2011 Forsyth County Community Health Action Plans

For more information to get involved with the Forsyth County Healthy Community Coalition and the different Health Action Teams, visit our website: http://www.healthycommunity.ws

Forsyth County Department of Public Health

Report of the Epidemiology & Health Surveillance Division
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Forsyth County Community Health Action Plan 2011

Designed to address Community Health Assessment priorities

County: Forsyth **Partnership**: Healthy Community Coalition **Period Covered:** 2012 - 2015

LOCAL PRIORITY ISSUE

- Priority issue: Forsyth County Breastfeeding Initiative
- Was this issue identified as a priority in your county's most recent CHA? _X_ Yes __ No

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

- By (year): **2014**
- Objective: Reduce Forsyth County infant mortality rate from 7.7 to 7.0 (infant deaths per 1,000 live births) by 2015
- Original Baseline**:** 7.7 (infant deaths per 1,000 live births)
- Date and source of original baseline data: 2010 data / NC State Center for Health Statistics

POPULATION(S)

- Describe the local population(s) experiencing disparities related to this local community objective: Non-Hispanic African American infants.
- Total number of persons in the local disparity population(s): 1,346 Non-Hispanic African American births (2010)
- Number you plan to reach with the interventions in this action plan: 50% (673) Non-Hispanic African American infants.

HEALTHY NC 2020 FOCUS AREA ADDRESSED

__ Tobacco Use
__ Physical Activity and Nutrition
__ Substance Abuse
__ STDs/Unintended Pregnancy
__ Environmental Health
__ Social Determinants of Health (Poverty, Education, Housing)
_X_ Maternal and Infant Health
__ Injury
__ Mental Health
__ Oral Health
__ Infectious Diseases/ Food-Borne Illness
__ Chronic Disease (Diabetes, Colorectal Cancer, Cardiovascular Disease)
__ Cross-cutting (Life Expectancy, Uninsured, Adult Obesity)

- Check **one** Healthy NC 2020 focus area: (Which objective below most closely aligns with your local community objective?)
- **List HEALTHY NC 2020 Objective**: (Detailed information can be found at http://publichealth.nc.gov/hnc2020/ website)
- Objective 2: Reduce the Infant Mortality rate (per 1,000 live births from 8.2 (2008) to 6.3 by 2020.

RESEARCH RE. WHAT HAS WORKED ELSEWHERE*

List the 3-5 evidence-based interventions (proven to effectively address this priority issue) that seem the most suitable for your community and/or target group. **Training and information are available from DPH. Contact your regional consultant about how to access them.*

Intervention	Describe the evidence of effectiveness (type of evaluation, outcomes)	Source
Action 7 – Ensure that maternity care practices throughout the United States are fully supportive of breastfeeding – Hospitals work towards Baby-Friendly designation Action 9 – Provide education and training in breastfeeding for all health professionals who care for women and children. Action 11 – Ensure access to services provided by International Board Certified Lactation Consultants Action 14 – Ensure that employers establish and maintain comprehensive, high-quality lactation support programs for their employees Action 17 – Ensure that all child care providers accommodate the needs of breastfeeding mothers and infants	Recommended – Promising	http://www.surgeongeneral.gov/library/calls/breastfeeding/index.html The Surgeon General's Call to Action to Support Breastfeeding – 2011 – USDHHS
The Friendship Project (transportation)	Social support for women during pregnancy improves birth outcomes and is supported by NC Healthy Start	http://www.nchealthystart.org/public/friendship/index.htm#what
Baby Friendly Hospital Initiative – 10 Steps to Successful Breastfeeding (BFHI)	Educating hospital staff through a 3-day training program has been shown to enhance compliance with optimal maternity care practices and increase rates of breastfeeding – Birth facilities that have achieved BFHI designation typically experience an increase in breastfeeding rates.[6]	http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf Kramer MS, Chalmers B, Hodnett ED, et al. Promotion of Breastfeeding Intervention Trial (PROBIT): a randomized trial in the republic of Belarus. JAMA (Journal of the American Medical Association) 2001;285(4):413–20. Cattaneo A, Buzzetti R. Effect on rates of breastfeeding of training for the Baby Friendly Hospital Initiative. BMJ (British Medical Journal) 2001;323(7325):1358–62.
Peer Counseling - WIC has launched a national initiative to institutionalize **peer counseling** as a core service. This is replicated through a number of programs and models	In a systematic review to evaluate interventions that promote breastfeeding initiation, Fairbank et al. found peer support programs to be effective by themselves in increasing the initiation and duration of breastfeeding.	http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf Fairbank L, O'Meara S, Renfrew MJ, Woolridge M, Snowden AJ, Lister-Sharp D. A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. Health Technology Assessment 2000;4(25):1–171. McLorg PA, Bryant CA. Influence of social network members and health care professionals on infant feeding practices of economically disadvantaged mothers. Medical Anthropology 1989;10(4):265–78.

The Business Case for Breastfeeding- The U.S. Health Resources and Services administration Maternal and Child Health Bureau has launched a national workplace initiative that includes developing a resource kit for employers. The Business Case for Breastfeeding, developed to address barriers and the educational needs of employers, includes materials for upper management, human resource managers, and others involved in implementing on-site programs for lactation support. Also included is a tool kit with reproducible templates that can be adapted to the work setting. An outreach marketing guide helps local breastfeeding advocates and health professionals effectively reach out to employers.	Cohen et al.[28] examined the effect of corporate lactation programs on breastfeeding behavior among employed women in California. These programs included prenatal classes, **perinatal** counseling, and lactation management after the return to work. About 75% of mothers in the lactation programs continued breastfeeding at least 6 months, although nationally only 10% of mothers employed full-time who initiated breast-feeding were still breastfeeding at 6 months. Participants in the Mutual of Omaha's lactation program breastfed an average of 8.26 months, although nationally only 29% of mothers were still breastfeeding at 6 months.[29] Both of these programs are promising but may represent unique populations that may not be generalizable to all working mothers.	http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf Cohen R, Mrtek MB. The impact of two corporate lactation programs on the incidence and duration of breastfeeding by employed mothers. American Journal of Health Promotion 1994;8(6):436–41.

WHAT INTERVENTIONS ARE ALREADY ADDRESSING THIS ISSUE IN YOUR COMMUNITY?

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

Intervention	Lead Agency	Progress to Date
Perinatal Quality Collaboration of North Carolina project Close to Me to increase the exclusivity of breast feeding for well newborns. **Regional Lactation Consultant Program**	Forsyth Medical Center	80+ % women initiate breastfeeding at delivery, and 30% of those breastfeed exclusively Working towards Baby Friendly Designation at Forsyth Medical Center. No longer supply baby formula to mom's at hospital discharge
LeLeche League Peer Support	Winston Salem and Kernersville LeLeche League Chapters	Provide peer support to approximately 480 nursing mothers per year (includes meetings and telephone support)
WIC Peer Counseling and Education Program (FCDPH)	Forsyth County Department of Public Health (FCDPH)-WIC	Train 150 lactation educators per year, offer breastfeeding counseling to 1500 women per year, and teach prenatal breastfeeding classes to 1800 women.
Staff training with maternity nurses at Forsyth Medical Center to increase breastfeeding exclusivity with emphasis on mom-to-baby skin to skin contact while in the hospital	Forsyth Medical Center	Trained #77 nurses in 2011 Exclusive breastfeeding rate is %30 (2012)
Regional Lactation Consultant Program supporting nursing moms at Forsyth Medical Center	Forsyth Medical Center	1.25 International Board Certified Lactation Consultants (IBCLC) for NICU and 2 Registered Dietitians who are also IBCLC (Forsyth Medical Center) 7 Lactation Consultants in Mother/Baby Unit (5.25 FTE) (Forsyth Medical Center)

WHAT RELEVANT COMMUNITY STRENGTHS AND ASSETS MIGHT HELP ADDRESS THIS PRIORITY ISSUE?

Community, neighborhood, and/or demographic group	Individual, civic group, organization, business, facility, etc. connected to this group	How this asset might help
Advocacy Groups	Exchange Scan Welcome Baby LeLeche League	• Promote breastfeeding to new parents during hospital visits to new parents • Welcome Baby could offer breastfeeding support at new mom hospital visit and provide handout in welcome packet. • LaLeche League will provide peer support groups for nursing mothers in community settings
Community Coalitions	FC Infant Mortality Reduction Coalition	• Provide outreach education on breastfeeding support to clinicians and host community workshop • Collect existing or develop new clinician tools, schedule and deliver outreach education in-service sessions
Governmental Agencies	Senior Services FC WIC Program	• Senior services may provide meeting space for breastfeeding workshops • WIC can provide lactation education program, peer support program, and prenatal

		breastfeeding classes.
Community non-profits	Imprints YMCA Worksite Wellness Program	• Promote breastfeeding and offer breastfeeding education to clients • YMCA Wellness Program will offer businesses the option of a lactation room as component of corporate wellness
Media	Newspapers, TV, Radio	• Media partners could promote breastfeeding in the media
Child Care	Day Care Centers	• Promote breastfeeding to clients – adopt better policies to support breastfeeding infants
Faith Communities	Shepherd's Center Congregational Nurse Program; Ministers Conference	• Shepherds Center congregational nurses could promote breastfeeding among church members • Ministers Conference could promote breast feeding to church members and also provide lactation rooms.
Education	Winston Salem State University Grandparents program; Smart Start of Forsyth County	• WSSU Grandparents may transport moms to NICU to breastfeed baby. • Smart Start could assist in training child care centers to promote breastfeeding to clients through a workshop for day care centers
Health Care Agencies	Downtown Health Plaza;Forsyth Medical Center; Northwest Community Care Network	• Downtown Health Plaza could promote verbal and written breastfeeding education to clients • Assist in outreach education sessions to clinicians, consultation • Forsyth Medical Center can provide women access to Lactation Consultants and work to improve breastfeeding exclusivity. Train hospital staff in lactation support • Collect existing or develop new clinician tools, assist in scheduling and delivering clinical in-service sessions • Promote breastfeeding through pregnancy case managers
Funding Agencies	United Way; March of Dimes	• Offer funding of breastfeeding initiatives • March of Dimes could provide models for interventions and potential funding
Community based organizations / Case Management Systems	FCIMRC, Smart Start, WIC, NCCN, March of Dimes, and Pregnancy Case Management	• Provide community workshop to promote breastfeeding and referrals for lactation support.

