

2013

# Buncombe County Community Health Improvement Plan



# 2013 BUNCOMBE COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

August 2013

## **ACKNOWLEDGEMENTS**

The development of this document was led by Buncombe County Health and Human Services along with many partners as part of a community-wide collaborative process.

Our Community Health Improvement Process (CHIP) and plan were also supported by the technical assistance and tools available through our participation in WNC Healthy Impact, a partnership between hospitals and health departments in western North Carolina to improve community health: [www.WNCHealthyImpact.com](http://www.WNCHealthyImpact.com).

Please contact Marian Arledge at (828) 250-5094 if you have any questions or would like to get involved in the strategies currently included in our CHIP plan.

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## EXECUTIVE SUMMARY

### Overview of the Community Health Improvement Process

**Vision:** To build and sustain a healthy Buncombe County.

**Mission:** Individuals, families, and local leaders come together to make Buncombe County a community in which healthy choices are easy to make and are supported by the environment around them.

The Community Health Improvement Process (CHIP) creates collective impact among diverse organizations and individuals in order to improve the priorities identified through our Community Health Assessment (CHA).

#### **Community Health Assessment Priorities for 2012 – 2015:**

- Healthy Living – Physical Activity, Nutrition and Healthy Weight
- Tobacco Prevention and Cessation
- Preconception Health
- Early Childhood Development
- Access to Care

For more information on the Buncombe County 2012 CHA and the data that supports these priorities, visit our [www.BuncombeCounty.org/HealthReports](http://www.BuncombeCounty.org/HealthReports).

Large-scale social change for complex issues requires broad cross-sector coordination - not the isolated intervention of individual organizations. The CHIP uses a collective impact framework as we work with partners to create these keys to success:

- Common Agenda
- Shared measurement system
- Mutually reinforcing activities
- Continuous communication
- Backbone support

The CHIP is driven by two primary groups of individuals and organizations: the Public Health Advisory Council and the Priority Area Workgroups.

#### **The Public Health Advisory Council:**

The Public Health Advisory Council will serve as a catalyst for providing leadership, support, and coordination to assist the community in reaching its health goals. Council members will consider the data and information available through the CHA, provide guidance for the workgroups during the planning process, and oversee the implementation and evaluation of the plan. Members will be responsible for advocating for systems, policy, and environmental change in the community. The Council members will also serve in an advisory capacity to

submit recommendations to the Buncombe County Health and Human Services Board on topics such as public health policy, fee structure changes, and more.

Public Health Advisory Council 2013 Members:

Allison Jordan	Children First – Communities in Schools
Ann Von Brock	United Way of Asheville and Buncombe County
Beth Maczka	YWCA of Asheville
Carrie Runser-Turner	Land of Sky Regional Council
Charlie Jackson	ASAP (Appalachian Sustainable Agriculture Project)
Charlie Schoenheit	Western Highlands LME
David Gardner	NC Center for Health and Wellness
Don Locke	Center for Diversity Education
Hank Dunn	AB Tech
Kit Cramer	The Asheville Area Chamber of Commerce
Nicole Hinebaugh	Asheville Buncombe Food Policy Council
Paul Vest, Co-Chair	YMCA of Western North Carolina
Rebecca Bernstein	Mission Hospital
Richard Hudspeth, MD	Community Care of WNC
Richard Oliver	NC Regional Vet Laboratory
Robert Wagner	Western NC Alliance
Sonya Greck	Mission Hospital
Stephanie Kiser	Mission Hospital
Susanne Swanger, Co-Chair	Buncombe County School System
Terry Bellamy	Arc of Buncombe County
Tim Johnston	Sisters of Mercy

**Priority Area Workgroups:**

Workgroups are composed of representatives from organizations that are currently working on the priority areas: community members and interested Public Health Advisory Council members. Department of Health staff provide support in convening and facilitating the process for the Workgroups. The Workgroups harness existing resources to develop a unique community approach and achieve results beyond the scope of one single institution or organization. Representatives from the Workgroups will report regularly to the Public Health Advisory Council to share actions, emerging issues, and policy recommendations.

The first product of their work together is this CHIP plan.

We will be continuously engaging with new partners as they come to our attention.

Currently engaged partners include:

<ul style="list-style-type: none"> <li>• Addiction, Recovery, Prevention (ARP)</li> <li>• Arc of Buncombe County</li> <li>• ASAP (Appalachian Sustainable Agriculture Project)</li> <li>• Asheville Area Bike &amp; Pedestrian Task Force</li> <li>• Asheville Buncombe Community Christian Ministries</li> <li>• Asheville Buncombe Food Policy Council (and member organizations)</li> <li>• Asheville Buncombe Institute for Parity Achievement</li> <li>• Asheville Buncombe Youth Soccer Association</li> <li>• Asheville City Schools</li> <li>• Asheville Greenworks</li> <li>• BCHHS - Economic Services</li> <li>• BCHHS - Innovative Approaches</li> <li>• BCHHS - Nurse Family Partnership</li> <li>• BCHHS – Outreach and Wellbeing</li> <li>• BCHHS - School Health</li> <li>• BCHHS - Triple P-Positive Parenting Program</li> <li>• BCHHS - Under Six</li> <li>• BCHHS- Family Planning Clinic</li> <li>• BCHHS- Nurse Family Partnership</li> <li>• BCHHS- Youth Educators and Advocates for Health</li> <li>• Blue Ridge Bicycle Club</li> <li>• Bountiful Cities Project</li> <li>• Buncombe Bike Ed Network</li> <li>• Buncombe County Parks, Greenways and Recreation</li> <li>• Buncombe County Schools</li> <li>• Child Abuse Prevention Services</li> <li>• Child Care Health Consultation</li> <li>• Children First-Communities in Schools</li> <li>• Children’s Developmental Services Agency of WNC</li> <li>• City of Asheville</li> <li>• Community Action Opportunities</li> <li>• Community Care of WNC</li> </ul>	<ul style="list-style-type: none"> <li>• FEAST/ Slow Food Asheville</li> <li>• FIRST</li> <li>• Healthy Buncombe Eat Smart Move More Coalition</li> <li>• Innovative Approaches</li> <li>• Land of Sky Regional Council</li> <li>• MAHEC</li> <li>• MAHEC Family Medicine</li> <li>• MANNA Foodbank</li> <li>• Mission Health</li> <li>• Mount Zion Community Development, Inc.</li> <li>• Mountain Area Child &amp; Family Center</li> <li>• NC Cooperative Extension-Buncombe County Center</li> <li>• North Carolina Center for Health and Wellness</li> <li>• North Carolina Preconception Health Campaign/ Mission Health</li> <li>• Park Ridge Health</li> <li>• Pisgah Legal Services</li> <li>• Planned Parenthood Health Systems</li> <li>• Rainbow in My Tummy</li> <li>• Smart Start</li> <li>• The Success Equation</li> <li>• Town of Black Mountain</li> <li>• United Way of Asheville and Buncombe County</li> <li>• V.A. Medical Center: Charles George</li> <li>• Western North Carolina AIDS Project</li> <li>• Western North Carolina Community Health Services</li> <li>• WNC Alliance</li> <li>• WNC Health Network</li> <li>• WNC Pediatric Care Collaborative</li> <li>• WNC Trips for Kids</li> <li>• Women’s Wellbeing &amp; Development Foundation</li> <li>• YMCA of Western North Carolina</li> <li>• Youth Empowered Solutions</li> <li>• YWCA of Asheville</li> </ul>
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## CHIP Plan Outline

### Healthy Living - Physical Activity, Healthy Eating, and Healthy Weight

- Goal 1:** Increase consumption of nutritious, whole foods and beverages that support good health - including fruits and vegetables - among all residents of Buncombe County through improved access, availability, and education
  - Strategy 1.1: Access to foods from local farms
  - Strategy 1.2: Access to free, open, public food sources
  - Strategy 1.3: Retail sources of nutritious foods in low-access communities
  - Strategy 1.4: Financial access to nutritious foods among low-income residents
  - Strategy 1.5: Education about local sources for nutritious foods
  - Strategy 1.6: Organizational policy and environmental support for healthy food access
- Goal 2:** Increase physical activity and healthy eating among students and staff by creating environments in all school settings that promote healthy active lifestyles
  - Strategy 2.1: Policy and environmental supports for physical activity and healthy eating in schools
- Goal 3:** Increase daily physical activity through policy and environmental change to support active transportation
  - Strategy 3.1: Complete streets
  - Strategy 3.2: Organizational environments and policies that support active transportation
  - Strategy 3.3: Community support for active transportation
- Goal 4:** Increase physical activity by creating safe, supportive, and encouraging environments for fitness
  - Strategy 4.1: Community recreational and fitness resources
  - Strategy 4.2: Organizational environments to support physical activity
- Goal 5:** Increase the number of infants in Buncombe County that are breastfed by creating supportive, encouraging policies and environments for breastfeeding
  - Strategy 5.1: Breastfeeding policies
  - Strategy 5.2: Outreach and education
- Goal 6:** Increase the percent of Buncombe County residents at a healthy weight through community and clinical supports and linkages
  - Strategy 6.1: Clinical weight management



- Strategy 6.2: Community resources to support physician-directed clinical weight management

### **Tobacco Prevention and Cessation**

- **Goal 1:** Reduce tobacco use by increasing services and policies that support tobacco cessation
  - Strategy 1.1: Evidence-based practice in clinical settings
  - Strategy 1.2: Employer support for cessation
  - Strategy 1.3: QuitlineNC
  - Strategy 1.4: Access to cessation therapies
- **Goal 2:** Reduce exposure to tobacco-use and secondhand smoke by increasing tobacco-free and smoke-free policies
  - Strategy 2.1: Tobacco-free ordinances and laws
  - Strategy 2.2: Tobacco-free worksites
  - Strategy 2.3: Tobacco-free housing
- **Goal 3:** Prevent and reduce tobacco use among youth and young adults by increasing services and compliance with regulations
  - Strategy 3.1: Compliance with tobacco regulations among institutions that serve youth
- **Goal 4:** Increase public will for tobacco-related policy and environmental changes
  - Strategy 4.1: Influence community culture/norms around tobacco use
  - Strategy 4.2: Mass media campaigns that target youth and young adults

### **Preconception Health**

- **Goal 1:** Increase awareness of the importance of health before pregnancy
  - Strategy 1.1: Preconception health trainings for health care providers
  - Strategy 1.2: Preconception health trainings for consumers
  - Strategy 1.3: Community ambassador peer trainings in preconception health
- **Goal 2:** Increase reproductive health education and awareness among teens
  - Strategy 2.1: Making Proud Choices curriculum
  - Strategy 2.2: Promotional and educational activities by youth peer educators
  - Strategy 2.3: Growth and development and reproductive health and safety curriculum in schools
- **Goal 3:** Increase access to reproductive health services
  - Strategy 3.1: Expedited protocol for birth control prescription

- Strategy 3.2: Enrollment of eligible women in the Be Smart Family Planning Medicaid Waiver
- Strategy 3.3: School nurse family planning/STI case management
- Strategy 3.4: Women's healthcare at methadone clinics
- **Goal 4:** Increase opportunities for interconception care
  - Strategy 4.1: Case management, nursing assessment, and care plans for pregnant and postpartum women
  - Strategy 4.2: Postpartum visits
  - Strategy 4.3: Integrated interconception care

## Early Childhood Development

- **Goal 1:** Increase availability and sustained access to high quality early care and learning
  - Strategy 1.1: Training and technical assistance to support early educators and child-care providers in maintaining and increasing program quality
  - Strategy 1.2: Advocate for increased investment and ensure access to subsidized child-care through vouchers, NC Pre-K, Early Head Start, and Head Start
  - Strategy 1.3: Child care co-ops for low-income families
- **Goal 2:** Support and strengthen families
  - Strategy 2.1: Parenting education that supports effective parenting practices, healthy interaction with children, appropriate developmental expectations, and provides child development referral resources
  - Strategy 2.2: Parent support groups in the community for families to help them build on their strengths and enhance social support systems
  - Strategy 2.3: Community education and case management/care coordination for families experiencing or at risk for child maltreatment
- **Goal 3:** Increase early identification of and intervention/treatment for special healthcare and developmental needs
  - Strategy 3.1: High quality trainings for early educators to screen and for health care providers to identify young children with special health care and developmental needs
  - Strategy 3.2: Case management/care coordination for children with special health care and developmental needs
- **Goal 4:** Improve policies, systems, and environments for children through advocacy
  - Strategy 4.1: Education and advocacy initiatives to reduce the incidence of poverty and its impact on children and early childhood development

## Access to Care

- **Goal 1:** Improve the connection between community programs and clinical providers
  - Strategy 1.1: Create workgroup of clinical providers and community program directors to map out and make systems improvements between their fields

## Monitoring and Accountability

Monitoring and accountability are essential for a successful CHIP. As we use a collective impact framework, we are committed to advancing the use of shared measurements across agencies with related strategies. Buncombe County Health and Human Services staff are available to track key data, develop quality improvement projects with partners to enhance data sharing, and regularly communicate findings to partners and the public. Part of this ongoing tracking and transparency will involve the creation of an online dashboard of key health data and an online version of this CHIP plan, which will be updated regularly to reflect the progress of each strategy.

## CHAPTER 1 - INTRODUCTION

### What is a Community Health Improvement Plan (CHIP Plan)?

A successful Community Health Improvement Process (CHIP) is documented in a “CHIP plan” that outlines the priority health issues for a defined community and how these issues will be addressed. This plan was created through a community-wide, collaborative process that engages partners and organizations to develop, support, and implement the plan. It is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.

This shared plan is intended to help focus and solidify each of our key partner agencies’ commitment to improving the health of the community in specific areas. The goal is that, through sustained, focused effort on this overarching framework, a wide range of public health partners and stakeholders engaged in assessment, planning, and action will be able to document measured improvement on these key health issues over the coming years.

The next phase will involve broad implementation of the action plan details included here and monitoring/evaluation of the short-term and long-term outcomes and indicators.

This 2013 CHIP plan is focused on a six-month to three-year timeline. The CHIP is iterative and involves continuous monitoring; we plan to release an annual update of this document in December 2013 and again in December 2014. The next Community Health Assessment (CHA) will be conducted in 2015.

