doctors' offices	Program flyers; referral forms; provider handouts; staff time	Haywood Health and Human Services Agency/ Jeanine Harris, Lauren Wood, and Megan Hauser	March 2020
Promotion to general public	Newspaper article; printed flyers; staff time	Haywood Health and Human Services Agency/ Jeanine Harris, Lauren Wood, and Megan Hauser	March 2020
Bi-annual data reporting and evaluation of performance measures	NC Lifestyle Change Database; reporting templates from NC State University grant administrators; CDC evaluators; HHSA staff time; payment for Lifestyle Change Database subscription; performance measure data	Haywood Health and Human Services Agency/ Lauren Wood and Megan Hauser	November 2019, May 2020 (every November and May)

PM	CD	Number of participants enrolled in the 12-month Diabetes Prevention Program	2019	17	–	↗	1	31% ↑
PM	CD	Percentage of Diabetes Prevention Program participants achieving at least 5-7% weight loss	2019	41	–	→	0	0% →
PM	CD	Percentage of Diabetes Prevention Program participants reporting 150 minutes or more of weekly activity	2019	71	–	→	0	0% →