INTERVENTIONS: SETTING, & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
INTERVENTIONS SPECIFICALLY TARGETING HEALTH DISPARITIES		
Intervention: Hold Interest meeting for The Friendship Project – volunteer transportation for pregnant or nursing moms to prenatal appointments or to NICU to breastfeed Intervention: _X_ new __ ongoing __ completed Setting: Clinic / Community Start Date – End Date (09 /12 – 12/15) Level of Intervention - change in: __ Individuals _X_ Policy &/or Environment	**Lead Agency**: FCIMRC Role: Contact potential volunteers for transportation **Partners**: WIC, March of Dimes, Downtown Health Plaza, Imprints, Outreach Alliance for Babies, NCCN and various community groups. **Role**: Partners will assist in identifying key people from various community groups below who would be willing to provide transportation for pregnant or nursing mothers to potentially include: -Junior League -Lions Club -Rotary Club -Neighborhood Associations -Retired Nurses -Outreach Alliance for Babies -Newborns in Need -AARP -Hospital Volunteers - Masons Marketing of this intervention will be done via facebook, www.HelpOurBabies.org, FC County Website, and any other avenue possible.	**1. Quantify what you will do:** • Conduct one (#1) Transportation Workshop with approximately 10 agency leaders with community groups to request assistance for transporting nursing moms to breastfeed babies still in NICU. **Expected outcomes:** • This intervention will increase the number of mothers able to breastfeed while babies are in NICU who currently cannot due to lack of transportation.
Intervention: Case Management Systems Promote Breastfeeding Intervention: _X_ new __ ongoing __ completed Setting: Health Care Start Date – End Date (9/12 – 12/15): Level of Intervention - change in: __ Individuals _X_ Policy &/or Environment	The lead agency is NCCN and Pregnancy Case Managers will promote breastfeeding, offer breastfeeding support, give written education, and refer clients to WIC for lactation support if needed. **Other Partners will:** Downtown Health Plaza will encourage clients to breastfeed, offer breastfeeding support, give written education on breastfeeding, and refer clients to WIC or other source for lactation support if needed. Imprints will encourage clients to breastfeed, offer breastfeeding support through classes, give written education on breastfeeding, and provide breastfeeding support by a certified lactation educator during home visits. Welcome Baby (Exchange Scan) will continue to offer breastfeeding information to new parents at initial	**1. Quantify what you will do:** • Pregnancy Case Managers (NCCN) will reach approximately #500 (%80 African American and Hispanic) clients annually with breastfeeding information, support, and promotion through case management. • The Downtown Health Plaza will reach ~1800 clients annually with breastfeeding support and promotion. • Imprints will reach 100 clients annually with breastfeeding education, support and promotion through case management and classes. • Welcome Baby (Exchange Scan) will offer breastfeeding education, support, and promotion to #1000 families annually. **2. Expected outcomes:** • Breastfeeding will increase among childbearing women due to direct education, referral, and support; thereby creating healthier infants and reducing infant mortality.

	assessments, but will also supply a handout on the benefits of breastfeeding in the new parent package. **Marketing** will be through partnership email list serves, networks, www.HelpOurBabies.org, FC County Website, agency newsletters, and any other avenue possible.	
POLICY OR ENVIRONMENTAL CHANGE INTERVENTIONS		
Intervention: Outreach Education on breastfeeding to community agencies and daycares working with pregnant or parenting families Intervention: _X_ new __ ongoing __ completed Setting: Community Start Date – End Date: (9/12 – 12/15)	**Lead agency - Workshop #1** Smart Start will pull together daycare centers to offer workshop on supporting women who are breastfeeding **Partners:** FCIMRC, WIC, March of Dimes, FCDPH, and NCCN will assist in planning, hosting, and marketing the workshop for day care staff. **Lead Agency – Workshop #2** FCIMRC will work with Chamber of Commerce to host a workshop to promote breastfeeding support for women in the workplace – using "*Making the Business Case for Breastfeeding"* **Partners:** , March of Dimes, WIC, NCCN, YMCA and FCDPH will co-host a community conference to educate key agencies working with pregnant or parenting families on the importance of breastfeeding **Marketing** of this intervention will occur via facebook, partnership email listserves, www.HelpOurBabies.org, FC County Website, and any other avenue possible.	**1. Quantify what you will do:** • Community workshop on the public health benefit of breastfeeding to reduce infant mortality will be held for day care centers. • Workshop will be held for businesses to promote the health benefit of breastfeeding to reduce infant mortality **2. Expected outcomes:** • This workshops will educate key staff as to how they can support and promote breastfeeding in the **work place** and **day care setting. (Action 14 and 16 of Surgeon General Call to Action)**
Intervention: Outreach education to maternity care clinicians Intervention: _X__ new ___ ongoing ___ completed Setting: Health Care Start Date – End Date (09 /12 - 12/15)	**Lead Agency**: FCIMRC will collect existing or develop new tools to provide inservices and outreach education to clinicians working with mothers and infants to emphasize the importance of supporting breastfeeding as a standard of care **Partners**: NCCN will encourage clinicians to participate in outreach education. WIC and Forsyth Medical Center will consult on this project **Marketing** of this intervention will occur via facebook, partnership email listserves, www.HelpOurBabies.org, FC County Website, and any other avenue possible.	**1. Quantify what you will do:** • Outreach education for clinicians to provide training and technical support to enable them to offer breastfeeding support and counseling as routine standard of care in their health care practices. (Train the trainer to impact medical office protocol to recommend breastfeeding to all clients) **2. Expected outcomes:** • Identification of best practices and optimal care models has not been developed. Strategy to be used has worked locally in two previous interventions conducted by Forsyth County Infant Mortality Reduction Coalition and Northwest Community Care Network to impact clinical protocol for systems change.

Forsyth County Community Health Action Plan 2011

Designed to address Community Health Assessment priorities

County: Forsyth County **Partnership:** Healthy Community Coalition **Period Covered:** 2012-2015

LOCAL PRIORITY ISSUE

- Priority issue: Chronic Disease Management
- Was this issue identified as a priority in your county's most recent CHA? X Yes __ No

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

- By: December 2015
- Objective 1: To increase community awareness resources and services available for improved chronic disease management; Objective 2: To reduce the number of hospital readmissions within 30 days on discharge by 5% and improved access to support services by providing outreach and networking with 4 community agencies and/or hospitals
- Original Baseline:
  - Cancer, Heart Disease/High Blood Pressure, Diabetes and Weight Management/ Eating habits were the most frequently health topics/diseases that respondents wanted to learn about-*2011 Community Health Opinion Survey*
  - July 2008-June 2011-Pneumonia Readmission Rates: 23.7% @ Wake Forest Baptist Hospital; 17.9% @ Forsyth Medical Center- *NC Center for Hospital Quality and Patient Safety*
  - The most often mentioned major health-related problems stakeholders perceived in Forsyth County were Overweight and obesity (18);Mental health issues; lack of mental illnesses services (8); and Chronic illnesses such as diabetes, high blood pressure, heart disease (8)- *2011 Community Stakeholders Interview*
  - Had been told by a doctor that they had the following: 8.7%Diabetes; High Blood Pressure-33.1%;High Blood cholesterol-44.6%; heart Disease-4%-2009 BRFSS Forsyth County
  - 6.9% of respondents said they needed more information about going to the doctor for yearly check-ups and screenings-*2011 Community Health Opinion Survey*
  - High blood pressure, high cholesterol and overweight/obesity were the most frequently reported health conditions among respondents-*2011 Community Health Opinion Survey*
- Date and source of original baseline data: NC Center for Hospital Quality and Patient Safety; 2009 BRFSS Forsyth County results; 2011 Community Health Opinion Survey; 2011 Community Stakeholders Interview
- Updated information (For continuing objective only): N/A
- Date and source of updated information: N/A

POPULATION(S)

- Describe the local population(s) experiencing disparities related to this local community objective: Forsyth County Adults 50 and older who are newly diagnosed with or have poorly managed chronic disease such as diabetes, heart disease and high blood pressure.
- Total number of persons in the local disparity population(s): 13,000
- Number you plan to reach with the interventions in this action plan: 2,000

HEALTHY NC 2020 FOCUS AREA ADDRESSED

__ Tobacco Use
__ Physical Activity and Nutrition
__ Substance Abuse
__ STDs/Unintended Pregnancy
__ Environmental Health
__ Social Determinants of Health (Poverty, Education, Housing)
__ Maternal and Infant Health
__ Injury
__ Mental Health
__ Oral Health
__ Infectious Diseases/ Food-Borne Illness
X Chronic Disease (Diabetes, Colorectal Cancer, Cardiovascular Disease)
__ Cross-cutting (Life Expectancy, Uninsured, Adult Obesity)

- Check **one** Healthy NC 2020 focus area: (Which objective below most closely aligns with your local community objective?)
- **List HEALTHY NC 2020 Objective**: (Detailed information can be found at http://publichealth.nc.gov/hnc2020/ website)
  Objective 1: Reduce the cardiovascular disease mortality rate.
  Objective 2: Decrease the percentage of adults with diabetes.
  Objective 2: Increase the percentage of adults reporting good, very good or excellent health.