### How to Use this CHIP Plan

This CHIP plan is designed to be a broad, strategic framework for community health and will be a “living” document that will be modified and adjusted as conditions, resources, and external environmental factors change. It has been developed and written in a way that engages multiple voices and multiple perspectives. We are working toward creating a unified effort that helps improve the health and quality of life for all people who live, work, and play in our county.

We encourage you to review the priorities and goals, reflect on the suggested intervention strategies, and consider how you can join this call to action individually, within your organizations, and collectively as a community.

**To get involved or for questions about this document, please contact Marian Arledge at (828) 250-5094.**

## Connection to the 2012 Community Health Assessment

Community Health Assessment (CHA) is a core step in the larger CHIP for improving and promoting the health of a community. The role of CHA, as a process and product, is to identify factors that affect the health of a population and determine the availability of resources within the county to adequately address these factors.

The 2012 Buncombe County CHA investigated and described the current health status of the community, what has changed since the 2010 CHA, and what still needs to change to improve the health of the community. The process involved the collection and analysis of a large range of secondary data, including demographic, socioeconomic and health statistics, environmental data, as well as primary data such as personal self-reports and public opinion collected by survey, listening sessions, and other methods.

In the 2012 CHA, priorities were chosen by a diverse group of community stakeholders who drew from data and information gathered during the CHA process to make their decisions. The selected priorities do not negate the importance of other health topics, and they do offer opportunities for dramatically improving health outcomes based on the data that was collected and analyzed. Because it took place after only two years of community action since the 2010 assessment, the 2012 CHA did not involve an extensive re-prioritization process. The guiding principles of equity, access to resources, prevention, assets-based approach, and results, impact, and outcomes set by the 2010 CHA Steering Committee were used to clarify and focus 2012 priorities.

### **Community Health Assessment Priorities for 2012 – 2015:**

- Healthy Living: Physical Activity, Healthy Eating, and Healthy Weight
- Tobacco Prevention and Cessation
- Preconception Health
- Early Childhood Development
- Access to Care

The Buncombe County 2012 CHA and past assessments can be found at [www.BuncombeCounty.org/HealthReports](http://www.BuncombeCounty.org/HealthReports).

## WNC Healthy Impact

WNC Healthy Impact is a partnership between hospitals, health departments, and their partners, in western North Carolina to improve community health. As part of a larger, continuous community health improvement process, these partners are collaborating to conduct Community Health (Needs) Assessments across western North Carolina. See [www.WNCHealthyImpact.com](http://www.WNCHealthyImpact.com) for more details about the purpose and participants of this regional effort. The regional work of WNC Healthy Impact is supported by a steering committee, workgroups, local agency representatives, and a public health/data consulting team.

## CHAPTER 2 – HEALTHY LIVING: PHYSICAL ACTIVITY, HEALTHY EATING, AND HEALTHY WEIGHT

### Situational Analysis

Overweight and obesity is a challenging public health issue. And while the “obesity epidemic” is a term frequently seen in the press, the health concern is not weight in and of itself, but rather the long list of chronic disease and disabilities associated with unhealthy weight.

Overweight and obesity is a very complex issue to address given the many factors that influence eating behavior and physical activity, not to mention genetic factors associated with unhealthy weight. Research strongly links the social and built environment to unhealthy weight and, while it may seem counter intuitive, food insecurity is strongly associated.

Overweight is defined as having a Body Mass Index (BMI) of 25 or greater and is associated with chronic disease conditions, including coronary heart disease, type 2 diabetes, cancer,

hypertension, stroke, liver disease, sleep apnea, respiratory problems, osteoarthritis, gynecological problems, and poor health status. While Buncombe County is less overweight than the region and the state, the majority (62.6%) of our adult population still has a BMI of greater than 25. Of those adults who are overweight, almost half have a BMI of greater than 30, pushing them into the obese category. The percentage of the population that is overweight or obese increases with age. Although these rates do meet the Healthy People 2020 goal of adult obesity rates less than 30.6%, we are still far from meeting the Healthy People 2020 goals for both elevated cholesterol and high blood pressure.

Promisingly, trends in BMI-for-age data (which has been collected by Buncombe County School Health since 2004) show unhealthy weight among school-age children at a very slight downward trajectory.

### Did you know?

Only 36 percent of adults and 64 percent of children in grades K-5 are at a healthy weight.

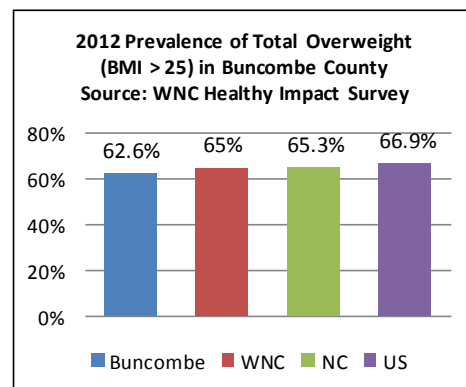
62 percent of Buncombe County residents report meeting the recommended level of weekly physical activity of 30 minutes of moderate physical activity most days of the week.

Less than 10% of residents report eating on average 5 daily fruit and vegetable servings.

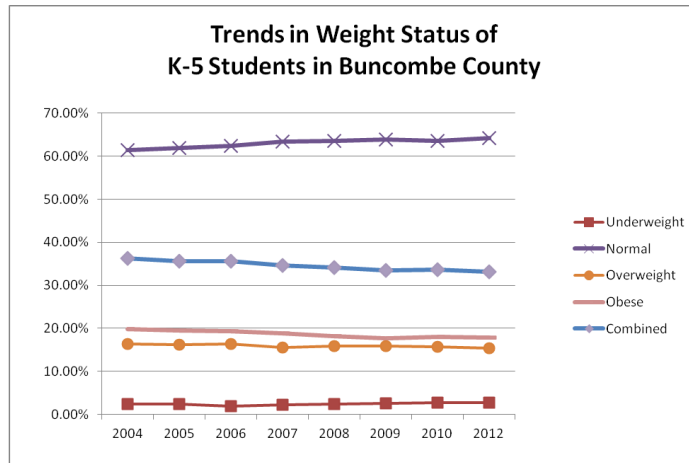
Over a quarter (26%) of residents tell us that during the past year they have been worried about having food run out before they had money to buy more.

Sources:  
WNC Healthy Impact  
Buncombe County School Health

*and behavioral epidemic of diseases are equity. Identifying will require Making these al commitment, families make es, ultimately a ina’s Plan to ight and 2020.*



The good news is that Buncombe County residents want to see their county become a healthier



place to live. More than 9 out of 10 respondents to the CHA telephone survey said they thought it was important that our communities make the following changes:

- Make it easier for people to access farmer’s markets, including mobile farmer’s markets and tailgate markets;
- Increase the public’s access to physical activity spaces at local organizations during off-times; and
- Improve access to trails, parks, and greenways.

Buncombe County has started to make these changes by expanding bike lanes, improving parks, enhancing sidewalks and street lighting, implementing a City Complete Streets Policy, expanding access to local fresh fruits and vegetables for low-income residents, and forming the Asheville Buncombe Food Policy Council to bring individuals and organizations together to address food insecurity.

## Spotlight on Success

### Asheville Buncombe Food Policy Council

Buncombe County is used to showing up on national “best of” lists. However, over the past few years it has had the unwelcome distinction of being on the top ten list of most food insecure communities. This high degree of food insecurity is in stark contrast to the growing local food movement and increasing support for area farmers. To address food insecurity and the much broader issue of a sustainable food system, the Asheville Buncombe Food Policy Council (ABFPC) was formed in 2011. The ABFPC has brought together a diverse group of community partners to identify and propose innovative solutions to spur local economic development and create environmentally-sustainable and socially-just food systems in Buncombe County. More than 150 community organizations and city/county residents came together to develop its mission and governance structure. By its first birthday, the ABFPC had successfully collaborated with the City of Asheville’s Office of Sustainability to develop the city’s first Food Action Plan and quickly assisted in getting zoning regulations changed to allow farmers’ markets in residentially zoned areas in Asheville. Since passage, three new markets have emerged. The ABFPC has also helped raise community awareness of food policy and food security issues across the county. Darcel Eddins, ABFPC co-founder, says, “We’ve done some really big, awesome things in the past year. And we’ve done it in a way that the community is paying attention and is starting to get engaged in a way that is respectful...[the ABFPC has] been unbelievably successful in elevating food in the community awareness.”

### Active Transportation

Awareness and support for active transportation in Buncombe County is an example of how steadily building a network of partners and step by step building on successes can lead to big changes and cultural shifts. Claudia Nix, owner of Liberty Bikes and Blue Ridge Bicycle Club's Advocacy Chair, says, "A decade ago we began to see the importance of broadening our work to partner with health and environmental organizations and make the shift to support all forms of active transportation." Bicycle commuters were not a common sight and urban community centers lacked adequate sidewalks and other safety features. The resulting Strive Not to Drive partnership included a diverse group of professionals and community advocates that has broadened far beyond the original focus of an annual community awareness event. They have consistently engaged in the process of moving policy and environmental change forward through grass-roots advocacy as well as partnering with the City of Asheville and Buncombe County. Their focus has broadly addressed the "5 E's": *Encouragement* - through annual awareness campaigns and walk/bike to school events; *Enforcement* - by working with Asheville Police Department to make streets safer for all users and collaborating in a bicycle head and tail light give-away program; *Education* - by using public health funding to support youth and adult bicycle education programs and provide certification for 10 local bicycle education instructors; *Evaluation* - by beginning efforts to annually count cyclists and pedestrians at key intersections; and *Engineering* - through policy change, including developing the first City Bicycle Plan (adopted 2008) and revising the City Pedestrian Plan (adopted 2008), adoption of the Buncombe County Greenways Master Plan (2012) achieving designation as a bronze level Bicycle Friendly Community (2012), and championing adoption of the City of Asheville's Complete Streets Policy (2012). The advocacy continues to expand and local funders in partnership with Quality Bicycle Products recently paid to send community leaders throughout western North Carolina to Minneapolis to learn innovative strategies to continue building a system that supports active transportation. Since 2009 when the partnership began to conduct bicycle and pedestrian counts at key intersections throughout the City of Asheville, the number of bicyclists and pedestrians has increased by 14% and 52% respectively.

### **The WNC Pediatric Care Collaborative**

The Western North Carolina Pediatric Collaborative (the Collaborative) is an example of what can happen when a group of pediatricians, community health providers, and public health partners come together to collaborate, improve practice, and improve community health. "A lot of people feel they're part of this. It's a grassroots, collaborative and consensus model," says Melissa Baker of the Buncombe County Health Department and Innovative Approaches, an integral partner in the Collaborative. The Collaborative aims to work with physicians to implement evidence-based asthma and obesity care for patients in 15 practices. Built upon existing partnerships and expertise among Community Care of WNC, the Mountain Area Health Education Center (MAHEC), and Buncombe County Health and Human Services, and led by a local pediatrician, the Collaborative is developing systems and procedures to assess and manage the practices' patient populations, track and share data related to asthma and obesity care within and among practices, and provide effective patient education and self-management support. The Collaborative also has a strong prevention focus and is partnering with WNC Healthy Kids to expand social marketing around the "5-2-1-Almost None" pediatric obesity messaging campaign (**5** fruits and vegetables, **2** hours or less of screen time, **1** hour of physical



activity and **almost no** sugar-sweetened beverages), as well as to develop and pilot a screening tool for patient engagement/motivational interviewing. Additionally, school nurses are involved to ensure their efforts to provide care to children/youth through the school setting aligns with primary care.

Carrier Pettler, Quality Improvement Specialist for Community Care of WNC, says the process "helps providers glean a population health perspective." They are able to do this in a "collaborative environment where they can bounce ideas off other providers, learn from people who are having successes, learn from other people's challenges, and implement these things into a practice in a seamless way. Their time in the office is more focused on the patient and the lessons they've learned from the Collaborative and less focused on trying to do that work individually in their practice on their provider time."

## Partners

Addressing physical activity, healthy eating, and healthy weight is complex and will require the collaborative planning, action, and coordination of multiple partners in our community. The following partner agencies and organizations are engaged in efforts to increase physical activity, healthy eating, and healthy weight in our community. As new partners are identified, we will continuously work to bring them into the process.

<b>Organizations:</b>	<b>Website or Contact Information</b>
Asheville Buncombe Community Christian Ministries	<a href="http://www.abccm.org/">http://www.abccm.org/</a>
Asheville Buncombe Food Policy Council (and member organizations)	<a href="http://www.abfoodpolicy.org/">http://www.abfoodpolicy.org/</a>
Asheville Buncombe Institute for Parity Achievement	<a href="http://abipa.org/">http://abipa.org/</a>
Asheville Buncombe Youth Soccer Association	<a href="http://abysa.org/">http://abysa.org/</a>
Arc of Buncombe County	<a href="http://www.arcofbc.org/">http://www.arcofbc.org/</a>
Asheville Greenworks	<a href="http://www.ashevillegreenworks.org/">http://www.ashevillegreenworks.org/</a>
ASAP (Appalachian Sustainable Agriculture Project)	<a href="http://www.asapconnections.org">http://www.asapconnections.org</a>
Asheville City Schools	<a href="http://www.ashevillecityschools.net/Pages/default.aspx">http://www.ashevillecityschools.net/Pages/default.aspx</a>
Asheville Area Bike & Pedestrian Task Force	<a href="http://www.abptaskforce.org/">http://www.abptaskforce.org/</a>
Blue Ridge Bicycle Club	<a href="http://blueridgebicycleclub.org">http://blueridgebicycleclub.org</a>
Buncombe Bike Ed Network	<a href="http://fbrmpo.org/bike_and_ped/buncombe_bike_ed">http://fbrmpo.org/bike_and_ped/buncombe_bike_ed</a>
Bountiful Cities Project	<a href="http://www.bountifulcities.org/">http://www.bountifulcities.org/</a>
Buncombe County Cooperative Extension	<a href="http://buncombe.ces.ncsu.edu/">http://buncombe.ces.ncsu.edu/</a>
Buncombe County Parks, Greenways and Recreation	<a href="http://www.buncombecounty.org/governing/depts/parks/Default.aspx">http://www.buncombecounty.org/governing/depts/parks/Default.aspx</a>