RESEARCH RE. WHAT HAS WORKED ELSEWHERE*

List the 3-5 evidence-based interventions (proven to effectively address this priority issue) that seem the most suitable for your community and/or target group. **Training and information are available from DPH. Contact your regional consultant about how to access them.*

Intervention	Describe the evidence of effectiveness (type of evaluation, outcomes)	Source
Addressing Chronic Disease through Community Health Workers: A policy and Systems-Level approach	In addition, CHWs educate health care providers and administrators about the community's health needs and the cultural relevancy of interventions by helping these providers and the managers of health care systems to build their cultural competence and strengthen communication skills. Using their unique position, skills, and an expanded knowledge base, CHWs can help reduce system costs for health care by linking patients to community resources and helping patients avoid unnecessary hospitalizations and other forms of more expensive care as they help improve outcomes for community members	http://www.cdc.gov/dhdsp/docs/chw_brief.pdf
Diabetes Prevention and Control: Self- Management Education	The Community Preventive Services Task Force recommends that diabetes self-management education (DSME) interventions be implemented in: • Community gathering places on the basis of sufficient evidence of effectiveness in improving glycemic control for adults with Type 2 diabetes • Homes of children and adolescents who have Type 1 diabetes on the basis of sufficient evidence of effectiveness in improving glycemic control among adolescents with Type 1 diabetes	http://www.thecommunityguide.org/diabetes/selfmgmteducation.html
Diabetes Prevention and Control: Self-Management Education in the Home for Children and Adolescents with Type 1 Diabetes	The home can be a good setting for DSME interventions because the educator can address issues that can be more difficult to deal with in the clinical setting, such as cultural, family, and environmental factors affecting lifestyle, self-monitoring of blood glucose, and barriers to optimal self-care. On the basis of Community Guide rules of evidence, there is sufficient evidence that DSME in the home is effective for improving glycemic control among adolescents with Type 1 diabetes, whether using home visits or computer-assisted instruction.	http://www.thecommunityguide.org/diabetes/supportingmaterials/RRhome1.html Task Force on Community Preventive Services. Recommendations for healthcare system and self-management education interventions to reduce morbidity and mortality from diabetes. [PDF - 67KB] *Am J Prev Med* 2002;22(4S):10-4.

WHAT INTERVENTIONS ARE ALREADY ADDRESSING THIS ISSUE IN YOUR COMMUNITY?

Are any interventions/organizations currently addressing this issue? Yes X No___ If so, please list below.

Intervention	Lead Agency	Progress to Date
Diabetes Healthsource helps patients learn new ways to manage their diabetes with confidence. The program is recognized by the American Association of Diabetic Educators, and its diabetes educators (nurses and dietitians) specialize in working with people who have diabetes and pre-diabetes. Services include expert medical supervision, education, counseling and compassionate support to help patients manage their disease and achieve maximum wellness. Diabetes HealthSource specialists work collaboratively with patients' physicians to ensure proactive medical care and early intervention for any problems that may arise.	Wake Health	Classes and programs are offered regularly to patients and community members; an average year has 110 classes with 512 participants.
Cardiovascular Risk Management Program -We offer a comprehensive preventive cardiology program that evaluates your cardiac risk factors and develops an action plan emphasizing optimal management of all risk factors, including your lipid and hypertension management and diabetes control. Risk management plan may also include nutrition counseling, education and exercise therapy	Novant Health	Classes and programs are offered regularly to patients and community members. Novant currently run more than 20 programs related to cardiovascular risk, including biometric screenings, stress management classes, nutrition/weight management programs and more. Classes are both one-time and multi-week series. Typically, a minimum of one program is held per week, averaging approximately 20 individuals per class.
Living a Healthy Life with Chronic Disease	Northwest Piedmont Council on Aging	Classes and programs are offered regularly to patients and community members.

WHAT RELEVANT COMMUNITY STRENGTHS AND ASSETS MIGHT HELP ADDRESS THIS PRIORITY ISSUE?

Community, neighborhood, and/or demographic group	Individual, civic group, organization, business, facility, etc. connected to this group	How this asset might help
Forsyth County Department of Public Health	Novant Health, Wake Health, City of Winston-Salem, Wake Forest University, Forsyth Futures, Pioneering Healthy Communities, Webster's, Forsyth County Cooperative Extension, Winston Salem State University	Lead agency for bringing different groups together to collaborate and support one another on the issues of chronic disease management
Forsyth Futures	Novant Health, Wake Health, City of Winston-Salem, Wake Forest University, Forsyth County Dept. of Public Health, Pioneering Healthy Communities, Forsyth County Cooperative Extension, Winston Salem State University	Lead agency for collecting community data; serving as a clearinghouse; and bringing different groups together to collaborate and support one another on the different data collection efforts/issues.

INTERVENTIONS: SETTING, & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
INTERVENTIONS SPECIFICALLY TARGETING HEALTH DISPARITIES		
Intervention: Support current initiatives that address chronic disease hospital to home program(s) among senior population Intervention: X new __ ongoing __ completed Setting: Community Agencies in Forsyth County Start Date – End Date (mm/yy): June 2012- December 2015 Level of Intervention - change in: X Individuals __ Policy &/or Environment	Partners: FCDPH, Novant Health, Forsyth County Cooperative Extension, Wake Health, Senior Services Roles to be determined Marketing to be determined	**1. Quantify what you will do** • Keep record the number of referrals to social support programs and services • Document number of meetings, attendance, and agency contributions • Document number agencies working together on this project • Document number of new agencies/ collaborations established from this project **2. Expected outcomes:** • Reduction in the number of readmissions due to lack of social support and access to care • Increase in number of referrals and utilization of social support programs • Improved medication management • Increase in improved health outcomes
INDIVIDUAL CHANGE INTERVENTIONS		
Intervention: Ongoing education of chronic disease management services/ programs offered at hospital and clinical level Intervention: __ new X ongoing __ completed Setting: Hospital systems in Forsyth County Start Date – End Date (mm/yy): Jan. 2012- December 2015	The lead agencies are Novant Health and Wake Health. The hospitals will review/assess the need for programs and services to assist clients with management of specific chronic diseases (hypertension, diabetes and cardiovascular disease) Forsyth County Department of PF, Senior Services, Community Care Clinic, Downtown Health Plaza Marketing the interventions or programs will be determined	**1. Quantify what you will do:** • Document number of classes offered quarterly • Document the number of participant attending programs **2. Expected outcomes**: • Increased access to targeted care • Increase management of disease (lower readmissions for chronic disease) lifestyle changes
POLICY OR ENVIRONMENTAL CHANGE INTERVENTIONS		
Intervention: Area agencies commit to pursuing one new community project to increase awareness and access to available resources Intervention: X new ___ ongoing ___ completed Setting: Agencies in Forsyth County Start Date – End Date (mm/yy): August 2012- July 2013	Novant Health; Wake Forest Baptist Health; Forsyth County Dept. of PH; Senior Services; University of NC at Greensboro; Winston-Salem State University ;TSI/PCEI; Faith-based organizations Other agencies to be determined Partners with assist with the study by reviewing internal policies and procedures; identify issues and mechanisms needed to support the program	**1. Quantify what you will do**: • Inventory and document community programs and social support networks in Forsyth County • Keep record of the number of new agency participation and/or collaborations established •Document how agencies cross promote external programs, services, etc. •Document number of meetings, attendance, participation and process of this project. **2. Expected outcomes:** • Higher utilization of clinical services and community resources to improve chronic disease management

Forsyth County Community Health Action Plan 2011

Designed to address Community Health Assessment priorities

County: Forsyth **Partnership:** Healthy Community Coalition **Period Covered:** 2012-2015

LOCAL PRIORITY ISSUE

- Priority issue: Healthy Families
- Was this issue identified as a priority in your county's most recent CHA? Yes

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

- By (year): 2015
- Objective: Decrease the percent of middle school students who describe themselves as slightly or very overweight.
- Original Baseline: 26% of WS/FC Middle School Students describe themselves as slightly or very overweight.
- Date and source of original baseline data: 2011 Youth Risk Behavior Survey WSFC Middle School Students

POPULATION(S)

- Describe the local population(s) experiencing disparities related to this local community objective: School Age families in Forsyth County. According to 2011 YRBS WFSC Middle School results, females, African Americans and sixth graders were more likely to report being slightly or overweight.
- Total number of persons in the local disparity population(s): 25,132 Elementary School students in Winston-Salem/ Forsyth County Schools
- Number you plan to reach with the interventions in this action plan: 50% of the K-5 student population and their families

HEALTHY NC 2020 FOCUS AREA ADDRESSED

__ Tobacco Use
X Physical Activity and Nutrition
__ Substance Abuse
__ STDs/Unintended Pregnancy
__ Environmental Health
__ Social Determinants of Health (Poverty, Education, Housing)
__ Maternal and Infant Health
__ Injury
__ Mental Health
__ Oral Health
__ Infectious Diseases/ Food-Borne Illness
__ Chronic Disease (Diabetes, Colorectal Cancer, Cardiovascular Disease)
__ Cross-cutting (Life Expectancy, Uninsured, Adult Obesity)

- **List HEALTHY NC 2020 Objective**: Objective1:Increase the percentage of high school students who are neither overweight or obese

RESEARCH RE. WHAT HAS WORKED ELSEWHERE*

List the 3-5 evidence-based interventions (proven to effectively address this priority issue) that seem the most suitable for your community and/or target group. **Training and information are available from DPH. Contact your regional consultant about how to access them.*

Intervention	Describe the evidence of effectiveness (type of evaluation, outcomes)	Source
Obesity Prevention: Technology-Supported multi-component coaching or counseling interventions to reduce weight and maintain weight loss (computers, pedometers, in-person counseling, manual tracking, printed lessons, written feedback)	The Task Force finding was made in June 2009. It was based on a systematic review of all available studies, conducted on behalf of the Task Force by a team of specialists in systematic review methods, and in research, practice and policy related to obesity prevention and control.	http://www.thecommunityguide.org/obesity/TechnologicalCoaching.html
Obesity Prevention: School based programs	While nine studies among children and one among adolescents qualified for the review, they did not identify comparable outcomes. The studies showed some positive effects on outcomes related to weight status, but changes were small and the measures used were varied. These results were based on a systematic review of all available studies, conducted on behalf of the Task Force by a team of specialists in systematic review methods, and in research, practice and policy related to obesity prevention and control.	http://www.thecommunityguide.org/obesity/schoolbased.html
Obesity Prevention: Worksite Wellness Worksite nutrition and physical activity programs are designed to improve health-related behaviors and health outcomes. These programs can include one or more approaches to support behavioral change including informational and educational, behavioral and social, and policy and environmental strategies.	Forty-seven studies qualified for the review and included three outcome measures: body mass index (BMI), weight, and percent body fat. • The most common intervention strategies included both informational and behavioral skills components (32 studies). Few studies (4 studies) looked at policy and environmental changes in the worksite. • Effects on the three outcomes consistently favored: ◦ The intervention group compared to the controls (31 studies) ◦ Those receiving more intensive versus less intensive strategies (9 studies). ◦ In individually randomized controlled trials, results showed that compared with control groups after 12 months, participating employees lost an average of 2.8 pounds (9 studies) and reduced their average BMI by 0.5 (6 studies). • No one focus, diet or physical activity, or combination of both appeared to be better than others in terms of its effect on weight loss. • Most of the studies involved a white collar workforce that included some employees with overweight or other chronic disease risk conditions. These results were based on a systematic review of all available studies, conducted on behalf of the Task Force by a team of specialists in systematic review methods, and in research, practice and policy related to worksite programs to prevent and control obesity.	http://www.thecommunityguide.org/obesity/workprograms.html