Buncombe County Schools • Child Nutrition	<a href="http://www.buncombe.k12.nc.us">http://www.buncombe.k12.nc.us</a>
Buncombe County Health and Human Services • School Health • Nutrition/WIC • Office of Minority Health Equity Grant	<a href="http://www.buncombecounty.org/Governing/Depts/health/SchoolHealth.aspx">http://www.buncombecounty.org/Governing/Depts/health/SchoolHealth.aspx</a>  <a href="http://www.buncombecounty.org/Governing/Depts/Health/Nutrition.aspx">http://www.buncombecounty.org/Governing/Depts/Health/Nutrition.aspx</a>
City of Asheville • Parks & Recreation • Transportation	<a href="http://www.ci.asheville.nc.us/">http://www.ci.asheville.nc.us/</a>
Community Care of WNC	<a href="http://www.communitycarewnc.org/">http://www.communitycarewnc.org/</a>
Community Transformation Grant Program	
FEAST/ Slow Food Asheville	<a href="http://feast.slowfoodasheville.org/">http://feast.slowfoodasheville.org/</a>
Healthy Buncombe Eat Smart Move More Coalition	<a href="http://www.healthybuncombe.org/">http://www.healthybuncombe.org/</a>
Innovative Approaches	
Land of Sky Regional Council	<a href="http://www.landofsky.org/">http://www.landofsky.org/</a>
MAHEC	<a href="http://www.mahec.net/">http://www.mahec.net/</a>
MANNA Foodbank	<a href="http://mannafoodbank.org/">http://mannafoodbank.org/</a>
Mission Health • Community Benefits • Health Education • Children's Hospital • Weight Management	<a href="http://www.mission-health.org/">http://www.mission-health.org/</a>
North Carolina Center for Health and Wellness	<a href="http://ncchw.unca.edu/">http://ncchw.unca.edu/</a>
Rainbow in My Tummy	<a href="http://www.rainbowinmytummy.com/">http://www.rainbowinmytummy.com/</a>
Smart Start – Shape NC	<a href="http://www.smartstart-buncombe.org/index.php/shape-nc">http://www.smartstart-buncombe.org/index.php/shape-nc</a>

Town of Black Mountain <ul style="list-style-type: none"> <li>• Greenways</li> <li>• Health Initiative</li> </ul>	<a href="http://www.townofblackmountain.org/">http://www.townofblackmountain.org/</a> <a href="http://www.townofblackmountain.org/greenway.htm">http://www.townofblackmountain.org/greenway.htm</a> <a href="http://www.townofblackmountain.org/health.htm">http://www.townofblackmountain.org/health.htm</a>
WNC Alliance	<a href="http://wnca.org/">http://wnca.org/</a>
WNC Health Network <ul style="list-style-type: none"> <li>• WNC Healthy Kids</li> <li>• WNC Health Impact</li> </ul>	<a href="http://www.wnchn.org/">http://www.wnchn.org/</a>
WNC Pediatric Care Collaborative	<a href="http://www.tac-consortium.org/western-north-carolina-pediatric-collaborative-an-organic-process/">http://www.tac-consortium.org/western-north-carolina-pediatric-collaborative-an-organic-process/</a>
WNC Trips for Kids	<a href="http://tripsforkidswnc.kintera.org">http://tripsforkidswnc.kintera.org</a>
Youth Empowered Solutions (YES!)	<a href="http://www.youthempoweredolutions.org/">http://www.youthempoweredolutions.org/</a>
YMCA of Western North Carolina	<a href="http://www.ymcawnc.org/">http://www.ymcawnc.org/</a>
YWCA of Asheville	<a href="http://www.ywcaofasheville.org/">http://www.ywcaofasheville.org/</a>

## Healthy Living: Physical Activity, Healthy Eating, and Healthy Weight Plan

### Vision of Impact

A county where healthy choices are the everyday choice and are supported by improving access, availability, education, and community support for physical activity and healthy food options in places where community members live, learn, earn, play, pray, and pay.

- Adapted from North Carolina's Eat Smart, Move More



### Core Values Statement

Community approaches to promote physical activity, healthy eating, and healthy weight will support all residents of Buncombe County, across the lifespan and of all abilities, with an emphasis on engaging and supporting county residents with greatest need.

State and National Objectives	Baseline/Indicator Source
<b>Related Healthy NC 2020 Objective:</b> Increase the percentage of adults getting recommended amount of physical activity [2011 Baseline: 46.8%; 2020 Target: 60.6%]	BRFSS
<b>Related NC Plan to Address Obesity 2013-2020<sup>1</sup> Objective:</b> By January 1, 2020, at least 61% of North Carolina adults will meet the physical activity recommendation for aerobic activities. [2011 Baseline: 46.8%; 2020 Target: 61 %]	BRFSS
<b>Related NC Plan to Address Obesity Objective:</b> By January 1, 2020, at least 58% of North Carolina children and youth ages 2 to 17 years will exercise, play a sport, or participate in physical activity that makes them sweat or breathe hard for at least 60 minutes on four or more days per week. [2011 Baseline: 53.5%; 2020 Target: 58%]	Child Health Assessment and Monitoring Program. North Carolina State Center for Health Statistics.
<b>Related Healthy NC 2020 Objective:</b> Increase the percentage of adults who report they consume fruits and vegetables five or more times per day. [2011 Baseline: 13.7%; 2020 Target: 29.3%]	BRFSS
<b>Related NC's Obesity Plan Objective:</b> By January 1, 2020, at least 29% of North Carolina adults will consume five or more servings of fruits and vegetables per day. [2011 Baseline: 13.7%; 2020 Target: 29%]	BRFSS
<b>Related NC's Obesity Plan Objective:</b> By January 1, 2020, at least 68% of North Carolina children and youth ages 1 to 17 years will consume five or more servings of fruits and vegetables, including 100% fruit juice, on a typical day. [2011 Baseline: 64%; 2020 Target: 68%]	Child Health Assessment and Monitoring Program. North Carolina State Center for Health Statistics.

<sup>1</sup> North Carolina's Plan to Address Obesity: Healthy Weight and Healthy Communities is consistent with and expands on Healthy NC 2020 Objectives.

<b>Related NC's Obesity Plan Objective:</b> By January 1, 2020, at least 68% of middle school students will be neither overweight nor obese. [2020 Target: 68%]	Child Health Assessment and Monitoring Program. North Carolina State Center for Health Statistics.
<b>Related NC's Plan to Address Obesity Objective:</b> By January 1, 2020, the percentage of North Carolina adults who report that their community has trails, greenways, bike paths, or sidewalks for biking, walking, or other activities will increase by 3.5 percentage points from 2012 baseline. [2012 Baseline: Data will be available in the summer of 2013.]	BRFSS
<b>Related NC's Plan to Address Obesity Objective:</b> By January 1, 2020, the percentage of North Carolina adults who report that it is easy to purchase healthy foods (e.g., whole grain foods, low-fat options, fruits, and vegetables) in their neighborhood will increase by 3.5 percentage points from 2012 baseline. [2012 Baseline: Data will be available in the summer of 2013.]	BRFSS
<b>Community Level Objectives</b>	
1. By December 2015, increase percentage of Buncombe adults engaging in recommended physical activity from 62.1 to 62.6 <sup>2</sup> . [2012 Baseline: 62.1%; 2015 Target: 62.6%]	WNC Healthy Impact
2. By 2015 develop measurement system to assess percent of youth ages 2-17 that exercise, play a sport, or participate in physical activity that makes them sweat or breathe hard for at least 60 minutes on four or more days per week.	TBD
3. By December 2015, the percentage of adults consuming recommended daily servings of fruits and vegetables will increase from 9% to 9.5%. [2012 Baseline: 9%; 2015 Target: 9.5%]	WNC Healthy Impact Survey
4. By 2015 no more than 36.5% of Buncombe adults will be overweight or obese. [2012 Baseline: 36.2%; 2015 Target: 36.5%]	WNC Healthy Impact
5. By 2015 at least 64.65% of students in K-5 public schools will be neither overweight nor obese (> 85th percentile BMI-for-age). [2012 Baseline: 64.15%; 2015 Target: 64.65 %]	Buncombe County School Health BMI Assessment

**Goal 1: Increase consumption of nutritious<sup>3</sup> whole foods and beverages that support good health, with emphasis on fruits and vegetables, among all residents of Buncombe County through improved access, availability, and education**

<sup>2</sup> Most targets are based on an increase by a half percentage point per year consistent with the approach used by Healthy NC 2020 and North Carolina's Plan to Address Obesity.

<sup>3</sup> **Nutritious food** for this document is defined as *fruits, vegetables, whole grains and other minimally processed foods low in added sugars and fats.*

## Strategy 1.1: Access to Foods from Local Farms

### Objective 1.1.1:

Increase the number of local and direct farm-to-consumer outlets in Buncombe County (including farm-to-individual, farm-to-organization, and farm-to-institution outlets)

**Indicator:** Number of farmers' markets, farm stands, and CSAs - North Carolina Fruit and Vegetable Outlet Inventory

### Objective 1.1.2:

Increase sales at **existing** local and direct farm-to-consumer outlets by strengthening, supporting, and sustaining community resources and infrastructure that connect Buncombe County residents, organizations, and institutions to local and direct food retail outlets

**Indicator:** Sales to local and direct farm-to-consumer outlets

### Objective 1.1.3:

Establish baseline and process for measuring the percent of individuals in low-access communities who report **transportation** as a barrier to accessing local/direct farm-to-consumer outlets

**Indicator:** Process for measuring transportation barriers to accessing local/direct farm-to-consumer outlets and indicators identified. (*Establish baseline year 1, year 2 increase*)

## Strategy Background

### Source:

Center for Training and Research Translation Intervention Strategies website:  
[http://www.centertrt.org/?p=find\\_strategies](http://www.centertrt.org/?p=find_strategies)

*Promising Strategies for Creating Healthy Eating and Active Living Environments.* Convergence Partnership, 2011. Available at: <http://www.convergencepartnership.org/atf/cf/%7B245a9b44-6ded-4abd-a392-ae583809e350%7D/PROMISING%20STRATEGIES-07.18.11.PDF>

*Recommended Community Strategies and Measurements to Prevent Obesity in the United States.* CDC, 2009. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>

**Evidence Base:** Several key sets of recommended strategies for increasing access to healthy foods recommend supporting infrastructure and providing incentives for the production, distribution, and processing of local and regionally grown healthy foods (Khan et al. 2009; Center for Training and Research Translation, Convergence Partnership 2011). Providing incentives to produce, distribute, procure, and consume food from local farms may increase the availability and consumption of locally produced foods by community residents, enhance the capacity of the food system, and increase the viability of local farms and food security for communities (Khan et al. 2009).

Mechanisms for purchasing food directly from farms include farmers' markets, farm stands, community-supported agriculture, "pick your own" farming operations, farm-to-school programs, and other farm-to-institution initiatives (universities, childcare, hospitals, etc.), as well as other community organizations such as food banks and businesses such as grocery stores and restaurants. Experts suggest these mechanisms have the potential to increase opportunities to consume more nutritious foods, such as fresh fruits and vegetables, by reducing costs of fresh foods through direct sales; making fresh foods available in areas without supermarkets; and harvesting fruits and vegetables at peak ripeness which might improve their nutritional value and taste (Khan et al. 2009).

Increasing linkages to support a direct link between purchasing foods from farms and improved diet is considered a promising strategy but evidence is limited. Two studies of initiatives to encourage participation in the Seniors Farmers' Market Nutrition Program (Kunkel 2003) and the WIC Farmers' Market Nutrition Program (Conrey 2003) report either increased intention to eat more fruits and vegetables or increased utilization of the program; however, neither study reported direct evidence that the programs resulted in increased consumption of fruits and vegetables. However, a North Carolina study has been funded to explore the potential nutritional and health benefits of eating locally grown foods (Khan et al. 2009).

**Type of Change:** Policy, Environment, Community

**Partner Agencies**

**Lead:** Asheville Buncombe Food Policy Council, ASAP (Appalachian Sustainable Agriculture Project), Bountiful Cities Project

**Collaborating:** Community Transformation Grant Project

**Supporting:** Youth Empowered Solutions, YWCA of Asheville

**Action Plan**

<b>Activity</b> <i>(what is being done?)</i>	<b>Resources Needed</b> <i>(who? how much?)</i>	<b>Anticipated Result</b> <i>(what will happen?)</i>	<b>Result Verification</b> <i>(how will you know?)</i>	<b>Target Date</b> <i>(by when?)</i>
<b>Complete annual Fruit and Vegetable Outlet inventory</b>	Staff time	Up-to-date inventory of all Buncombe County farmers' markets, tailgate markets, and farm stands	Completed inventory submitted to NC Healthy Living	August 30, 2013
<b>Convene partners to continue work on shared measures and roles/responsibilities</b>	Staff time  Working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
<b>Convene partners to develop system for managing data</b>	Staff time Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
<b>Develop detailed action plan for each strategy</b>	Staff time  Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013



<b>Develop communication strategies to increase collaboration and shared information &amp; resources</b>	Staff time  ACS, BCS, SHAC Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013
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### Strategy 1.2: Access to free, open, public food sources

#### Objective 1.2.1:

Maintain and/or increase the percent of the population served by **existing** community programs/services to connect Buncombe County residents to free, emergency, and public food sources (e.g., food pantries, community gardens, MANNA Packs, etc)

**Indicator:** Number of participants in existing programs and/or services (partners still identifying best measure)

#### Objective 1.2.2:

Increase the number of public food sources in Buncombe County that are accessible to all members of the community (e.g., free community/faith/school gardens, fruit and nut trees on public property)

**Indicator:** Number of public food sources

#### Objective 1.2.3:

Increase the percent of eligible residents participating in local emergency food assistance services and programs (e.g., food pantries)

**Indicator:** Per cent of eligible residents participating in local emergency food assistance services/programs

### Strategy Background

#### Source:

Center for Training and Research Translation Intervention Strategies website:

[http://www.centertrt.org/?p=find\\_strategies](http://www.centertrt.org/?p=find_strategies).

*Promising Strategies for Creating Healthy Eating and Active Living Environments.* Convergence Partnership, 2011. Available at: <http://www.convergencepartnership.org/atf/cf/%7B245a9b44-6ded-4abd-a392-ae583809e350%7D/PROMISING%20STRATEGIES-07.18.11.PDF>.

*Recommended Community Strategies and Measurements to Prevent Obesity in the United States.* CDC, 2009. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>.