Behavioral and Social approaches to increase physical activity: Individually-adapted health behavior change programs to increase physical activity teach behavioral skills to help participants incorporate physical activity into their daily routines. The programs are tailored to each individual's specific interests, preferences, and readiness for change.	The Community Preventive Services Task Force recommends implementing individually-adapted health behavior change programs based on strong evidence of their effectiveness in increasing physical activity and improving physical fitness among adults and children.	http://www.thecommunityguide.org/pa/behavioral-social/individuallyadapted.html
Behavioral and Social approaches to increase physical activity: Enhanced school-based physical education This review evaluated the effectiveness of enhancing physical education (PE) curricula by making classes longer or having students be more active during class in order to increase the amount of time students spend doing moderate or vigorous activity in PE class	The Community Preventive Services Task Force recommends implementing programs that increase the length of, or activity levels in, school-based physical education classes based on strong evidence of their effectiveness in improving both physical activity levels and physical fitness among school-aged children and adolescents.	http://www.thecommunityguide.org/pa/behavioral-social/schoolbased-pe.html

WHAT INTERVENTIONS ARE ALREADY ADDRESSING THIS ISSUE IN YOUR COMMUNITY?

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

Intervention	Lead Agency	Progress to Date
Transformation Nation	YMCA, Forsyth Medical Center, WXII News 12	This 16 week program began in January 2012 and has had great success. WXII and the YMCA were even featured on the Dr. Oz show for this outstanding program.
Weigh to Wellness	Forsyth Medical Center	Weigh to Wellness is a comprehensive 10 week program led by licensed experts.
Healthy, Fit and Strong	WSFC Schools, YMCA	12-15 week pilot program for parents of school aged children. Currently in one school, working to add extra schools. Focus on physical activity and nutrition.
Best Health	Wake Health	Hold community classes at Hanes Mall for adults and children.
Brenner Fit	Brenner's Children Hospital/ Wake Health	Comprehensive pediatric weight management program. Outpatient clinic is available by referral for both English and Spanish speaking families. Also offers free community workshops.
Be Healthy School Kids	Forsyth County Department of Public Health	Nutrition/physical activity program that uses the Organ Wise Guys Curriculum in 16 elementary schools to promote healthy lifestyle choices. Behealthy campaigns were run in 9 schools for the 2011-2012 school year.
Cancer Services – Body & Soul	Cancer Services	Program was developed by the American Cancer Society for African American churches. This program focuses on physical activity and nutrition.
Healthy Kids Day	YMCA	A national initiative of the Y to improve the health and well-being of kids. More than 1,900 Y's across the country are taking part in the celebration with free

		community events for families, meant to kick start physical activity and learning throughout the summer. (William G. White Jr. YMCA hold one every year)
PACES (Program for Active Children Eating Smarter)	YMCA	12-week program where young people will learn about nutrition and engage in exercising and fun activities. Ages 10-15 years old.

WHAT RELEVANT COMMUNITY STRENGTHS AND ASSETS MIGHT HELP ADDRESS THIS PRIORITY ISSUE?

Community, neighborhood, and/or demographic group	Individual, civic group, organization, business, facility, etc. connected to this group	How this asset might help
LaDeara Crest Community	WSSU (nursing students do health screenings) FCDPH-Behealthy School Kids Program, Youth Tobacco Prevention Program	Individual community center hosts health resource fairs for residents to visit to get health screenings and get information that would help them make healthier lifestyle choices. This event is for the families in the neighborhood and organizations and universities partner to bring them health information.
School Wellness Policy Committee/School Wellness Councils	FCDPH, Parents, Students, hospitals, Child Nutrition (Chartwells), YMCA	Working with several community groups/organizations for the well-being of students in the school system can bridge relationships and create more opportunity for collaboration for healthy living.
SHAC	FCDPH Health Director, WSFCS Superintendent, Wake Forest Baptist Health, Downtown Health Plaza	Discuss issues of students' health and wellness with health department staff, hospitals, other medical staff, principals, and community members
Behealthy Schools	WSFCS	Provide nutrition and physical activity education in elementary schools. Work with School Wellness Policy Committee.
YMCA/YWCA After School Programs	Local school systems in the five-county area.	Activities in the curriculum include health & wellness, arts & humanities, science & technology and service learning projects
Forsyth County Department of Public Health (FCDPH)	WSFCS, YMCA, Wake Baptist Health, Novant Health, WSSU	Lead agency for bringing different groups together to collaborate and support one another on the issues of Healthy Families
Novant Health/Forsyth Hospital	FCDPH, WSFCS	Responsibility for many interventions and activities that focus on the health of the community.

INTERVENTIONS: SETTING, & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
INTERVENTIONS SPECIFICALLY TARGETING HEALTH DISPARITIES		
Intervention: Peer Education on nutrition and physical activity topics Intervention: _X_ new __ ongoing __ completed Setting: WSFC Schools Start Date – End Date (mm/yy): School year 2013- ongoing Level of Intervention - change in: __ Individuals _X_ Policy &/or Environment	Lead Agency: WSFC Schools Role: Sponsor and support a peer education program Partners: Forsyth Medical Center Role: Provide adult leaders, and current student health club for pilot program Partners: YMCA Role: Provide adult leaders, and students from the government club for pilot program. Partners: Youth Empowered Solutions (YES!) Role: Provide training for adult leaders, and designated students. Partners: Forsyth County Health Dept. Role: Serve on advisory committee, provide advice and support for the program as needed.	**1. Quantify what you will do** • 2 Pilot groups of students: 1) West Forsyth High School, 2) YMCA Youth in Government • Send adult leaders to one YES! Training • Provide YES! Training for designated student participants. • Conduct pre/post surveys for student knowledge about perception of physical activity and nutrition • Use teen groups to provide peer education for Title I schools. **2. Expected outcomes:** • This intervention will use the evidence-based peer education model that was developed by Youth Empowered Solutions (YES!) • The West Forsyth High School student group will provide peer education at their school. The expected outcome being the creation of a new social norm related to physical activity and nutrition • The YMCA Youth in Government groups will work with multiple schools to provide peer education on physical activity and nutrition. This group will also work on writing policies that improve physical activity and nutrition.
INDIVIDUAL CHANGE INTERVENTIONS		
Intervention: Transformation Nation: Families Intervention: _X_ new __ ongoing __ completed Setting: Forsyth County Start Date – End Date (mm/yy): July 2012- June 2015	The lead agencies are: YMCA Partnering Agencies: Novant Health, WXII, WSFC Schools, Parks & Recreation, Forsyth County Department of Public Health, Family Services Include how you're marketing the intervention: WXII media partner, School and Community Newsletters, Social Media	**1. Quantify what you will do**: • 1,000 + participants • 4 month program • 1+ classes per week • Track total pounds loss or other biometric data **2. Expected outcomes:** • Increase health of families in Forsyth County

Intervention: Community collaboration for increased health of individuals and families. Intervention: _X_ new __ ongoing __ completed Setting: Forsyth County Start Date – End Date (mm/yy): July 2012-ongoing	Agencies partnering for this intervention include: WSFC Schools; Forsyth County Department of Public Health; YMCA City of Winston-Salem; Forsyth County; Novant Health; Wake Health Include how you're marketing the intervention: Cross promotion of programs and services via newsletters, social media, emails, word of mouth.	**1. Quantify what you will do:** ●Increase community partners at the table for program planning ●Communicate via meetings or Google group to check-in on current initiatives and hold each other accountable. **2. Expected outcomes:** • Increased collaboration between community partners to increase the health of families in Forsyth County. • Community partners working together on events and activities in Forsyth County that relate to nutrition and physical activity. • Expansion and enrichment of currently offered programs and services in Forsyth County related to wellness.
POLICY OR ENVIRONMENTAL CHANGE INTERVENTIONS		
Intervention: Create and promote unified health messaging that relates to physical activity, nutrition and health. Intervention: _X_ new __ ongoing __ completed Setting: Forsyth County Start Date – End Date (mm/yy): July 2012-June 2015	The lead agency is the Be Healthy Coalition Partnering agencies include: WSFC Schools; Forsyth County Department of Public Health; YMCA; Novant Health; Wake Health Include how you're marketing the intervention Meet with designated agencies to request their partnership in using the created unified message.	**1. Quantify what you will do:** • Work as a community collaboration to create a unified message for physical activity and nutrition. (Example: 5-3-2-1-Almost None) • Gain support for unified message from all schools, hospitals, physician offices, health department, recreation facilities and other organizations that that promote health. **2. Expected outcomes:** • To reduce confusion in Forsyth County as it relates to physical activity, nutrition and healthy living by having the same message given by all. • Increase health of Forsyth County residents through unified messaging.
Intervention: School Wellness Policy Evaluation Intervention: _X__ new ___ ongoing ___ completed Setting: Winston Salem/ Forsyth County School System Start Date – End Date (mm/yy): 2012-2015 (every 2 years)	The lead agencies are: WSFC Schools and they will provide support and facilitate collaboration of school/ health department relationship. Participating agencies: Forsyth County Department of Public Health will administer electronic survey Include how you're marketing the intervention Email distribution Presentations to Board of Education, Board of Health, PTA groups, etc.	**1. Quantify what you will do**: • Yearly survey distribution to all WSFC Schools • Survey distributed to each school principal or designated teacher. • Receive yearly reports from school wellness committees updating on their school's compliance with the policy. • Provide community presentations about the policy. **2. Expected outcomes:** • To gain knowledge on resources being used in each school as it relates to obesity prevention. • To follow-up with individual school wellness committees, and offer support on their committee. • Increase parental and community knowledge of the school wellness policy and what it means for children in Forsyth County.