**Evidence Base:** Community gardens and edible plantings on public land parcels can help increase access to nutritious foods. Several studies have shown that community gardens and

garden-based nutrition intervention programs are associated with increased fruit and vegetable intake among both youth and adults, and may increase willingness to taste fruits and vegetables among youth (Alaimo 2008, Robinson-O'Brien and Heim 2009).

Food insecurity is another important factor to address in improving access to nutritious food sources. More than 1 in 5 (21.8%) of residents of the Asheville Metropolitan Statistical Area experience "food hardship" (defined as not having enough money to buy food for self or family in the past twelve months) (Food Research and Action Center 2013). Emergency food sources such as food pantries can be important resources to alleviate the effects of food insecurity.

**Type of Change:** Policy, Environmental Change

**Partner Agencies**

**Lead:** Asheville Buncombe Food Policy Council, ASAP

**Collaborating and/or Supporting:** Women's Wellness Development Foundation, ABIPA, Coop Extension, MANNA, BCPGR, YMCA, MSJ Community Benefits, WNC Gardens That Give, Healthy Buncombe

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Collaborate with AB Food Policy Asset Mapping Cluster, WNC Gardens that Give, MANNA Food Bank and others to identify baseline measures for nutritious food retail outlets in low-access communities	-Staff time	Up-to-date inventory of all convenience stores, tiendas, and other retail outlets in low-access communities	Completed inventory of public food outlets shared with partners	October/November 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
Develop detailed action plan for each strategy	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
Develop communication strategies to increase collaboration and shared information & resources	-Staff time -ACS, BCS, SHAC Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

### **Strategy 1.3: Retail sources of nutritious foods in low-access communities**

#### **Objective 1.3.1:**

Increase the number of retail outlets in low-access communities within Buncombe County that offer nutritious, whole foods (e.g., convenience/corner stores, mobile markets)

**Indicator:** Number of retail outlets

### **Strategy Background**

#### **Source:**

Food Research and Action Center: [www.frac.org](http://www.frac.org)

*Recommended Community Strategies and Measurements to Prevent Obesity in the United States*. CDC, 2009. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>.

**Evidence Base:** Limited availability of healthier food and beverage choices in underserved communities is a significant barrier to improving nutrition and achieving healthy weight (Morland et al. 2002). Many low-access urban and rural communities do not have grocery stores. In Buncombe County, 16.1% of low-income residents live more than one mile from the nearest grocery store and do not own a car (WNC Healthy Impact 2012). Many of these residents may rely on corner stores or convenience stores which tend to stock and serve mostly unhealthy pre-packaged foods, snacks, and sugar-sweetened beverages. Multiple studies examining associations between children's diets and access to different types of food stores found that youth who had greater access to convenience stores consumed fewer fruits and vegetables (Jago 2007, Timperio 2008). In addition, several studies found that greater availability of healthy food in stores was related to increased consumption of healthy foods at home (Bodor et al. 2008, Cheadle et al. 1991, Fisher et al. 1999). Cross-sectional studies indicate that the presence of retail venues offering healthier food and beverage choices is associated with increased consumption of fruits and vegetables and lower BMI (Zenk 2005).

Supporting methods for lower-income communities to access healthy foods through corner store development programs is a recommended strategy (Leadership for Healthy Communities 2011). In addition, mobile produce markets have been shown to increase access to fruits and vegetables. For example, the New York City Green Carts Initiative aims to increase access to fresh fruits and vegetables by issuing permits to street vendors selling fresh fruits and vegetables. New York City's annual Community Health Survey indicates a significant increase in the consumption of healthy foods since the start of the Green Cart Initiative in 2008. In high-poverty neighborhoods served by the Green Carts, the percentage of adults who said they ate no fruits or vegetables in the previous day dropped from 19 percent in 2004 to less than 15 percent in 2010 (Laurie M. Tisch Illumination Fund).

**Type of Change:** Policy, Environment

**Partner Agencies**

**Lead:** Asheville Buncombe Food Policy Council

**Collaborating:** Community Transformation Grant Project, Youth Empowered Solutions

**Supporting:** Buncombe County WIC Program, University of North Carolina Asheville, Healthy Buncombe

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Collaborate with Youth Empowered Solutions (YES!), AB Food Policy Asset Mapping group and others to identify baseline measures for nutritious food retail outlets in low-access communities	-Staff time	Up-to-date inventory of all convenience stores, tiendas, and other retail outlets in low-access communities	Completed inventory of food outlets shared with partners	October/November 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
Develop detailed action plan for each strategy	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
Develop communication strategies to increase collaboration and shared information & resources	-Staff time -ACS, BCS, SHAC Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

**Strategy 1.4: Financial access to nutritious foods for low-income residents**

**Objective 1.4.1:**  
Increase the number of food retail outlets that accept federal food assistance program benefits (SNAP/EBT, WIC, SFMNP), including farmers' markets, farm stands, CSAs, convenience/corner stores, full-service grocers, and others

**Indicator:** Retail outlets accepting SNAP/EBT, WIC & SFMNP

**Objective 1.4.2:**

Increase the number of low-income residents that receive education about enrolling in federal nutrition assistance programs

**Indicator:** Number of low-income residents receiving education about enrolling in federal nutrition assistance programs

**Objective 1.4.3:**

Increase percent of eligible residents enrolled in federal food assistance programs

**Indicator:** % of eligible residents enrolled in federal food assistance programs

**Objective 1.4.4:**

Increase the consumption of fruits and vegetables by low-income clients of Buncombe County Health and Human Service (those receiving WIC and Nutrition Assistance services)

**Indicator:** BCDHHS client fruit and vegetable consumption

## Strategy Background

**Source:**

Center for Training and Research Translation Intervention Strategies website:

[http://www.centertrt.org/?p=find\\_strategies](http://www.centertrt.org/?p=find_strategies)

*A Guide for Local and State Leaders Working to Create Healthy Communities and Prevent Childhood Obesity.* Leadership for Healthy Communities, 2011. Available at:

<http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/02/action-strategies-toolkit.html>

*Local Government Actions to Prevent Childhood Obesity.* Institute of Medicine (IOM), 2009.

Available at: [http://www.nap.edu/catalog.php?record\\_id=12674](http://www.nap.edu/catalog.php?record_id=12674)

*Recommended Community Strategies and Measurements to Prevent Obesity in the United States.* CDC, 2009. Available at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>

**Evidence Base:** Low-income community members may be challenged to afford more nutritious foods, which tend to be perceived as more expensive than less healthy options. More than 1 in 5 (21.8%) residents of the Asheville Metropolitan Statistical Area experience “food hardship” (defined as not having enough money to buy food for self or family in the past twelve months) (Food Research and Action Center 2013).

Federal nutrition assistance programs support financial access to food for low-income families, who are at greatest risk for food insecurity. These programs include the Supplemental Nutrition Assistance Program (SNAP), the Women, Infants, and Children Program (WIC), and others. Participation in federal nutrition assistance programs has been shown to improve the diets and health of young children (Bitler 2003, Stang and Bayerl 2010, VerPloeg et al. 2009). Research

suggests participating in programs that subsidize nutritious foods and meals may reduce obesity risk among young children (Kimbrow and Rigby 2010), although these results have not been replicated. Some evidence does suggest a positive association between both food insecurity and long-term SNAP participation and weight gain in women (Ver Ploeg and Ralston 2008). However, it is difficult to infer a causal relationship between SNAP participation and obesity because there are many other variables that can influence the likelihood of obesity (Ver Ploeg and Ralston 2008).

The Convergence Partnership and others recommend leveraging the purchasing power of WIC and SNAP program participants to encourage small stores and farmers' markets to offer fruits and vegetables in low-income neighborhoods through Electronic Benefit Transfer (EBT) access. Evidence-based examples include the [New York City Health Bucks](#) program. The Convergence Partnership also recommends improving outreach and efficiency in SNAP delivery and nutrition education (Convergence Partnership 2011).

**Type of Change:** Policy, Environment, Community, Individual

**Partner Agencies**

**Lead:** Asheville Buncombe Food Policy Council, ASAP

**Collaborating:** Community Transformation Grant Project

**Supporting:** Buncombe County DHHS, Community Care of Western North Carolina Healthy Buncombe

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Convene partners to continue work on shared measures and roles/responsibilities</b>	-Staff time -Buncombe Co. DHHS, WC, ASAP & CTG -Other identified working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
<b>Convene partners to develop system for managing data</b>	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
<b>Develop detailed action plan for each strategy</b>	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
<b>Develop communication strategies to increase collaboration and shared information &amp; resources</b>	-Staff time -ACS, BCS, SHAC -Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

## **Strategy 1.5: Education about local sources for nutritious foods**

### **Objective 1.5.1:**

Increase the number of individuals (organizations) that receive education about available sources of nutritious whole foods in their community and how to use them, including: local and direct food retail outlets; free, open, public food sources (gardens, fruit/nut trees); nutritious food retail outlets in low-income communities; local emergency food assistance services; and others

**Indicator:** Number of individuals (organizations) that receive education from working group partners about available sources of nutritious, whole foods

Number of residents that receive media communications

### **Objective 1.5.2:**

Increase the number of residents who receive education about producing and preparing their own food (e.g., home gardening, cooking, preserving, etc.)

**Indicator:** Number of residents who receive direct education from partners about producing and preparing their own food

## **Strategy Background**

### **Source:**

Center for Training and Research Translation. Intervention Strategies website. Available at: [http://www.centertrt.org/?p=find\\_strategies](http://www.centertrt.org/?p=find_strategies)

**Evidence Base:** Nutrition education focused on improving individual knowledge, attitudes, and beliefs about healthy eating is a critical component to improving healthy eating behaviors. Education is most effective when paired with policy and environmental change to support healthy eating behaviors. Education may involve group classes or individual education/counseling. The Center for Training and Research Translation recommends individual counseling as an effective strategy for positively changing an individual's healthy eating behaviors (Center for Training and Research Translation). Group nutrition education programs have also been shown to be effective in improving participants' eating behaviors. For example, data from the USDA Expanded Food and Nutrition Education Program (EFNEP) shows that individuals eat a diet closer to MyPlate recommendations after participating in EFNEP than they did before (U.S. Department of Agriculture 2012).

**Type of Change:** Individual, Community

### **Partner Agencies**

**Lead:** TBD

**Collaborating:** Buncombe County WIC Program, Community Care of Western North Carolina, Asheville Buncombe Food Policy Council, University of North Carolina Asheville

**Supporting:** Smart Start of Buncombe, Land-of-Sky Regional Council, Mission Health/NC Preconception Health Campaign, FEAST, YWCA of Asheville, NC Cooperative Extension, Healthy Buncombe

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Convene partners to continue work on shared measures and roles/responsibilities</b>	-Staff time -BCDHHS, WIC, Coop Extension, ASAP, FEAST, Mission Health -Other identified working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
<b>Convene partners to develop system for managing data</b>	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
<b>Develop detailed action plan for each strategy</b>	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
<b>Develop communication strategies to increase collaboration and shared information &amp; resources</b>	-Staff time -ACS, BCS, SHAC -Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

**Strategy 1.6: Organizational policy and environmental support for healthy food access**

**Objective 1.6.1:**

Establish baseline for outreach contacts to organizations for encouraging and/or creating organizational environments that support healthy food access

**Indicator:** Baseline measures identified (*Establish baseline year 1, year 2 increase*)

**Objective 1.6.2:**

Increase the number of organizations, institutions, businesses, and workplaces that have environments and/or policies to support nutritious food access

**Indicator:** Number of organizations, institutions, businesses, and workplaces that have environments and/or policies to support nutritious food access

**Strategy Background**

**Source:**

Center for Training and Research Translation. Intervention Strategies website. Available at: [http://www.centertrt.org/?p=find\\_strategies](http://www.centertrt.org/?p=find_strategies).



*Local Government Actions to Prevent Childhood Obesity*. Institute of Medicine (IOM), 2009. Available at: [http://www.nap.edu/catalog.php?record\\_id=12674](http://www.nap.edu/catalog.php?record_id=12674).

**Evidence Base:** Organizational environments (e.g., worksites, hospitals, schools, childcare programs, recreation facilities) can support healthy food choices. For example, many children spend a significant amount of time in after-school programs, childcare, and recreation centers. Research suggests that the nutritional quality of meals and snacks in childcare settings can be poor and activity levels may be inadequate (Ball et al. 2008, Padget and Briley 2005, Story et al. 2006). Creating strong nutrition policies and practices for publicly-operated facilities and programs that serve children and adults can also support environments for promoting healthy eating choices.

Many of the evidence-based strategies already described may be applied in the organizational setting. For example, hospital cafeterias and school nutrition programs may choose to purchase food from local farms. Work sites can make nutritious foods and beverages more available in vending machines, stores, and canteens. Childcare programs can increase participation in the Child and Adult Care Food Program. In addition, organizations, institutions, businesses, and work sites can implement evidence-based strategies such as comprehensive nutrition programs, point-of-purchase prompts and point-of-decision-making labeling to encourage healthier food choices, pricing food items to favor healthier options, and providing social support for healthy eating (Center for Training and Research Translation).

**Type of Change:** Policy, Environment

**Partner Agencies**

**Lead:** TBD

**Collaborating:** WNC Health Network, WNC Healthy Kids Initiative, ASAP, University of North Carolina Asheville

**Supporting:** Youth Empowered Solutions, Buncombe County Health and Human Services (OMH Grant), Healthy Buncombe

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -WNC Health Network, WNC Healthy Kids, ASAP, UNC Asheville -Other identified working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
Develop detailed action plan for each	-Staff time -Working group	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013

<b>strategy</b>	<b>participants</b>			
<b>Develop communication strategies to increase collaboration and shared information &amp; resources</b>	-Staff time -ACS, BCS, SHAC Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

**Goal 2: Increase physical activity and healthy eating among students and staff by creating environments in all school settings that promote healthy active lifestyles**

**Strategy 2.1: Policy and environmental supports for physical activity and healthy eating in schools**

**Objective 2.1.1:**  
 Increase the percent of public schools in Buncombe County (ACS & BCS) that improve their Zone Health Assessment by implementing policy/environmental changes that support physical activity and healthy eating  
**Indicator:** Zone Health Assessment scores

**Objective 2.1.2:**  
 Increase the number of opportunities for students to be active in educational settings (before, during, after, and on the way to and from school)  
**Indicator:** TBD – will work with partners to identify indicators

**Objective 2.1.3:**  
 Improve the percent of a la cart items offered in public schools that meet USDA guidelines  
**Indicator:** Percent of a la cart items that meet USDA guidelines (approach for this will be identified with consideration of new USDA regulations)

**Objective 2.1.4:**  
 Increase the number of partnerships between schools and community organizations to support physical activity and healthy eating  
**Indicator:** Number of community/school physical activity and healthy eating partners

**Strategy Background**

**Source:**

*Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation*. IOM, 2012. Available at: <http://www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx>.

*School District Wellness Policies: Evaluating Progress and Potential for Improving Children's Health Five Years after the Federal Mandate. School Years 2006–07 through 2010–11. Volume 3*. Bridging the Gap, 2013. Available at: [http://www.bridgingthegapresearch.org/\\_asset/13s2jm/WP\\_2013\\_report.pdf](http://www.bridgingthegapresearch.org/_asset/13s2jm/WP_2013_report.pdf).

**Evidence Base:** Evidence supports building activity into the school day outside of physical education, increasing availability of nutritious foods, and decreasing availability of less healthy foods positively impact healthy weight (Chriqui et al. 2013). Since 2006, federal law has required local school districts participating in federal nutrition programs to develop wellness policies that: include goals for nutrition education; assure school meals meet the minimum federal school meal standards; establish guidelines for foods and beverages sold or served outside of school meal programs; establish goals for physical activity and other school-based activities; and develop plans for implementation. While there has been progress to implement, strengthen, and/or increase the comprehensiveness of these policies, there is still a wide gap in compliance among the mandatory policy provisions (Chriqui et al. 2013). In addition, implementation and enforcement of these policies could be stronger, largely due to inadequate funding.

The Task Force on Community Preventive Services 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 (Guide to Community Preventive Services 2009). By increasing the required amounts of vigorous physical activity in schools, elementary and high school students in 13 studies conducted from 1983 to 1999 had consistently improved fitness levels (Active Living Research 2007). Research has also shown strong snack food and beverage standards can play a significant role in the school food environment (Bridging the Gap 2013). School nutrition environments will be impacted by new USDA guidelines for competitive foods in schools.

**Type of Change:** School, policy

#### **Partner Agencies**

**Lead:** Buncombe County Schools, Asheville City Schools, School Health Advisory Council, Blue Ridge Bicycle Club (for SRTS advocacy)

**Collaborating:** Smart Start of Buncombe, Asheville Buncombe Food Policy Council, Buncombe County Parks Greenways and Recreation, Buncombe County Health and Human Services, ASAP

**Supporting:** WNC Health Network, WNC Healthy Kids Initiative, Community Transformation Grant Project, Blue Ridge Bicycle Club, Youth Empowered Solutions, University of North Carolina Asheville, YWCA of Asheville, Healthy Buncombe

## Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Develop community partner inventory	-Staff time -Working group participants School Wellness Committees	Up-to-date inventory of organizations partnering with schools to assist in promotion of healthy eating and/or physical activity	Completed inventory posted on ACS and BCS websites and CHIP online document	Oct/November 2013
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -WNC Health Network, WNC Healthy Kids, ASAP, UNC Asheville -Other identified working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
Develop detailed action plan for each strategy	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
Develop communication strategies to allow schools and supporting organizations to connect and increase physical activity and healthy eating support	-Staff time -ACS, BCS, SHAC Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

## Goal 3: Increase daily physical activity through policy and environmental change to support active transportation

### Strategy 3.1: Complete Streets

#### Objective 3.1.1:

Increase the number of city and county policies adopted that promote complete streets policies

**Indicator:** Percent of Buncombe County governments with complete streets policies

#### Objective 3.1.2:

Increase the total mileage of bicycle and pedestrian facilities that support safe, active transportation (sidewalks, greenways and bike lanes/routes)

**Indicator:** Miles of bicycle facilities  
Miles of sidewalks & greenways

#### Objective 3.1.3:

Increase the mileage of continuous bicycle and pedestrian facilities that support safe, active

transportation (sidewalks, greenways and bike lanes/routes)

**Indicator:** Miles of continuous bicycle and pedestrian facilities

**Objective 3.1.4:**

Increase the number of bicycle transportation routes supported by wayfinding signage

**Indicator:** Miles of bicycle routes supported by wayfinding signage

## Strategy Background

**Source:**

Center for Training and Research Translation Intervention Strategies website:

[http://www.centertrt.org/?p=find\\_strategies](http://www.centertrt.org/?p=find_strategies).

National Complete Streets Coalition: <http://www.completestreets.org/>

*Recommended Community Strategies and Measurements to Prevent Obesity in the United States*. CDC, 2009. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>.

**Evidence Base:** Comprehensive reviews of research on the impact of active transportation determined that improved bicycling infrastructure, as well as street-scale urban design and land use policies that support walking, are effective in increasing levels of physical activity (Macbeth 1999, Dill and Carr 2003, Nelson and Allen 1997, Heath et al. 2006). The few studies examining the relationship between public transportation and physical activity have found a positive association. For example, one study found transit users have higher levels of physical activity because they walked to transit stops (Zheng 2008).

To support active transportation, communities across the country are adopting “Complete Streets Policies” that ensure transportation planners and engineers consistently design and operate the entire roadway with all users in mind – including bicyclists, public transportation vehicles and riders, and pedestrians of all ages and abilities (National Complete Streets Coalition). A total of 488 Complete Streets Policies are now in place across the nation at all levels of government, including in 42 regional planning organizations, 38 counties, and 379 municipalities in 48 states (SmartGrowth America 2013). The National Complete Streets Coalition has identified ten elements of a comprehensive Complete Streets Policy that local governments are encouraged to incorporate into their transportation policies.

**Type of Change:** Policy, Environment

### Partner Agencies

**Lead:** City of Asheville Transportation Department, Blue Ridge Bicycle Club

**Collaborating:** Buncombe County Parks Greenways and Recreation Services

**Supporting:** Community Transformation Grant Project, Healthy Buncombe

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
Develop detailed action plan for each strategy	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
Develop communication strategies to increase collaboration and shared information & resources	-Staff time -Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

**Strategy 3.2: Organizational environments and policies that support active transportation**

**Objective 3.2.1:**

Establish baseline for outreach contacts to organizations for encouraging and/or creating organizational environments that support active transportation

**Indicator:** Outreach contact baseline identified (*Establish baseline year 1, year 2 increase*)

**Objective 3.2.2:**

Provide educational programs and opportunities to business, civic, and community organizations and leaders

**Indicator:** Establish baseline for educational contacts (*Establish baseline year 1, year 2 increase*)

**Objective 3.2.3:**

Increase the number of organizations, institutions (schools, universities, hospitals), businesses, and workplaces that have environments and/or policies to support active transportation

**Indicator:** Inventory of organizations with environments and/or policies that support active transportation (*Establish baseline year 1, year 2 increase*)

**Strategy Background**

**Source:**

Center for Training and Research Translation Intervention Strategies website:  
[http://www.centertrt.org/?p=find\\_strategies](http://www.centertrt.org/?p=find_strategies)

National Center for Safe Routes to School: <http://www.saferoutesinfo.org/>

*Recommended Community Strategies and Measurements to Prevent Obesity in the United States.* CDC, 2009. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>

**Evidence Base:** Organizational environments can support active transportation among employees and other groups. For example, Walk and Ride programs, rather than Park and Ride, combines active transportation with public transportation. Bike-to-Work Fridays, showers, and bike racks at office buildings can support employees biking to work (Center for Training and Research Translation).

In addition, schools can support students actively traveling to or from school. Children who walk or bicycle to school have higher levels of physical activity and better cardiovascular fitness than children who do not actively commute to school (Davison et al. 2008). Further, riding a bicycle at least two or more days per week is associated with a decreased likelihood of childhood overweight (Dudas and Crocetti 2008). The national percentage of youth ages 5 to 18 who walk or ride a bicycle to school dropped from 42 percent in 1969 to only 16 percent in 2001 (National Household Transportation Survey 2003). Safe Routes to School (SRTS) Programs address infrastructure, education, and safety concerns to support students biking and walking to school. For example, a SRTS program in Marin County, CA that included both safety improvements and encouragement to walk to school, increased the number of children walking to school by 64 percent in two years (Staunton et al. 2003).

**Type of Change:** Policy, Environment

**Partner Agencies**

**Lead:** Buncombe County Parks Greenways and Recreation Services

**Collaborating:** Blue Ridge Bicycle Club

**Supporting:** Blue Ridge Bicycle Club, City of Asheville Transportation Department, Youth Empowered Solutions, Land-of-Sky Regional Council - Land Use & Transportation, Healthy Buncombe

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting	Data management and accountability system and timeline for strategy	Internet-based system established	Oct/November 2013

	partners	developed		
<b>Develop detailed action plan for each strategy</b>	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
<b>Develop communication strategies to increase collaboration and shared information &amp; resources</b>	-Staff time -Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

### Strategy 3.3: Community support for active transportation

#### Objective 3.3.1:

Increase resident awareness of active transportation options through promotional/informational materials and multimedia

**Indicator:** Indicator for resident awareness TBD  
Number of community/media communications

#### Objective 3.3.2:

Increase resident perceptions of active transportation as desirable and convenient through promotion and education

**Indicator:** Indicator of perceptions TBD  
Number of promotional messages

#### Objective 3.3.3:

Increase the number of residents safely using active transportation

**Indicator:** Number of pedestrians, number of bicyclists, and helmet usage from annual bicycle and pedestrian count  
Pedestrian/bicycle accidents per capita (measurement approach TBD)

### Strategy Background

#### Source:

Center for Training and Research Translation Intervention Strategies website:  
[http://www.centertrt.org/?p=find\\_strategies](http://www.centertrt.org/?p=find_strategies)

*Local Government Actions to Prevent Childhood Obesity.* Institute of Medicine (IOM), 2009.  
Available at: [http://www.nap.edu/catalog.php?record\\_id=12674](http://www.nap.edu/catalog.php?record_id=12674)

*Recommended Community Strategies and Measurements to Prevent Obesity in the United States.* CDC, 2009. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>



**Evidence Base:** Community awareness, perceptions, and knowledge about active transportation options impact active transportation behaviors. For example, perceived safety has a significant effect on walking for both children and adults (Carver et al. 2008, Cleland et al. 2008, Weir et al. 2006). The Center for Training and Research Translation recommends comprehensive community-wide campaigns to increase physical activity as an evidence-based strategy. These campaigns include raising awareness, educating, and building support among community members to increase physical activity. Mass media, social support programs, individual education, health fairs, physical activity events, and environmental changes may be components of these comprehensive community-wide campaigns (Center for Training and Research Translation).

**Type of Change:** Community, Individual

**Partner Agencies**

**Lead:** Buncombe County Parks Greenways and Recreation Services, Blue Ridge Bicycle Club

**Collaborating:** Buncombe County Health and Human Service, Office of Minority Health Grant, City of Asheville Transportation Department

**Supporting:** Blue Ridge Bicycle Club, Healthy Buncombe

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
Develop detailed action plan for each strategy	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
Develop communication strategies to increase collaboration and shared information & resources	-Staff time -Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

**Goal 4: Increase physical activity by creating safe, supportive, and encouraging environments for fitness**

**Strategy 4.1: Community recreational and fitness resources**

**Objective 4.1.1:**

Increase the number of shared-use agreements for community-based facilities (schools, churches, businesses, etc.) available for recreational physical activity in Buncombe County

**Indicator:** Number of shared-use agreements

**Objective 4.1.2:**

Establish baseline for recreational and fitness programs and facilities available to residents of Buncombe County

**Indicator:** Baseline identified for number of recreational and fitness programs/facilities (*Establish baseline year 1, year 2 increase*)

**Objective 4.1.3:**

Develop approach to evaluate and improve opportunities for individuals using/participating in physical activity and establish baseline indicators

**Indicator:** Evaluation strategy for physical activity participation developed (*Establish baseline year 1, year 2 increase*)

**Strategy Background****Source:**

Center for Training and Research Translation Intervention Strategies website:  
[http://www.centertrt.org/?p=find\\_strategies](http://www.centertrt.org/?p=find_strategies).

ChangeLab Solutions Joint Use Agreement webpage:  
<http://changelabsolutions.org/childhood-obesity/joint-use>

The Guide to Community Preventive Services website. Available at:  
<http://www.thecommunityguide.org/pa/environmental-policy/improvingaccess.html>

NC Healthy Schools Joint Use guide: <http://www.nhealthyschools.org/docs/home/use-agreements.pdf>

**Evidence Base:** Creating or enhancing access to places for physical activity has strong evidence of effectiveness in increasing physical activity and improving physical fitness (The Guide to Community Preventive Services, Creation of or Enhanced Access to Places for Physical Activity). A comprehensive review of 108 studies indicated that access to facilities and programs for recreation near their homes and time spent outdoors correlated positively with increased physical activity among children and adolescents (Sallis et al. 2000). In addition, a 10-study review concluded that increasing access to places for physical activity, when combined with educational activities, can effectively increasing physical activity (Kahn 2002).

Specific strategies to increase the accessibility of existing physical spaces include making sure physical activity facilities are safe, clean, and appealing, and/or extending operation hours to accommodate a variety of daily schedules. This strategy of increasing access is often used in combination with informational and social support strategies or as part of a community-wide campaign (Center for Training and Research Translation). "Joint-use" or "shared-use" agreements are another promising strategy involving a written agreement between two public or private organizations (e.g., a school district and a county parks & recreation department) that establishes terms and conditions for sharing the use of facilities (ChangeLab Solutions 2010). Joint use agreements are being increasingly adopted in communities across the country, and many states and communities are developing policies that support joint use. North Carolina law allows local school boards to enter into joint use agreements.