Forsyth County Community Health Action Plan 2011

Designed to address Community Health Assessment priorities

County: Forsyth **Partnership:** Healthy Community Coalition **Period Covered:** 2012-2015

LOCAL PRIORITY ISSUE

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

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

- By (year): 2015
- Objective: Increase the percentage of adults who consume five or more servings of fruits and vegetables per day to 29.3%
- Original Baseline: 24.7% of the Forsyth County Adults reported eating five or more servings of fruits and vegetables per day
- Date and source of original baseline data: 2009 BRFSS Survey Results-Forsyth County
- Updated information (For continuing objective only): N/A
- Date and source of updated information: N/A

POPULATION(S)

- Describe the local population(s) experiencing disparities related to this local community objective:

  Fruit and vegetable consumption among adults: Increasing education and income are both positively associated with fruit and vegetable intake. Individuals with a high school diploma are 1.5 times less likely to eat five fruits and vegetables daily than college graduates. Similarly, individuals earning less than $15,000 are 1.5 times less likely to eat five or more fruits and vegetables a day than those earning more than $75,000 (2009).
- Total number of persons in the local disparity population(s): 147,281 adults with ≥ high school diploma or GED;

  38, 574 Families Living below the Poverty Level (11% of total population)
- Number you plan to reach with the interventions in this action plan: 500

HEALTHY NC 2020 FOCUS AREA ADDRESSED

__ Tobacco Use
X Physical Activity and Nutrition
__ Substance Abuse
__ STDs/Unintended Pregnancy
__ Environmental Health
__ Social Determinants of Health (Poverty, Education, Housing)
__ Maternal and Infant Health
__ Injury
__ Mental Health
__ Oral Health
__ Infectious Diseases/ Food-Borne Illness
__ Chronic Disease (Diabetes, Colorectal Cancer, Cardiovascular Disease)
__ Cross-cutting (Life Expectancy, Uninsured, Adult Obesity)

- Check **one** Healthy NC 2020 focus area: (Which objective below most closely aligns with your local community objective?)
- **List HEALTHY NC 2020 Objective**: (Detailed information can be found at http://publichealth.nc.gov/hnc2020/ website) Objective 3: Increase the percentage of adults who report they consume fruits and vegetables five or more times per day.

RESEARCH RE. WHAT HAS WORKED ELSEWHERE*

List the 3-5 evidence-based interventions (proven to effectively address this priority issue) that seem the most suitable for your community and/or target group. **Training and information are available from DPH. Contact your regional consultant about how to access them.*

Intervention	Describe the evidence of effectiveness (type of evaluation, outcomes)	Source
Cleveland's Steps Program	• The 31 new community gardens engaged 1085 new gardeners in physical activity and increased access to fresh produce for hundreds of families. • Thousands of pounds of fresh fruits and vegetables have been donated to area food pantries. • A new farmers' market was created in Cleveland's Central Neighborhood. Six young people are employed to sell the fresh produce they grow at a local Steps community garden through a program sponsored by St. Vincent's Charity Hospital. This new program is sustained through sales at the market, as well as grants and donations from the Greater Cleveland community. • Local foundations and businesses supported an additional seven gardens through grants totaling more than $30,000 for infrastructure improvements and the creation of garden-related programs.	http://www.cdc.gov/steps/success_stories/pdf/cleveland.pdf
Strategies to Prevent Obesity and Other Chronic Diseases: *The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables*. Centers for Disease Control and Prevention. Atlanta: U.S. Department of Health and Human Services; 2011.	An evaluation of a large urban gardening project found that gardeners reported a higher consumption of specific vegetables and a lower consumption of milk, citrus, and sweet foods and drinks than non-gardeners. Focus groups conducted with inner-city youth revealed that those involved in garden programs reported more willingness to eat healthy food and try unfamiliar food than those not involved in a program. Other studies have found an association between gardening and fruit and vegetable consumption, even when the gardening activity occurred in the past.	http://www.cdc.gov/obesity/downloads/FandV_2011_WEB_TAG508.pdf

Communities Succeed at Creating Healthier Environments	CDC's Healthy Communities Program has a successful history of investing in communities' health and quality of life by supporting evidence - and practice-based interventions that reduce the burden of chronic disease. Through the Healthy Communities Program, coalitions collaborate with partners to educate local leaders on the importance of creating healthy places for people to live, work, learn, and play. These successes illustrate the exemplary work communities undertake. • Nine community and school gardens and five farmers' markets were established in the **Grand Rapids, Michigan**, low-income areas to increase access to fruits and vegetables. • Residents in rural **Montgomery County, Alabama**, have increased their access to fruits and vegetables through nine community gardens located in parks and schools. • More than 7,200 children in the Enlarged City School District of Middletown located in **Orange County, New York**, have increased access to fruits and vegetables through a farm-to-school program. • YMCA after-school programs in **Pittsburgh, Pennsylvania**, improved access to fresh fruits and vegetables to under-resourced communities. • Persons with developmental disabilities in **Schenectady County, New York**, have improved access and consumption of fresh produce by constructing wheelchair accessible raised-planting beds and creating a garden-based nutrition curriculum. • More than 136,000 residents in in **Tacoma-Pierce County, Washington**, have access to fruits and vegetables through community gardens in MetroParks. • Children and adults living in a 111 unit public housing complex in **Alexandria, Virginia**, are provided with access to healthy foods and opportunities for physical activity by weeding, watering, and picking produce from a garden.	http://www.cdc.gov/healthycommunitiesprogram/evaluation-innovation/successes.htm

WHAT INTERVENTIONS ARE ALREADY ADDRESSING THIS ISSUE IN YOUR COMMUNITY?

Are any interventions/organizations currently addressing this issue? Yes X No___ If so, please list below.

Intervention	Lead Agency	Progress to Date
Community Gardening Program	Forsyth County Cooperative Extension	Currently there are 20 community gardens supported by Cooperative Extension. Extension also facilitates a community garden advisory council.
Research Studies	Wake Forest University/ Wake Health/ Translational Sciences	Studying food insecurities. Food deserts, location of full service groceries, fruit and vegetable access, etc. These institutions have released 4 studies/ papers to the community about their findings and recommendations

WHAT RELEVANT COMMUNITY STRENGTHS AND ASSETS MIGHT HELP ADDRESS THIS PRIORITY ISSUE?

Community, neighborhood, and/or demographic group	Individual, civic group, organization, business, facility, etc. connected to this group	How this asset might help
Forsyth County Department of Public Health	Novant Health, Wake Health, City of Winston-Salem, Wake Forest University, Forsyth Futures, Pioneering Healthy Communities, Webster's, Forsyth County Cooperative Extension, Winston Salem State University	Lead agency for bringing different groups together to collaborate and support one another on the issues of nutrition, food access and healthy eating.
Forsyth Futures	Novant Health, Wake Health, City of Winston-Salem, Wake Forest University, Forsyth County Dept. of Public Health, Pioneering Healthy Communities, Webster's, Forsyth County Cooperative Extension, Winston Salem State University	Lead agency for collecting community data; serving as a clearinghouse; and bringing different groups together to collaborate and support one another on the different data collection efforts/issues.

INTERVENTIONS: SETTING, & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
INTERVENTIONS SPECIFICALLY TARGETING HEALTH DISPARITIES		
Intervention: Expanding the community garden program and the distribution of produce grown Intervention: X new __ ongoing __ completed Setting: Forsyth County Start Date – End Date: June 2012- Dec. 2015 Level of Intervention - change in: X Individuals __ Policy &/or Environment	Lead Agency: Forsyth County Cooperative Extension Role: Coordinating the community program; convening community talks, lectures, etc.; facilitating meeting between agencies, community garden managers and other parties as appropriate Community gardens will be marketed through partner agencies, churches, CBOs, hospitals, and others	**1. Quantify what you will do** • Number of community gardens • Number of pounds distributed in the community **2. Expected outcomes:** • Increase accessibility to fresh fruits and vegetables • Increase in consumption of fresh fruits and vegetables • Improves the quality of life for people in the garden • Provides a catalyst for neighborhood and community development • Stimulates and fosters Social Interaction • Beautifies Neighborhoods • Reduces Family Food Budgets • Creates opportunity for recreation, exercise, therapy, and education • Creates income opportunities and economic development • Provides opportunities for

		intergenerational and cross-cultural connections
INDIVIDUAL CHANGE INTERVENTIONS		
Intervention: Increase community collaboration and cross-promotion of programs related to nutrition, food access, local foods and food security. Intervention: X new __ ongoing __ completed Setting: Community- based organizations Start Date – End Date (mm/yy): June 2012- December 2015	List of partnering agencies and what they plan to do: FCDPH; Forsyth Medical Center WFBH;Cooperative Extension Service; WSFCS;YMCA;YWCA TSI/PCEI Other agencies/ programs are to be determined	**1. Quantify what you will do** • Number of agencies working together on this project • Number of new agencies/ collaborations established **2. Expected outcomes:** • Increase produce donations • Increase produce consumption • Increase health outcomes
POLICY OR ENVIRONMENTAL CHANGE INTERVENTIONS		
Intervention: Increase the number of Farmers' Markets in low wealth communities in Winston-Salem. Intervention: _X_ new __ ongoing __ completed Setting: Forsyth County Start Date – End Date (mm/yy): July 2013-June 2015	The lead agency is the Behealthy Coalition Partnering agencies include: Local congregations Farmers Cooperative Extension Service Include how you're marketing the intervention: • Through faith-based institutions in close proximity to new market • Employers in close proximity to the new market. • Local Neighborhood Associations. • Articles in local newspapers. • Press release.	**1. Quantify what you will do:** • Add at least one Farmers Market in a low wealth neighborhood in Winston Salem. **2. Expected outcomes:** • Improve food access in low wealth communities • Increase in consumption of fruits and vegetables • Increase in revenue for participating farmers
Intervention: Increase participation in SNAP (EBT) and WIC Farmers Market Nutrition Program at Farmers Markets in Forsyth County. **Intervention:** **_X_ new __ ongoing __ completed** **Setting: Forsyth County** **Start Date – End Date (mm/yy): July 2013-June 2015**	The lead agency is the Be Healthy Coalition Partnering agencies include: Local Farmers Markets Farmers Include how you're marketing the intervention: • Press release • Articles in local newspapers • Promote Farmers Markets that accept EBT and/or WIC Farmers Market Program with clients in health department and DSS •	**1. Quantify what you will do:** • Add SNAP/EBT and WIC Farmers Market Nutrition Program as payment method options in local Farmers Markets. **2. Expected outcomes:** • Improve food access in low wealth communities • Increase in consumption of fruits and vegetables • Increase in revenue for participating farmers