**Type of Change:** Policy, Environment

**Partner Agencies**

**Lead:** Buncombe County Parks Greenways and Recreation Services, Asheville Parks

**Collaborating:** Buncombe County Health and Human Service Office of Minority Health Grant, Community Transformation Grant Project

**Supporting:** University of North Carolina Asheville, YWCA of Asheville, Blue Ridge Bicycle Club

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
Develop detailed action plan for each strategy	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
Develop communication strategies to increase collaboration and shared information & resources	-Staff time -Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

**Strategy 4.2: Organizational environments to support physical activity**

**Objective 4.2.1:**

Establish baseline for outreach contacts to organizations for encouraging and/or creating

organizational environments that support physical activity and fitness

**Indicator:** Outreach strategy developed

Baseline for outreach contacts established (*Establish baseline year 1, year 2 increase*)

**Objective 4.2.2:**

Inventory organizations, institutions, businesses, and workplaces that have environments, programs, and/or policies to support physical activity (*Establish baseline year 1, year 2 increase*)

**Indicator:** Inventory of organizations that have environments, programs, and/or policies to support physical activity completed

**Objective 4.2.3:**

Develop and implement a comprehensive communication campaign about new and existing physical activity opportunities through community-based networks (e.g. community centers, churches, neighborhood associations, coalitions)

**Indicator:** Communication campaign developed  
Communication campaign implemented

## Strategy Background

**Source:**

Center for Training and Research Translation Intervention Strategies website:

[http://www.centertrt.org/?p=find\\_strategies](http://www.centertrt.org/?p=find_strategies)

*Early Childhood Obesity Prevention Policies*. Institute of Medicine (IOM), 2011. Available at:

[http://www.nap.edu/catalog.php?record\\_id=13124](http://www.nap.edu/catalog.php?record_id=13124)

*Local Government Actions to Prevent Childhood Obesity*. IOM, 2009. Available at:

[http://www.nap.edu/catalog.php?record\\_id=12674](http://www.nap.edu/catalog.php?record_id=12674)

**Evidence Base:** Institutions, worksites, child care centers, after-school programs, and other organizations can create environments that support regular physical activity. Changes in institutional practices and the built environment which structurally integrate physical activity into routines can increase automatic physical activity (Bower et al. 2008, Donnelly et al. 2009, Lara et al. 2008). There is also observational evidence that the availability of play equipment increases physical activity in child care centers (IOM 2009). Observational evidence supports developing worksite policies and practices that build physical activity into routines. The Center for Training and Research Translation cites examples including office-wide exercise breaks and walking meetings that provide opportunities for employees to be active during the work day. Point-of-decision prompts such as signs or banners posted near elevators, escalators, moving walkways, and stairwells can encourage individuals to use stairwells or climb/walk rather than taking a more passive option. Such prompts have been evaluated in worksites and community settings, such as malls, airports, and office buildings (Center for Training and Research Translation).

In addition to changing organizational environments and policies, raising awareness, educating, and building support among community members is an important component of comprehensive community-wide campaigns to increase physical activity. Mass media, social support programs, individual education, health fairs, physical activity events, and environmental changes may be components of these comprehensive community-wide campaigns (Center for Training and Research Translation).

**Type of Change:** Policy, Environment, Community

**Partner Agencies**

**Lead:** Buncombe County Parks Greenways and Recreation Services, City of Asheville

**Collaborating:** Blue Ridge Bicycle Club, Blue Ridge Bicycle Club

**Supporting:** Blue Ridge Bicycle Club, City of Asheville Transportation Department, Healthy Buncombe

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
Develop detailed action plan for each strategy	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
Develop communication strategies to increase collaboration and shared information & resources	-Staff time -Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013
Develop inventory of organizations, institutions, businesses, and workplaces that have environments, programs, and/or policies to support physical activity	-Staff time -Working group partners	Inventory of organizations with environments, programs or policies to support physical activity	Completed inventory of organizations	November 2013
Develop community campaign/outreach strategy to promote organizational	-Staff time -Working group partners	Campaign/ outreach strategy developed	Strategy shared with partners and published on CHIP internet site	Nov/December 2013

support for physical activity				
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**Goal 5: Increase the number of infants in Buncombe County that are breastfed by creating supportive, encouraging policies and environments for breastfeeding**

**Strategy 5.1: Breastfeeding policies**

**Objective 5.1.1:**  
 Identify and increase community and government breastfeeding policies that support breastfeeding in the community (i.e. recreation facilities, restaurants, marketplaces)

**Indicator:** Number of community and government organizations with breastfeeding policies  
*(Establish baseline year 1, increase year 2)*

**Objective 5.1.2:**  
 Increase the number of workplaces that offer appropriate breastfeeding facilities and policies to allow breastfeeding mothers to pump or feed

**Indicator:** Number of workplaces with breastfeeding policies  
*(Establish baseline year 1, increase year 2)*

**Strategy Background**

**Source:**

*The CDC Guide to Breastfeeding Interventions.* CDC, 2005. Available at:  
<http://www.cdc.gov/breastfeeding/resources/guide.htm>

**Evidence Base:** Policies that create supportive environments for breastfeeding can be established in a variety of settings, including hospitals (e.g., Baby Friendly Hospital initiatives), out-patient medical facilities, community clinics, restaurants, stores, libraries, and other public places. Workplace policies in particular are a key strategy to increase breastfeeding. A mother working outside the home is associated with a shorter duration of breastfeeding, and intentions to work full time are significantly associated with lower rates of breastfeeding initiation and shorter duration (Fein and Roe 1998). Low-income women are more likely than their higher-income counterparts to return to work earlier and to be engaged in jobs that make it challenging for them to continue breastfeeding (Lindberg 1996).

A supportive workplace environment might include written policies, staff training, appropriate breastfeeding facilities, flexible work environments that allow breastfeeding infants to be brought to work, onsite child care services, provision of breast pumps, professional support services, and paid or extended maternity leave (Shealy et al. 2005).

One systematic review analyzing the relationship between environmental interventions to support breastfeeding and childhood obesity-related outcomes could not identify any randomized control trials that have tested the effectiveness of workplace interventions promoting breastfeeding (Abdulwadud and Snow 2007). However, another study demonstrated that women who directly breastfed at work and/or pumped breast milk at work breastfed at a higher intensity than women who did not either breastfeed or pump at work (Fein et al. 2008) . Furthermore, evaluations of individual interventions that support breastfeeding in the workplace showed increased initiation rates and duration of breastfeeding compared with national averages (Shealy et al. 2005).

**Type of Change:** Policy, Environment

**Partner Agencies**

**Lead:** TBD

**Collaborating:** Buncombe County WIC Program, Community Care of Western North Carolina, Mission Health

**Supporting:** YWCA of Asheville

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Convene partners to continue work on shared measures and roles/responsibilities</b>	Staff time  working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
<b>Convene partners to develop system for managing data</b>	Staff time Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
<b>Develop detailed action plan for each strategy</b>	Staff time  Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
<b>Develop communication strategies to increase collaboration and shared information &amp; resources</b>	Staff time  Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013
<b>Develop inventory of community organizations and government policies to support breast feeding</b>	Staff time  Working group partners	Inventory of organizations with environments, programs or policies to support breastfeeding	Completed inventory of organizations.	November 2013
<b>Develop inventory of</b>	Staff time	Inventory of workplaces	Completed inventory of	Nov/December 2013

<b>workplaces that have policies to support breast feeding</b>	Working group partners	with environments, programs or policies to support breastfeeding	workplaces.	
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## Strategy 5.2: Outreach and education

### Objective 5.2.1:

Increase the number of individuals and organizations receiving promotional information and education about breastfeeding

**Indicator:** The number of individuals and organizations receiving promotional information and education about breastfeeding

## Strategy Background

### Source:

CDC Guide to Breastfeeding Interventions:

<http://www.cdc.gov/breastfeeding/resources/guide.htm>

**Evidence Base:** Educating mothers, support networks, and the community at large is important in building support for breastfeeding. A review of 30 controlled trials and 5 systematic reviews determined education on breastfeeding to be the single most effective intervention for increasing breastfeeding initiation and short-term duration (Guise et al. 2003). Another review of 20 controlled trials found that prenatal education in small groups is effective in increasing breastfeeding initiation rates (Sikorski et al. 2003). Social marketing and media campaigns targeting mothers, support systems, care providers, and the general public can help increase acceptance of breastfeeding. A 2000 Cochrane review suggests that media campaigns, particularly television commercials, have been shown to improve attitudes toward breastfeeding and increase initiation rates. The review cited a study demonstrating that a comprehensive social marketing approach including interventions to increase public awareness (through media and other outlets) increased rates of initiation and duration while also improving perceptions of community support for breastfeeding. This same review found that targeting only specific groups such as healthcare providers or the general public have not shown evidence of effectiveness on their own (Fairbank et al. 2000).

**Type of Change:** Community

### Partner Agencies

**Lead:** TBD

**Collaborating:** Buncombe County WIC Program, Community Care of Western North Carolina, Mission Health

**Supporting:** YWCA of Asheville, Women’s Wellness Development Foundation



## Action Plan

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Develop detailed action plan for each strategy</b>	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
<b>Develop communication strategies to increase collaboration and shared information &amp; resources</b>	-Staff time -Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013
<b>Develop community campaign/ outreach strategy to promote organizational support breastfeeding</b>	-Staff time -Working group partners	Campaign/ outreach strategy developed	Strategy shared with partners and published on CHIP internet site	Nov/December 2013

**Goal 6: Increase the percentage of Buncombe County residents at a healthy weight through community and clinical supports and linkages**

**Strategy 6.1: Clinical weight management**

**Objective 6.1.1:**

Assess and inventory current practices of primary and pediatric practices to determine status of evidenced-based weight management practice in Buncombe County

**Indicator:** Inventory complete (*Establish baseline year 1, increase year 2*)

**Objective 6.1.2:**

Contribute to evidence-based practice through research and funding partnerships

**Indicator:** TBD

**Strategy Background**

**Source:**

Childhood Obesity Action Network Guidelines: <http://www.nichq.org/documents/coan-papers-and-publications/COANImplementationGuide62607FINAL.pdf>

NIH/NHLBI Clinical Guidelines for Adult Obesity:  
[http://www.nhlbi.nih.gov/guidelines/obesity/ob\\_gdlns.htm](http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.htm)

**Evidence Base:** The Childhood Obesity Action Network has published guidelines for assessing, preventing, and treating child and adolescent overweight and obesity in a clinical setting. These guidelines focus on incorporating obesity prevention efforts into Well Care Visits. All Well Care Visits should include a BMI percentile-for-age screening, an assessment of physical activity and nutrition behaviors and attitudes, and other screenings for other risk factors such as blood pressure. If a child or adolescent is identified as overweight (BMI between the 85th and 94th percentile-for-age) or obese (BMI greater than the 95th percentile-for-age), a staged approach to treatment is recommended. Stage 1 involves "Prevention Plus" visits with a physician or health professional trained in pediatric weight management and behavioral counseling, and focuses on behavior changes including decreasing sugar-sweetened beverage consumption, consuming at least 5 servings of fruits and vegetables daily, decreasing screen time to 2 hours per day or less, increasing physical activity to one hour or more daily, preparing meals at home as a family more often, eating a healthy breakfast daily, and involving the entire family in these lifestyle changes. If Stage 1 is not effective, treatment progresses to Stage 2 by recruiting additional support from qualified healthcare professionals and community resources (for example, Registered Dietitians and community fitness programs). Stage 3 involves a comprehensive, multidisciplinary intervention with a multidisciplinary team experienced in childhood obesity, and more frequent (weekly) visits. Stage 4 involves partnering with tertiary care centers and may involve medications, very low calorie diets, or gastric surgery (Childhood Obesity Action Network 2007).

A variety of clinical-based therapies may be used to treat overweight and obesity in adults. A review of randomized clinical trials of various therapies resulted in the following recommendations for clinical treatment: Low-Calorie Diets; physical activity; combining reduced-calorie diets and increased physical activity; behavior therapy in combination with other strategies; understanding that standard approaches may work differently in diverse populations; weight loss drugs as part of a comprehensive weight loss program including diet and physical activity for patients with a BMI of  $\geq 30$  with no concomitant obesity-related risk factors or diseases or for patients with a BMI of  $\geq 27$  with concomitant obesity-related risk factors or diseases; and surgical intervention for carefully selected patients with clinically severe obesity (a BMI  $\geq 40$  or  $\geq 35$  with comorbid conditions) when less invasive methods of weight loss have failed and the patient is at high risk for obesity-associated morbidity and mortality (NIH/NHLBI 1998).

**Type of Change:** Policy, Environment

**Partner Agencies**

**Lead:** Innovative Approaches, Mission Health, Buncombe County Health and Human Services  
- Office of Minority Health Grant

**Collaborating:** UNC-Chapel Hill, Mission Health/NC Preconception Health Campaign, Community Care of Western North Carolina, WNC Health Network, WNC Healthy Kids Initiative, MAHEC

**Supporting:** TBD

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
Develop detailed action plan for each strategy	-Staff time -Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
Develop communication strategies to increase collaboration and shared information & resources	-Staff time -Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

**Strategy 6.2: Community resources to support physician-directed clinical weight management**

**Objective 6.2.1:**

Assess and inventory community efforts supporting weight management

**Indicator:** Inventory complete (*Establish baseline year 1, increase year 2*)

**Objective 6.2.2:**

Develop community-based intensive PA, nutrition programming for families receiving clinical weight management services

**Indicator:** Plan developed for intensive PA and nutrition for clinical weight management service participants

**Objective 6.2.3:**

Increase the number of clinical providers that actively link patients to community resources to support healthy weight management

**Indicator:** Assessment of clinical providers completed (*Establish baseline year 1, increase year 2*)

**Strategy Background**

**Source:**

*Community Resources: Key Points.* NICHQ. Available at:  
[http://www.nichq.org/childhood\\_obesity/tools/CommResourcesKeyTips.pdf](http://www.nichq.org/childhood_obesity/tools/CommResourcesKeyTips.pdf).

**Evidence Base:** The National Initiative for Children’s Healthcare Quality (NICHQ) Care Model for Child Health involves the health care system collaborating with community resources to optimize self-management support by informed, activated patients. The model describes how health care providers can use community partnerships to identify effective programs, encourage appropriate patient participation, develop evidence-based programs and policies supportive of chronic care, and encourage coordination among health plans of chronic illness guidelines, measures, and care resources (NICHQ).

**Type of Change:** Policy, Environment

**Partner Agencies**

**Lead:** Buncombe County Health and Human Services - Office of Minority Health Grant

**Collaborating:** Community Transformation Grant Project, Community Care of Western North Carolina, Land-of-Sky Regional Council, Mission Health, MAHEC

**Supporting:** WNC Health Network, WNC Healthy Kids Initiative

**Action Plan**

Activity	Resources Needed	Anticipated Result	Result Verification	Target Date
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(what?)	(who? how much?)	(what will happen?)	(how will you know?)	(by when?)
<b>Convene partners to continue work on shared measures and roles/responsibilities</b>	Staff time working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
<b>Convene partners to develop system for managing data.</b>	Staff time Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
<b>Develop detailed action plan for each strategy</b>	Staff time Working group participants	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013
<b>Develop communication strategies to increase collaboration and shared information &amp; resources.</b>	Staff time Working group participants	Communication plan developed	Communication plan posted in online CHIP document	Sept/October 2013

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## CHAPTER 3 – TOBACCO PREVENTION AND CESSATION

### Situational Analysis

Tobacco use remains the leading cause of preventable disease, disability, and death across North Carolina and the nation. It causes lung cancer and many other forms of cancers throughout the body. Additional health risks caused by smoking include heart attacks, strokes, and lung diseases such as emphysema and chronic bronchitis.