Forsyth County Community Health Action Plan 2011

Designed to address Community Health Assessment priorities

County: Forsyth **Partnership:** Healthy Community Coalition **Period Covered:** 2012-2015

LOCAL PRIORITY ISSUE

- Priority issue: Physical Activity
- Was this issue identified as a priority in your county's most recent CHA? _X_ Yes __ No

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

- By (year): *2015*
- Objective: Increase the percent of Forsyth County adults who report getting the recommended amount of physical activity.
- Original Baseline: 42% of Forsyth County Adults reported getting the recommended amount of physical activity (30 minutes per day, 5 days per week.)
- Date and source of original baseline data: 2009 Forsyth County BRFSS Survey results

POPULATION(S)

- Describe the local population(s) experiencing disparities related to this local community objective: Forsyth County Adult Residents (18yrs and older
- Total number of persons in the local disparity population(s): 265,000
- Number you plan to reach with the interventions in this action plan: 15% of the population

HEALTHY NC 2020 FOCUS AREA ADDRESSED

__ Tobacco Use
X Physical Activity and Nutrition
__ Substance Abuse
__ STDs/Unintended Pregnancy
__ Environmental Health
__ Social Determinants of Health (Poverty, Education, Housing)
__ Maternal and Infant Health
__ Injury
__ Mental Health
__ Oral Health
__ Infectious Diseases/ Food-Borne Illness
__ Chronic Disease (Diabetes, Colorectal Cancer, Cardiovascular Disease)
__ Cross-cutting (Life Expectancy, Uninsured, Adult Obesity)

- **List HEALTHY NC 2020 Objective**: Objective 2: Increase the percentage of adults getting the recommended amount of physical activity

RESEARCH RE. WHAT HAS WORKED ELSEWHERE*

List the 3-5 evidence-based interventions (proven to effectively address this priority issue) that seem the most suitable for your community and/or target group. **Training and information are available from DPH. Contact your regional consultant about how to access them.*

Intervention	Describe the evidence of effectiveness (type of evaluation, outcomes)	Source
Campaigns and Informational approaches to increase physical activity: Community-wide campaigns to increase physical activity are interventions that: • Involve many community sectors • Include highly visible, broad-based, multicomponent strategies (e.g., social support, risk factor screening or health education) • May also address other cardiovascular disease risk factors, particularly diet and smoking	The Community Preventive Services Task Force recommends community-wide campaigns on the basis of strong evidence of effectiveness in increasing physical activity and improving physical fitness among adults and children.	http://www.thecommunityguide.org/pa/campaigns/community.html
Behavioral and Social approaches to increase physical activity: Individually-adapted health behavior change programs to increase physical activity teach behavioral skills to help participants incorporate physical activity into their daily routines. The programs are tailored to each individual's specific interests, preferences, and readiness for change. These programs teach behavioral skills such as: • Goal-setting and self-monitoring of progress toward those goals • Building social support for new behaviors • Behavioral reinforcement through self-reward and positive self-talk • Structured problem solving to maintain the behavior change • Prevention of relapse into sedentary behavior	The Community Preventive Services Task Force recommends implementing individually-adapted health behavior change programs based on strong evidence of their effectiveness in increasing physical activity and improving physical fitness among adults and children.	http://www.thecommunityguide.org/pa/behavioral-social/individuallyadapted.html
Behavioral and Social approaches to increase physical activity: Social support interventions in community settings These social support interventions focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system, making contracts with others to complete specified levels of physical activity, or setting up walking groups or other groups to provide friendship and support).	The Community Preventive Services Task Force recommends implementing efforts made in community settings to provide social support for increasing physical activity based on strong evidence of their effectiveness in increasing physical activity and improving physical fitness among adults. In all nine studies reviewed, social support interventions in community settings were effective in getting people to be more physically active, as measured by various indicators (e.g., blocks walked or flights of stairs climbed daily, frequency of attending exercise sessions, or minutes spent in physical activity).	http://www.thecommunityguide.org/pa/behavioral-social/community.html

WHAT INTERVENTIONS ARE ALREADY ADDRESSING THIS ISSUE IN YOUR COMMUNITY?

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

Intervention	Lead Agency	Progress to Date
Cycling Sunday	Winston-Salem DOT	Held twice each year, this event promotes cycling on public streets.
Safe Routes To School	Winston-Salem DOT	Promotes safe walking and cycling to school for students.
Bike to work week	Winston-Salem DOT	Local organizations partner to host Bike to Work Week events at their facility. Employees are encouraged to ride their bike to work or to other places they typically take their car.
Family Fit 5k	Forsyth Medical Center	Family friendly event for all ages and activity levels (run/walk). This event benefits Girls on the Run Forsyth County.
Mistletoe Run	YMCA	Family event with a 27 year history… goal is to raise awareness and funds for local childhood obesity programs.
Transformation Nation	YMCA/ Novant Health/ WXII	This 16 week program began in January 2012 and has had great success. WXII and the YMCA were even featured on the Dr. Oz show for this outstanding program.

WHAT RELEVANT COMMUNITY STRENGTHS AND ASSETS MIGHT HELP ADDRESS THIS PRIORITY ISSUE?

Community, neighborhood, and/or demographic group	Individual, civic group, organization, business, facility, etc. connected to this group	How this asset might help
Winston-Salem	Cycling Sunday	Help individuals gain comfort with riding on city roads/ in bike lanes.
Winston-Salem & Forsyth County	Parks & Greenways	Low cost/ free physical activity opportunities

INTERVENTIONS: SETTING, & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
INTERVENTIONS SPECIFICALLY TARGETING HEALTH DISPARITIES		
Intervention: Step Up Forsyth Intervention: ___ new __X_ ongoing ___ completed Setting: Forsyth County Start Date – End Date (mm/yy): 2012-2015	The lead agency is Forsyth County Department of Public Health and it will design, implement and evaluate the program. Other partners include: Be Healthy Coalition – will guide and support the design and evaluation of the program, and will help advertise. Cancer Services – provide health recipes for newsletters YMCA – provide physical activity and exercise tips Program will be advertised in multiple formats to reach as many Forsyth County residents as possible. Potential marketing includes: social media, web stories, newspaper ads/ articles, magazine ads/ articles, bus ads, etc.	**1. Quantify what you will do:** • Hold one 8 week physical activity program each year • Reach 1,500 people in Forsyth County with this program • Provide weekly newsletters, tweets and emails for the 8 week program • Promote 8-10 local parks and greenways each year through this program • Promote local foods **2. Expected outcomes:** • Increase the number of people in Forsyth County who are physically active. • Increase the number of people who use the local parks and greenways. • Provide support to help individuals maintain participant's physical activity goals by connecting them with free/ low-cost physical activity resources.
INDIVIDUAL CHANGE INTERVENTIONS		
Intervention: Promote new and ongoing initiatives that support physical activity and alternative modes of transportation Intervention: _X_ new __ ongoing __ completed Setting: Forsyth County Start Date – End Date (mm/yy): 2012-Ongoing	Partnering agencies: FCDPH, YMCA, DOT, Winston Salem Parks & Recreation, Forsyth County Parks & Recreation,WSFC Schools, Faith Community, Wake Health Novant Health Marketing: Cross promotion of programs and resources available to increase physical activity.	**1. Quantify what you will do:** • Promote and support existing programs: Cycling Sunday, Safe Routes to Schools program, Bike to Work Week, Transformation Nation, etc. • Promote and support use of local parks and greenways. • Support bike lane initiatives. • Promote and support new programs as they are created. **2. Expected outcomes:** • Increase physical activity for adults and children • Increase use of alternative modes of transportation (walking, cycling, etc)
POLICY OR ENVIRONMENTAL CHANGE INTERVENTIONS		
Intervention: Support the Legacy Plan Intervention: _X__ new ___ ongoing ___ completed Setting: Winston-Salem Start Date – End Date (mm/yy): 2012-2015	The lead agency is Be Healthy Coalition and it will support and provide coalition members with updates on legacy plan.	**1. Quantify what you will do:** • Provide coalition members with updates on progress of plan as information is available. • Support the Legacy Plan. **2. Expected outcomes:**

		Legacy Plan Visions: • A more compact, balanced development pattern • A more balanced, sustainable transportation system • Regional cooperation in planning and development • A vital and diverse economy • Concern for the environment balanced with economic development • A regional system of parks, natural areas and open space connected by a network of trails • Winston-Salem's downtown and small town downtowns are the focal points of our communities • Livable neighborhoods • A community with special character and identity • A high quality of life • Active citizenship

Forsyth County Community Health Action Plan 2011

Designed to address Community Health Assessment priorities

County: Forsyth **Partnership, if applicable: Healthy Community Coalition** **Period Covered: 2012 -2015**

LOCAL PRIORITY ISSUE

- Priority issue: *Tobacco prevention and cessation*
- Was this issue identified as a priority in your county's most recent CHA? _X_ Yes __ No

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

- By (year): 2015
- Objective: Reduce the percent of high school students who report using tobacco products on a daily basis by 1%.
- Original Baseline: 18% of High School students reported smoking cigarettes on one or more days in the past 30 days.
- Date and source of original baseline data: 2011 YRBS for Winston-Salem Forsyth County Schools (WSFCS)

POPULATION(S)

- Describe the local population(s) experiencing disparities related to this local community objective: Middle and High school students in Forsyth County
- Total number of persons in the local disparity population(s): 27,127 students
- Number you plan to reach with the interventions in this action plan: 25% of the middle and high school population

HEALTHY NC 2020 FOCUS AREA ADDRESSED

_X_ Tobacco Use
__ Physical Activity and Nutrition
__ Substance Abuse
__ STDs/Unintended Pregnancy
__ Environmental Health
__ Social Determinants of Health (Poverty, Education, Housing)
__ Maternal and Infant Health
__ Injury
__ Mental Health
__ Oral Health
__ Infectious Diseases/ Food-Borne Illness
__ Chronic Disease (Diabetes, Colorectal Cancer, Cardiovascular Disease)
__ Cross-cutting (Life Expectancy, Uninsured, Adult Obesity)

- Check **one** Healthy NC 2020 focus area: (Which objective below most closely aligns with your local community objective?)
- **List HEALTHY NC 2020 Objective**:
  - **Objective 2**: Decrease the percentage of high school students reporting current use of any tobacco product.