It is well known from national research that secondhand smoke is also deadly, containing over 7,000 chemicals - hundreds of which are toxic and at least 69 of them cause cancer. When nonsmokers are exposed to secondhand smoke, they inhale many of the same cancer-causing chemicals that smokers inhale. Therefore breathing secondhand smoke causes similar health effects to smoking. Children who are exposed to secondhand smoke are more likely to have lung problems, ear infections, and severe asthma. It is also a known cause of Sudden Infant Death Syndrome (SIDS).

National evidence-based research has demonstrated that implementing regulations to support tobacco-free lifestyles is an effective strategy for reducing tobacco use and secondhand smoke exposure.

In Buncombe County, we have a successful history of implementing policies and laws that help protect us, our families, our neighbors, and visitors from the health risks caused by tobacco use. During the past two decades, 24 tobacco prevention and control regulations have been adopted. Community efforts have resulted in tobacco free schools, hospitals, community college campuses, prisons, and governmental and municipal buildings, grounds, and vehicles, as well as smoke-free restaurants and bars across the state.

There is still much work to be done. We spend nearly \$31 million every year in Buncombe County on smoking-related Medicaid costs. About 18% of adults in Buncombe County smoke.

### *Did you know?*

Secondhand smoke triggers heart attacks. Smoking bans drastically cut heart attack rates.

If nobody smoked, 1 of every 3 cancer deaths in the United States would not happen.

No amount of tobacco smoke is safe. Any exposure to tobacco smoke – even an occasional cigarette or exposure to secondhand smoke – is harmful to health.

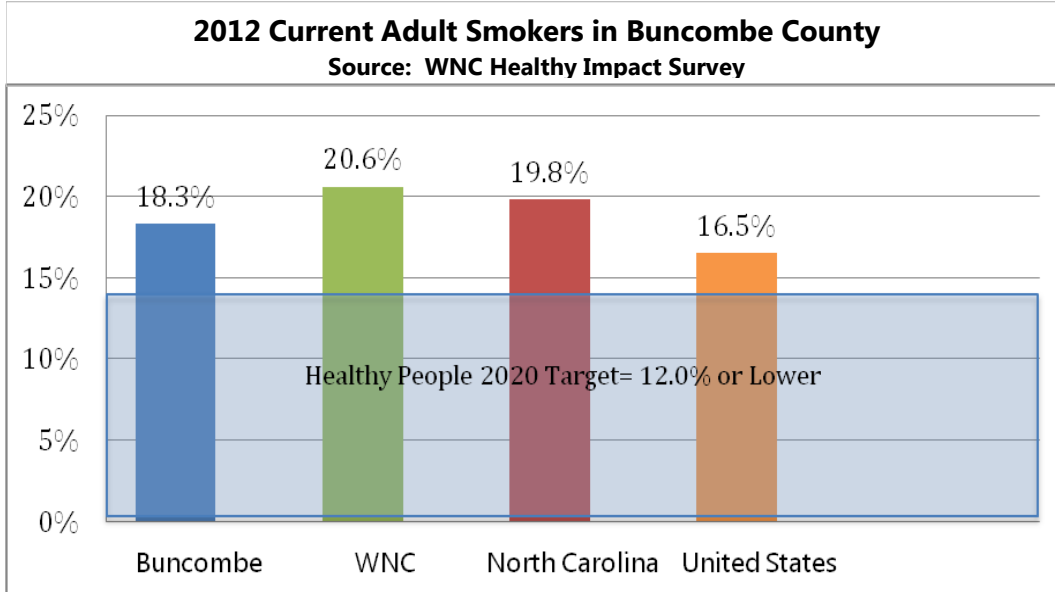
A person does not have to be a heavy smoker or a long-time smoker to get a smoking-related disease or have a heart attack or asthma attack that is triggered by tobacco smoke.

Separate “no smoking” sections do NOT protect anyone from secondhand smoke. Neither does filtering the air or opening a window.

#### *Sources:*

##### *U.S. Surgeon General Reports*

- *2006 –The Health Consequences of Involuntary Exposure to Tobacco Smoke*
- *2010 - How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease*



Our most recent data (2010) for youth smoking rates indicate that 17% of our youth in Buncombe County smoke. Between the years 2005 to 2009, the youth smoking rate in the county decreased by 37%. This significant drop is attributed to the successes our local schools and youth empowerment programs were able to achieve with funding from the Health and Wellness Trust Fund (HWTF) for youth tobacco prevention and cessation programs. Research shows that community-based programs such as these are effective at reducing teen tobacco use. Since the HWTF funds were abolished in 2011, we will very likely begin to see youth rates rise in our county.

### Spotlight on Success

Youth advocates who have been formally trained and empowered to become change agents in our community have made valuable contributions in Buncombe County during the past decade. Their efforts have been a big part of our success in educating policy makers and advocating for policies and laws that protect people from exposure to secondhand smoke and the effects of tobacco use in our community.

These empowered youth of TATU Club (Teens Against Tobacco Use) and YES! (Youth Empowered Solutions) have been involved with holding events, presenting information, and gaining support from



**Youth advocates with city, county, and state officials.**

key officials including: city, county, and state legislators; the Buncombe County Board of Health; school boards; and others. These youth have helped us move ahead as a model city and county in working for policies that support tobacco-free lifestyles and smoke-free places.

This year one youth advocate, Tyler Long—a senior at Asheville High School—received national recognition for his achievements. The Campaign for Tobacco Free Kids honored Tyler with the 2013 National Youth Advocate of the Year Award as the top young leader across the nation for his fight to promote tobacco prevention legislation, expose tobacco marketing to kids, and keep peers from using tobacco. He received the award in a formal banquet and ceremony in Washington, D.C.

See Tyler’s brief interview video at:

[www.tobaccofreekids.org/what\\_we\\_do/youth\\_initiatives/gala/#long](http://www.tobaccofreekids.org/what_we_do/youth_initiatives/gala/#long)

*“Personally, my work in tobacco control has improved my public speaking, training, facilitation, and many other skills as well as providing me with many opportunities to expand my work to both a regional and national level.”*

Tyler Long, Asheville High School Senior  
2013 National Youth Advocate of the Year  
Campaign for Tobacco Free Kids

“In middle school I began to see how some of my peers believed that tobacco would make them ‘cool’ and I knew that I wanted to become part of the fight against tobacco,” said Tyler. “My community has gained awareness, tobacco free parks, restaurants and bars from the work I have done, we have also brought teen smoking rates to an all-time low in North Carolina, saving thousands of lives.”

## Partners

Addressing tobacco prevention and cessation is complex and will require the collaborative planning, action, and coordination of multiple partners in our community. The following partner agencies and organizations are engaged in efforts to reduce tobacco use in our community. As new partners are identified, we will continuously work to bring them into the process.

<b>Organizations:</b>	<b>Website or Contact Information</b>
Addiction Recovery Prevention (ARP)	<a href="http://www.arpnc.org/">http://www.arpnc.org/</a>
Asheville City Schools	<a href="http://www.ashevillecityschools.net">http://www.ashevillecityschools.net</a>
Buncombe County Schools	<a href="http://www.buncombe.k12.nc.us">http://www.buncombe.k12.nc.us</a>
Buncombe County Department of Health (BCDH)	<a href="https://www.buncombecounty.org/Governing/Depts/Health/HealthEd/Tobacco.aspx">https://www.buncombecounty.org/Governing/Depts/Health/HealthEd/Tobacco.aspx</a>
Community Transformation Grant Project - Region 2 (CTGP)	Jill Simmerman (910) 619-7711 ctp.region2@gmail.com
Mission Hospital Nicotine Dependence Program	<a href="http://www.missionmd.org/nicotine-dependence-program">http://www.missionmd.org/nicotine-dependence-program</a>
NC 2-1-1 / United Way of Asheville and Buncombe County	<a href="http://www.unitedwayabc.org/">http://www.unitedwayabc.org/</a>
Park Ridge Health	<a href="http://www.parkridgehealth.org/">http://www.parkridgehealth.org/</a>
V.A. Medical Center: Charles George (VA)	<a href="http://www.asheville.va.gov/">http://www.asheville.va.gov/</a>

## Tobacco Prevention and Cessation Plan

### Vision of Impact

A future free of the disease, disability, and death caused by tobacco use

State and National Objectives	Baseline/Indicator Source
<b>Healthy NC 2020 Objective:</b> Decrease the proportion of adults who smoke [2011 BC Baseline: 21.8%; 2020 Target: 13%]	BRFSS
<b>Healthy NC 2020 Objective:</b> Decrease teen tobacco use among high school students [2010 BC Baseline: 17%; 2020 Target: 15%]	Youth Tobacco Survey and NC Tobacco Prevention and Control Branch (TPCB)
<b>Healthy NC 2020 Objective:</b> Decrease exposure to secondhand smoke by reducing percentage of workers that are exposed to secondhand smoke indoors at their workplaces [2010 NC baseline: 7.8%; 2020 Target: 0%]	BRFSS and NC TPCB
<b>Healthy NC 2020 Objective:</b> Decrease the percentage of pregnant women who smoke during pregnancy [2009 NC Baseline: 10.2%; 2020 Target: 6.8%]	SCHS Birth Certificate Data
<b>NC TPCB Vision 2020 Objective:</b> Decrease exposure of high school youth to secondhand smoke in homes [2011 NC Baseline: 26.9%; 2020 Target: 16.8%]	Youth Tobacco Survey and NC TPCB
<b>NC TPCB Vision 2020 Objective:</b> Decrease exposure of middle school youth to secondhand smoke in homes [2011 NC Baseline: 27.3%; 2020 Target: 17.9%]	Youth Tobacco Survey and NC TPCB

## Goal 1: Reduce tobacco use by increasing services and policies that support tobacco cessation

### Strategy 1.1: Evidence-based practice in clinical settings

#### Objective 1.1.1:

Increase the number of health and dental providers who use evidence-based practice to address tobacco use with every patient

**Indicator:** Number of health and dental providers who use evidence-based practice to address tobacco use with every patient

#### Objective 1.1.2:

Increase the number of health practices that establish a provider-reminder system to identify, intervene with, and educate tobacco-using patients and in-patients

**Indicator:** Number of health practices with a provider-reminder system

### Strategy Background

#### Source:

The Guide to Community Preventive Services; Centers for Disease Control and Prevention (CDC); [www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)

**Evidence Base:** Provider Oriented Interventions: The overarching goals of these recommendations is that clinicians strongly recommend the use of effective tobacco dependence counseling and medication treatments to their patients who use tobacco and that health systems, insurers, and purchasers assist clinicians in making such effective treatments available. The effectiveness of clinical-based strategies to reduce tobacco use is well-documented, and the U.S. Department of Health and Human Services has developed clinical practice guidelines (US DHHS 2008). The Community Guide specifically recommends provider reminder systems as an effective strategy because research shows even brief provider advice has a significant effect on getting clients to quit tobacco use. A systematic review of seven studies found provider reminder systems were effective in: increasing the number of clients who quit smoking by approximately 4 additional clients per 100; increasing the number of clients who providers advise to quit smoking by approximately 13 additional clients per 100; and increasing the determination of client smoking status by providers by approximately 32 additional clients per 100 (Community Guide 2000).

**Type of Change:** Policy

#### Partner Agencies

**Lead:** Mission, BCDH

**Collaborating:** TBD

**Supporting:** VA, CTGP

## Action Plan

<b>Activity</b> <i>(what is being done?)</i>	<b>Resources Needed</b> <i>(who? how much?)</i>	<b>Anticipated Result</b> <i>(what will happen?)</i>	<b>Result Verification</b> <i>(how will you know?)</i>	<b>Target Date</b> <i>(by when?)</i>
<b>Implement an inpatient “Quit Tobacco” system where every patient is asked about tobacco at every visit. Mission is working with NC Prevention partners on this</b>	Mission staff	All health providers at Mission Hospital will inquire about tobacco use and provide necessary follow-up with each patient and in-patient.	A provider reminder system is implemented that prompts providers to inquire about tobacco use.	July 2014
<b>Assess needs of doctors regarding tobacco cessation, develop programs, and roll out an educational plan for docs</b>	Mission staff, Assessment tool, Educational plan	Identify the needs of hospital doctors, develop a program to support the needs, and train providers	Program developed and doctors educated.	July 2015
<b>Ask every client/veteran ever identified as a tobacco user annually about tobacco use; advise and assist with meds/classes</b>	VA staff	Veterans who receive VA services and are identified as tobacco users are asked about tobacco use every year and provided with assistance to help quit.	A provider reminder system is in place	July 2014
<b>Encourage primary care practices to work on improving screening and treating of tobacco use</b>	CTGP tobacco lead	Tobacco users are connected to community supports outside of doctors’ offices. Change packets through MAHEC include tobacco prompts for physicians.	Database established of MAHEC physicians who screen patients for tobacco use.	September 2014
<b>Provide 5A Cessation Counseling educational sessions to health and dental providers</b>	Mission; BCDH; Educational Cessation packets	Additional health providers in the community will implement the 5A’s Cessation Counseling method.	A database of health providers who implement the 5A’s will be in place to establish a baseline.	September 2014

### Strategy 1.2: Employer support for cessation

#### Objective 1.2.1:

Increase the number of employers that offer evidence-based cessation services/resources to employees

**Indicator:** Number of employers that offer evidence-based cessation services/resources to employees

### Strategy Background

#### Source:

The Guide to Community Preventive Services; Centers for Disease Control and Prevention (CDC); [www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)

**Evidence Base:** Reducing out-of-pocket costs for evidence-based cessation treatments involves policy or program changes that make evidence-based treatments, including medication, counseling or both, more affordable. To achieve this, new benefits may be provided, or changes may be made to the level of benefits offered that reduce costs or co-payments (Community Guide 2013). The Community Guide recommends worksite-based incentives and competitions when combined with additional interventions to support individual cessation efforts based on strong evidence of effectiveness in reducing tobacco use among workers. Interventions that were combined with incentives and competitions included: client education, smoking cessation groups, self-help cessation materials, telephone cessation support, workplace smoke-free policies, and social support networks (Community Guide 2005).