RESEARCH RE. WHAT HAS WORKED ELSEWHERE*

List the 3-5 evidence-based interventions (proven to effectively address this priority issue) that seem the most suitable for your community and/or target group.

Intervention	Describe the evidence of Effectiveness (type of evaluation, outcomes)	Source
Tobacco Reality Unfiltered (TRU) State-wide program to reduce teen tobacco use.	Since the start of the state-wide TRU campaign in 2003, there are 53,000 fewer teen tobacco users in North Carolina.	**http://www.realityunfiltered.com/**
Reducing tobacco use initiation: mass media campaigns combined with other interventions	The Community Preventive Services Task Force recommends mass media campaigns based on strong evidence of their effectiveness in reducing tobacco use among adolescents when implemented in combination with tobacco price increases, school-based education, and other community education programs.	**http://www.thecommunityguide.org/tobacco/initiation/massmediaeducation.html**
Reducing minors' access to tobacco products: Community mobilization and additional interventions	The Community Preventive Services Task Force recommends community mobilization combined with additional interventions —such as stronger local laws directed at retailers, active enforcement of retailer sales laws, and retailer education with reinforcement—on the basis of sufficient evidence of effectiveness in reducing youth tobacco use and access to tobacco products from commercial sources.	**http://www.thecommunityguide.org/tobacco/restrictingaccess/communityinterventions.html**

WHAT INTERVENTIONS ARE ALREADY ADDRESSING THIS ISSUE IN YOUR COMMUNITY?

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

Intervention	Lead Agency	Progress to Date
100% Tobacco Free Schools Policy	WSFC Schools	All school grounds are 100% tobacco free
Smoke free restaurants and bars	North Carolina	All restaurants and bars in NC are 100% smoke free
TRU Youth Advisory Council	FCDPH	TRU youth from various WSFC middle and high schools meet to discuss tobacco prevention; and provide school and community peer education.
ASPIRE – teen tobacco prevention and cessation online tool	WSFC School – ISS program	Students caught using tobacco products on school grounds are often referred to complete the ASPIRE program during ISS. This program is also used in health classes, etc. for prevention purposes.

WHAT RELEVANT COMMUNITY STRENGTHS AND ASSETS MIGHT HELP ADDRESS THIS PRIORITY ISSUE?

Community, neighborhood, and/or demographic group	Individual, civic group, organization, business, facility, etc. connected to this group	How this asset might help
Public Schools	WSFC Schools	Allow TRU to set up school displays about tobacco prevention Create announcements at school sporting events
Private/ Christian Schools	First Christian Academy	Hold TRU trainings for all private/ Christian schools in Forsyth County. Encourage schools to start TRU programs at their site.
After-school Care	Rec Centers, Boys & Girls Club, School based after-school care programs, etc.	Provide opportunity for TRU youth to provide peer education to younger students
Medical Community	WIC, Downtown Health Plaza, Physician Offices	Promote smoke-free homes/ prevention of youth exposure to second hand smoke.

INTERVENTIONS: SETTING, & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
INTERVENTIONS SPECIFICALLY TARGETING HEALTH DISPARITIES		
Intervention: TRU Youth Advisory Council Intervention: __ new _X_ ongoing __ completed Setting: Forsyth County Start Date – End Date (mm/yy): 2012 - ongoing	The lead agency is Forsyth County Department of Public Health and it will coordinate the TRU Youth Advisory Council Partnering Agencies: WSFC Schools Include how you're marketing the intervention School advertisement – flyers/ posters/ announcements Community advertisement – media/ website/ Social Media	**1. Quantify what you will do** • Recruit new TRU members yearly to keep a minimum of 15 active youth members • Hold 2+ meetings each month to discuss tobacco prevention and to plan school and community events • Hold quarterly school/ community events to raise awareness about the dangers of tobacco use **2. Expected outcomes:** • Raise awareness about the dangers of tobacco use. • Increase the number of youth saying NO to tobacco.
INDIVIDUAL CHANGE INTERVENTIONS		
Intervention: ASPIRE program Intervention: __ new _X_ ongoing __ completed Setting: Forsyth County Start Date – End Date (mm/yy): 2012 - ongoing	The lead agency is WSFC Schools and it will promote and use the program for youth caught using tobacco products on school grounds. Partnering Agencies: FCDPH – provide ongoing ASPIRE support Include how you're marketing the intervention: Information packets given to all ISS teachers and school administration.	**1. Quantify what you will do** • Hold annual training for teachers using ASPIRE. • Present ASPIRE program to school administration at quarterly meetings of principals/ assistant principals. **2. Expected outcomes:** • Increase youth knowledge about the dangers of tobacco use • Decrease the number of youth using tobacco products.
POLICY OR ENVIRONMENTAL CHANGE INTERVENTIONS		
Intervention: Secondhand Smoke prevention Intervention: _X_ new __ ongoing __ completed Setting: Forsyth County Start Date – End Date (mm/yy): 2012 - ongoing	The lead agency is Forsyth County Department of Public Health and it will promote the "Keep Childhood Smoke free" message through community interventions and media campaigns. Partnering Agencies: WSFC Schools WIC Downtown Health Plaza Physician Offices Include how you're marketing the intervention Social Media/ Flyers/ Pledge Cards	**1. Quantify what you will do** • Distribute pledge cards and information about keeping childhood smoke free (Smoke Free Homes campaign) • Collect numbers monthly from agencies participating to track use of pledge cards to reduce second hand smoke. **2. Expected outcomes:** • Decrease youth exposure to second hand smoke • Increase awareness about the harmful effects of second hand smoke.

Forsyth County Department of Public Health
Promoting Health, Improving Lives

NCPH North Carolina Public Health

Forsyth County Community Health Action Plan _2011_

Designed to address Community Health Assessment priorities

County: Forsyth **Partnership, if applicable:** Healthy Community Coalition **Period Covered:** 2012-2015

LOCAL PRIORITY ISSUE

- Priority issue: Translating Social Determinants Messages for Lay Audiences
- Was this issue identified as a priority in your county's most recent CHA? _X_ Yes __ No

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

- By (year): 2015
- Objective: To raise public awareness of social determinants of health
- Original Baseline: Baseline data will be established within 2-3years (Pre & Post measurement of campaign awareness of SDH using social media tools.)
- Date and source of original baseline data: N/A
- Updated information (For continuing objective only): N/A
- Date and source of updated information: N/A

POPULATION(S)

- Describe the local population(s) experiencing disparities related to this local community objective: FC Adult Residents and Diverse Community leaders.
- Total number of persons in the local disparity population(s): 250,000
- Number you plan to reach with the interventions in this action plan: 150,000

HEALTHY NC 2020 FOCUS AREA ADDRESSED

__ Tobacco Use
__ Physical Activity and Nutrition
__ Substance Abuse
__ STDs/Unintended Pregnancy
__ Environmental Health
__ Social Determinants of Health (Poverty, Education, Housing)
__ Maternal and Infant Health
__ Injury
__ Mental Health
__ Oral Health
__ Infectious Diseases/ Food-Borne Illness
__ Chronic Disease (Diabetes, Colorectal Cancer, Cardiovascular Disease)
__ Cross-cutting (Life Expectancy, Uninsured, Adult Obesity)
_X_ Other

- Check **one** Healthy NC 2020 focus area: (Which objective below most closely aligns with your local community objective?)
  - **List HEALTHY NC 2020 Objective**: (Detailed information can be found at http://publichealth.nc.gov/hnc2020/ website)
  - **Healthy People 2020 New Topic: Social Determinants of Health.** http://www.healthypeople.gov/2020/about/default.aspx
  - **Goal-** Create social and physical environments that promote good health for all.
  - **Objective:** Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress. This will achieve greater consensus among diverse leaders about the social factors that affect health and the need to act across sectors to improve the health of Forsyth County residents.

RESEARCH RE. WHAT HAS WORKED ELSEWHERE*

List the 3-5 evidence-based interventions (proven to effectively address this priority issue) that seem the most suitable for your community and/or target group.

Intervention	Describe the evidence of effectiveness (type of evaluation, outcomes)	Source
Breaking Through on the SDH and Health Disparities: An Approach to Message Translation (issue brief: translating social determinants messages for lay audiences) Engaging public and private sector decision makers by overcoming challenge of translating the technical information about social determinants and health disparities into language that would resonate with a diverse group of leaders. Explains Commission's faming of issues, describes research based process used to develop messages and shares messages for broader use.	Messages were used by Commissioners representing different sectors and points of view (political). Acceptance as an accomplishment and a measure of success of how topics were positioned.	Robert Wood Johnson Foundation http://www.rwjf.org/pr/product.jsp?id=53235
A Participatory Method to Identify Root Determinants of Health: Co-learning as a principle of CBPR. Must engage community in participatory dialogues around root factors. Use of photo-elicitation process allowed a community-academic partnership to engage members in a dialogue. Similar of focus group processes, photo-elicitation uses photographs and questions to prompt reflection and dialogue. PE opens the dialogue to those with low literacy, focus on institutional and collective events, partnerships. Sustainable Livelihoods framework to guide the PE process.	Community Members were able to discuss how historical and structural factors have affected health. Allowed for understand of how community members perceive the relationship of factors (education and employment) within local context. Programs and Policies need to consider the social, political, economic, and historical contexts to be successful.	Barnridge, E., Baker, E. A., Motton, F., Rose, F., & Fitzgerald. (2010). A Participatory Method to Identify Root Determinants of Health: The Heart of the Matter. *Progress in Community Health Partnerships: Research, Education, and Action, 4*(1), 55-63.
The Value of Good Health-California: Process of creating community health as a new infrastructure. Putting community health at the center of how we do business. To do so: Raise consciousness about community health, change organizational and government practices, and promote policies that ill improve community health. Includes elements of effective tools and process. Includes indicators and accountability questions.	Community Indicator Report-set of indicators to track social, health, and economic conditions in a defined geographic area. Report Cards-community indicator reports that use letter grades or ranking.	Prevention Institute http://www.preventioninstitute.org/component/jlibrary/article/id-85/127.html
Message Design Strategies to Raise Public Awareness of Social Determinants of Health… Focuses on message framing, narratives, and visual imagery. Offers a framework. Based upon prior studies, evidence shows that framing messages should acknowledge a role for individuals decisions about behavior, but emphasizes a SDH.		Robert Wood Johnson Foundation http://www.rwjf.org/pr/product.jsp?id=35691
A New Way to Talk About the Social Determinants of Health Health starts where we live, learn, work and play. A portfolio that shares a way to create more compelling, effective and persuasive messages that resonate across the political spectrum. Includes, evaluation and measurement of ideas put forward. Tested messages which worked to help them communicate more effectively. 3 Steps-Determined how		Robert Wood Johnson Foundation http://www.rwjf.org/pr/product.jsp?id=66428

policy-makers see the world of health, developed messages that we can road test, 3 strengthened the messages with testing. Which words, phrases, and framing work and why. Chapters on Choosing Words (best practices); Finding Fact to fight fiction (data source identification); Thinking in Picture (metaphors); & Changing Frame of mind.		

WHAT INTERVENTIONS ARE ALREADY ADDRESSING THIS ISSUE IN YOUR COMMUNITY?

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

Intervention	Lead Agency	Progress to Date
Promote translational studies in basic, clinical, health services, behavior, policy and population-based research aimed at improving minority health outcomes and eliminating health disparities. Increase the knowledge-base of students, faculty, researchers, healthcare providers and community stakeholders regarding minority health and health disparities. Disseminate and translate research findings to community residents and provide opportunities for investigators and providers to obtain important information from the community. Recommend policies, practices, strategies and programs for healthcare providers, insurers, educators, community organizations and other stakeholders related to improving minority health outcomes and eliminating health disparities.	Center of Excellence for the Elimination of Health Disparities- Winston-Salem State University- http://www.wssu.edu/centers/center-of-excellence-for-the-elimination-of-health-disparities/default-m.aspx	**2012 Health Equity Town Hall Meeting**-To bring forth a community voice by providing a forum for learning through dialogue about health disparities and health care reform, in order to create a course of action for individuals and the community to collectively eliminate health disparities.
Conducting translational research to impact population health, Developing sustainable and mutually-beneficial community partnerships, and Delivering educational initiatives to diversify the clinical, biomedical, and public health workforce	Maya Angelou Center for Health Equity- Wake Forest School of Medicine: http://www.wakehealth.edu/MACHE/	**2012 First Annual Maya Angelou Center for Health Equity Bowl**- Interdisciplinary Student Health Care Competition
The Health Equity Action Team addresses challenges and problems created from racism and poverty. Focus areas of this team include: • The link between neighborhood characteristics & health disparities and a health advisory body that works with the City-County Planning Board to ensure that development in minority neighborhoods positively impacts the health of residents. • Empowering minority population through voters' registration drives that impact voter turn out and future public policies. • Facilitating the planning and hosting of a County Health, Housing & Neighborhood Summit that addresses neighborhood	Health Equity Action Team- Forsyth County Healthy Community Coalition: http://www.healthycommunity.ws/racial.aspx	•Using "Unnatural Causes" in ongoing outreach efforts • A living minimum wage policy to raise income and improve overall health and economic development in minority neighborhoods in our community. This initiative is in partnership with CHANGE, Communities Helping All Neighbors Gain Empowerment. As its first step, the team has encouraged the City of Winston-Salem to set a minimum wage of $9.00 per hour for all its employees

characteristics and health disparities.		

WHAT RELEVANT COMMUNITY STRENGTHS AND ASSETS MIGHT HELP ADDRESS THIS PRIORITY ISSUE?

Community, neighborhood, and/or demographic group	Individual, civic group, organization, business, facility, etc. connected to this group	How this asset might help
Community organization	CHANGE (Communities Helping All Neighbors Gain Empowerment)	• Advocating for different health and wellness issues. • Build a stronger community by developing relationships across racial, ethnic, economic, political, social, and religious lines.
Community Coalition	Healthy Community Coalition with its action teams • Healthy Equity • Environmental Health • Infant Mortality Reduction Coalition • BeHealthy coalition • Domestic violence	• Address specific health concerns and advance healthy policies in Forsyth County
Education	Center of Excellence for the Elimination of Health Disparities-Winston-Salem State University	• Improve minority health outcomes and eliminate health disparities within the community, state and nation through research, education, and community outreach activities.
Education	Maya Angelou Center for Health Equity-Wake Forest School of Medicine	• Conducting translational research to impact population health, • Developing sustainable and mutually-beneficial community partnerships, and • Delivering educational initiatives to diversify the clinical, biomedical, and public health workforce.
Media	WFDD, Newspaper, TV, Radio, social media	• Promote the awareness of social determinants of health through media stories
Funding Agencies	Winston-Salem Foundation Kate B. Reynolds Charitable Trust	• Provide funding to address community/neighborhood projects that highlight effects of social determinants of health and equity
Businesses	Targeted businesses with healthy behavior practices e.g Johnson Control	• Highlight businesses with a list of healthy behavior practices for their workforce with measurable success

INTERVENTIONS: SETTING, & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
INTERVENTIONS SPECIFICALLY TARGETING HEALTH DISPARITIES		
Intervention: Community Forums to raise consciousness and awareness of Social Determinants of Health among diverse community leaders and residents. Intervention: _X_ new __ ongoing __ completed Setting: Community	**Lead Agency:** FC Healthy Community Coalition: Health Equity Action Team Role: Convene and Mobilize Partners Partners: Center of Excellence for the Elimination of Health Disparities-Winston-Salem State University	**1. Quantify what you will do:** • Number of community forums convened • Health Equity Awards for agency, neighborhood or individual who advocates for a healthy community • Number of human interest stories or interviews conducted regarding

Start Date – End Date (September 2012-December 2015): Level of Intervention - change in: _X_ Individuals __ Policy &/or Environment	Role: Organizing and convening different partner groups Partners:_ Maya Angelou Center for Health Equity-Wake Forest School of Medicine: Role Organizing and convening different partner groups Marketing of this intervention will be done through public TV & Radio e.g. WFDD, Channel 13 and social media	health equity **2. Expected outcomes:** • Community forums will increase the number of Forsyth County residents who are aware of the social determinants of health\equity. • At least 4 elected officials are made aware of the Social Determinants of Health
INDIVIDUAL CHANGE INTERVENTIONS		
Intervention: Blue Zones Project campaign to make Forsyth County the healthiest county in North Carolina. Intervention: _X_ new __ ongoing __ completed Setting: Home or Agencies or Neighborhoods Start Date – End Date (September 2012—No End Date	The lead agency is Healthy Community Coalition and it will encourage individuals to utilize and understand Blue Zone Projects and for the community to make healthy choices available (easy & Convenient) to all Forsyth County residents. List other agencies and what they plan to do: Public & Private Sectors, Educational institutions, Businesses, Neighborhood and Media outlets Community –wide campaign for all Forsyth County residents transforming their neighborhoods into happier, healthier places to live, work and play Forsyth Futures will keep track of Community participation and progress towards Blue Zone Community designation. Marketing of this intervention will be through social media, websites of different agencies, coalitions, community organization	**1. Quantify what you will do:** • Number of individuals, families, agencies, neighborhoods who have registered or joined the Blue Zones Project. • Number of events held **2. Expected outcomes:** • Forsyth County residents will begin to think about choices that affect their long-term health. They will make better choices as it relates to their individual health to live longer and better. • Evidence: Blue Zones study of world's long-lived, happiest people and applications into evidence-based interventions. In a pilot project one community raised life expectancy, lost 12,000 pounds, and dropped healthcare costs of city workers by 40%.
POLICY OR ENVIRONMENTAL CHANGE INTERVENTIONS		
Intervention: Social Determinants of Health Media Campaign for Lay Persons Intervention: _X__ new ___ ongoing ___ completed Setting: Community Start Date – End Date (September 2012-December 2015):	The lead agency is Healthy Community Coalition will convene, mobilize and advocate for social determinants of health to be a part of community wellness dialogue. List other agencies and what they plan to do: Media outlets Educational Institutions Public & Private Businesses Coalitions & Community Agencies Will assist in planning, organizing, and framing messages acknowledging individual decision about behavior but emphasizing	**1. Quantify what you will do:** • Partner with one or more media outlet to promote the coalition's community health message. • These partnerships will result in the number of TV segments/ads/ commercials, Radio Discussions/commercials, and Print articles/ads as a form of media advocacy to encourage policy change. • Community Surveys **2. Expected outcomes:** • Educating county residents,

	social determinants of health. Marketing of this intervention will be through social media, websites of different agencies, coalitions, community organization.	organizations, and businesses to engage in practice and policy change to promote health through social determinant of health improvements.
Intervention: County Wide Social Determinants of Health Dialogue and Promotion Intervention: _X__ new ___ ongoing ___ completed Setting: Community Start Date – End Date (September 2012-December 2015):	The lead agency is Healthy Community Coalition. It will engage local elected leaders in discussions on social determinants of health and county entities in promoting practices that address social determinants of health. List other agencies and what they plan to do: Urban League (Election Forums) Facilitate forums, interviews regarding possible initiatives or ways to address social determinants of health for candidates running for elected office Include how you're marketing the intervention Marketing of this intervention will be through organizing agencies and possibly social media	**1. Quantify what you will do:** • Number of SDH discussions or forums held • Community Forum participation • Candidate Forum participation **2. Expected outcomes:** • Increased awareness of SDH among elected candidates • Increased awareness of SDH among Forsyth County residents within their own organization, power, or realm.