**Type of Change:** Policy

**Partner Agencies**

**Lead:** BCDH, Mission

**Supporting/Collaborating:** TBD

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Facilitate worksite policy changes and determine how to keep companies engaged.</b>	BCDH staff; Mission staff; educational information on the economic benefits of a new or improved policy	Additional employers will implement a policy to provide cessation services or resources to employees.	A database of employers that provide cessation services or resources will be in place to establish a baseline.	July 2014
<b>Work with internal employees when insurance plans change: as insurance rates increase (and cessation is expensive) develop a plan to provide free cessation benefits</b>	Mission;	Mission employees will have access to free cessation support	A plan is developed and in place to provide free cessation support to Mission employees who want to quit using tobacco.	July 2015
<b>Educate and encourage employers to provide evidence-based cessation coverage as a new benefit.</b>	BCDH; Mission; educational information on the economic benefits of providing cessation services to employees	Additional employers will provide cessation services to employees.	Increased number of employers, as data collected for database	December 2014



## **Strategy 1.3: QuitlineNC**

### **Objective 1.3.1:**

Increase the number of calls and referrals to QuitlineNC originating from Buncombe County each year

**Indicator:** Number of calls and referrals to QuitlineNC originating from Buncombe County

### **Objective 1.3.2:**

Continue advocating for Quitline funding and increase those advocacy efforts

**Indicator:** Number of local advocacy efforts to increase funding

## **Strategy Background**

### **Source:**

[The Guide to Community Preventive Services](http://www.thecommunityguide.org/tobacco/index.html); Centers for Disease Control and Prevention (CDC); [www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)

**Evidence Base:** Quitline interventions include the use of telephone contact to provide evidence-based behavioral counseling and support to help tobacco users who want to quit. Three interventions effective at increasing use of quitlines are:

1. Mass-reach health communication interventions that combine cessation messages with a quitline number
2. Provision of free evidence-based tobacco cessation medications for quitline clients interested in quitting
3. Quitline referral interventions for health care systems and providers.

Tobacco cessation quitline interventions—particularly proactive quitlines that offer follow-up counseling calls—are recommended by the Community Guide based on strong evidence of effectiveness in increasing tobacco cessation among clients interested in quitting. Evidence also shows that quitlines can expand the use of evidence-based services by tobacco users in populations with the lowest access to these services (Community Guide 2000).

**Type of Change:** Individual, Organizational

### **Partner Agencies**

**Lead:** BCDH, Mission

**Collaborating:** VA, CTGP

**Supporting:** NC 211/United Way

## Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Develop and implement a media plan to promote tobacco cessation and QuitlineNC (ex. place radio, print, TV ads; submit letters to the editor, etc.)	BCDH; CTGP; funding for media placement; Work group participation for LTE's	Media placements will encourage more tobacco users in Buncombe County to call QuitlineNC to get help quitting.	Monthly reports received from NC TPCB will show increased number of callers to QuitlineNC for the year from Buncombe County.	July 2014
Promote the use and referral to the Quitline, during 5A Cessation Counseling trainings to health and dental providers.	BCDH; Mission; Educational cessation packets	Health and dental providers will refer patients who are ready to quit.	Monthly reports received from NC TPCB will show increased number of referrals for the year from Buncombe County health providers.	July 2014
When working with employers to offer cessation services, promote the Quitline as an easy resource for employees.	BCDH staff; Mission staff; Quitline materials (brochures, pocket cards, etc.)	Employers promote the Quitline to employees as a free and easy quitting resource for employees.	Monthly reports received from NC TPCB will show increased number of callers to QuitlineNC for the year from Buncombe County.	July 2014
Promote the use of the Quitline to the public	BCDH; Mission; VA; 211; CTGP	QuitlineNC promoted to general population as a free and easy resource for help in quitting.	Monthly reports received from NC TPCB will show increased number of callers to QuitlineNC for the year from Buncombe County.	July 2014
Advocate for Quitline funding with public officials	BCDH	Funding for Quitline at the state level is secure.	Quitline continues to be supported by NC legislature	July 2015

### Strategy 1.4: Access to cessation therapies

#### Objective 1.4.1:

Increase access to tobacco cessation services and resources by reducing barriers (financial and transportation) to cessation therapies (including meds/cessation groups)

**Indicator:** Number of organizational changes made to reduce barriers and increase access

### Strategy Background

#### Source:

[The Guide to Community Preventive Services](http://www.thecommunityguide.org/tobacco/index.html); Centers for Disease Control and Prevention (CDC); [www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)

**Evidence Base:** Reducing out-of-pocket costs for evidence-based cessation treatments involves policy or program changes that make evidence-based treatments, including medication, counseling, or both, more affordable. To achieve this, new benefits may be provided, or changes may be made to the level of benefits offered that reduce costs or co-payments. The Community Guide recommends policies and programs that reduce tobacco users' out-of-pocket costs for evidence-based cessation treatments. These interventions have strong evidence of effectiveness in increasing the number of tobacco users who quit, based on the results of a systematic review of 18 studies plus 13 additional studies. These studies included both findings from clinic-based trials and population-based policy evaluations of reduced out-of-pocket costs for both cessation counseling and medications (Community Guide 2012).

**Type of Change:** Individual, Community, Policy

**Partner Agencies**

**Lead:** Park Ridge, Mission, VA

**Collaborating:** BCDH

**Supporting:** ARP, 211/United Way

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Provide tobacco cessation to internal clients and employees</b>	Mission; ARP; educational materials	More internal clients and employees to Mission and ARP will quit tobacco use.	Internal databases will be in place to establish a baseline. Increased number of clients and employees will have quit.	July 2015
<b>Offer Freedom From Smoking classes every quarter in a variety of locations to reach more people. In Buncombe (only in the south part of the county)</b>	Park Ridge, Mission, VA; in-kind funding for classes	FFS cessation classes offered to reach diverse populations and geographies in the county	Reports from partners will show that FFS cessation classes were offered in at least three locations in Buncombe.	July 2014
<b>Work with multi-unit housing complexes (apartments) adopting a smoke-free policy to support cessation for residents</b>	BCDH; Mission; database	Cessation services or resources are provided to residents who live in multi-unit complexes that are planning to adopt a smoke free policy	Develop a database of multi-unit housing complexes that adopt a smoke-free policy. Track number of complexes that provide cessation support.	July 2014
<b>Expand work within internal business system to establish resources and meet the cessation needs of the communities they serve</b>	VA; Mission	More cessation resources accessible within hospital systems	Systems expanded; Partner documentation	July 2015
<b>Develop an evidence-based tobacco cessation program to support community members in quitting tobacco.</b>	Mission; assistance from cessation researchers	An updated and improved cessation program is put into practice at Mission.	Tobacco cessation program in completed per Mission reports.	December 2015

<p><b>Provide outreach and offer creative tobacco cessation opportunities to veterans who otherwise may not be able to participate, due to disability, transportation issues, etc.</b></p> <ul style="list-style-type: none"> <li>• Provide clinical video tele-health to offer FFS series in Rutherford and Franklin</li> <li>• Offer FFS series for veterans and all community members at Haywood County Health Department</li> <li>• Provide community outreach for veterans in rural counties and conduct FFS classes.</li> <li>• Offer group phone-based classes (based on FFS)</li> <li>• Reduce out of pocket expense for cessation meds for veterans, by offsetting costs for NRT (patch, gum, or lozenges) and Rx (Chantix and Bupropion)</li> <li>• Provide free cessation classes to support person who accompanies veteran to classes</li> </ul>	VA	Evidence-based cessation classes are offered to reach more veterans who don't have access to tobacco cessation help	Reports from VA will show that cessation classes were offered to veterans via at least two venues in Buncombe.	July 2014
<p><b>Keep practices and providers abreast of resources that are available for patients in their communities</b></p>	Park Ridge; Mission; BCDH; 211	Tobacco users are connected to community supports through the health providers.	Database established of health providers who screen patients for tobacco use and provide resources for quitting.	September 2014

**Goal 2: Reduce exposure to tobacco-use and secondhand smoke by increasing tobacco-free and smoke-free policies**

**Strategy 2.1: Tobacco-free ordinances and laws**

**Objective 2.1.1:**  
 Increase the number of tobacco-free ordinances in public places, and local government buildings, grounds, and vehicles

**Indicator:** Number of tobacco-free ordinances in public places, and local government buildings, grounds, and vehicles

## Strategy Background

### Source:

The Guide to Community Preventive Services; Centers for Disease Control and Prevention (CDC); [www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)

**Evidence Base:** Smoke-free policies are public-sector regulations that prohibit smoking in indoor spaces and designated public areas. State and local ordinances establish smoke-free standards for all, or for designated, indoor workplaces, indoor spaces, and outdoor public places. Public and private organizational smoke-free policies are recommended by the Community Guide. Two systematic reviews indicate smoke-free policies are effective in: reducing exposure to secondhand smoke; reducing prevalence of tobacco use; reducing tobacco consumption among tobacco users; increasing quit rates among tobacco users; reducing initiation of tobacco use among young people; and reducing tobacco-related morbidity and mortality, including acute cardiovascular events (Community Guide 2012).

**Type of Change:** Policy

### Partner Agencies

**Lead:** BCDH, CTGP

**Collaborating:**

**Supporting:** Mission

### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
<b>Advocate for smoke free public places that are not currently covered under any policy or law (ex. laundry mats, convenience stores, office building lobbies, bingo halls, etc.)</b>	BCDH; CTGP; Support from local officials	Increased regulations that support smoke-free public places.	New polices or laws passed that mandate public places to be smoke-free.	December 2014
<b>Build capacity and support among policy makers and elected officials for smoke-free ordinances for the Towns of Biltmore Forest and Woodfin</b>	BCDH; CTGP	Increased support for a new or improved smoke-free ordinance.	At least 2 elected officials support and help advocate for improved ordinances	September 2014
<b>Provide education and technical assistance for local establishments to maintain compliance with the NC Smokefree Restaurants and Bars Law.</b>	BCDH staff time; compliance materials	Compliance is improved for the restaurants/bars we receive a violation notice.	No additional reports on restaurants/bars.	On-going

## Strategy 2.2: Tobacco-free worksites

### Objective 2.2.1:

Increase the number of smoke-free or tobacco-free policies within worksites

**Indicator:** Number of new or improved smoke-free or tobacco-free policies within worksites

## Strategy Background

### Source:

The Guide to Community Preventive Services; Centers for Disease Control and Prevention (CDC); [www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)

County Health Rankings, 2013. What Works for Health: Smoking Bans and Restrictions. <http://www.countyhealthrankings.org/policies/smoking-bans-restrictions>.

**Evidence Base:** Smoke-free policies include private-sector rules that prohibit smoking in indoor spaces and designated public areas. These policies may ban all tobacco use on private property or restrict smoking to designated outdoor locations. Worksites are one setting where evidence supports the effectiveness of smoke-free policies. Research shows smoking bans substantially reduce respiratory symptoms and secondhand smoke exposure among hospitality workers. Smoking prevalence and secondhand smoke exposure may not drop as readily for lower-income workers, especially if bans are not uniformly implemented across worksites (County Health Rankings 2013).

**Type of Change:** Policy

### Partner Agencies

**Lead:** BCDH, Mission

**Collaborating/Supporting:** TBD

### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Educate and encourage employers to implement tobacco free policies in their worksites	BCDH staff; Mission staff; educational information on the economic benefits of a new or improved policy	Additional employers will implement a policy that will protect employees from secondhand smoke exposure and encourage tobacco users to quit.	A database of employers with any tobacco-related policy will be in place to establish a baseline.	July 2014

## Strategy 2.3: Tobacco-free housing

### Objective 2.3.1:

Increase the number of smoke-free or tobacco free multi-unit housing complexes

**Indicator:** Number of multi-unit housing complexes that implement a smoke-free policy

## Strategy Background

### Source:

The Guide to Community Preventive Services; Centers for Disease Control and Prevention (CDC); [www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)

**Evidence Base:** Smoke-free policies include private-sector rules that prohibit smoking in indoor spaces and designated public areas. These policies may ban all tobacco use on private property or restrict smoking to designated outdoor locations. Public and private organizational smoke-free policies are recommended by the Community Guide. Two systematic reviews indicate smoke-free policies are effective in: reducing exposure to secondhand smoke; reducing prevalence of tobacco use; reducing tobacco consumption among tobacco users; increasing quit rates among tobacco users; reducing initiation of tobacco use among young people; and reducing tobacco-related morbidity and mortality, including acute cardiovascular events (Community Guide 2012).

**Type of Change:** Policy

### Partner Agencies

**Lead:** BCDH, CTGP

**Collaborating:** TBD

**Supporting:** Mission

### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Develop an inventory of multi-unit housing (MUH) properties and identify those that are smoke-free	BCDH in collaboration with CTGP	Identification of MUH properties that are smoke-free	A database of MUH properties with a policy will be established as a baseline	July 2014
Contact managers of MUH properties who are interested and provide technical assistance for implementing smoke-free policies	BCDH; CTGP; Educational materials	Increase the number of properties with a smoke-free policy	A database of MUH properties with a policy will be established as a baseline	July 2014
Provide cessation support to residents and managers of	Mission; Cessation	Cessation services or resources are provided to	Develop a database of multi-unit housing	July 2014

<b>MUH properties</b>	materials	residents who live in multi-unit complexes that are planning to adopt a smoke free policy	complexes that adopt a smoke-free policy. Track number of complexes that provide cessation support.	
<b>Hold a lunch and learn on smoke-free multi-unit housing in 2015</b>	BCDH; CTGP; Training materials; speakers	Educate manager/owners of MUH properties and increase interest in adopting a policy.	Training completed and documented.	June 2015
<b>Provide technical assistance to residents who live in MUH that is not smoke-free</b>	BCDH	Residents who request information are educated about tobacco free homes	Documentation reports on technical assistance provided	June 2015
<b>Provide technical support and education to advance smoke-free policies in MUH, including market rate, affordable housing, and subsidized housing.</b>	BCDH; CTGP Educational materials	Increase the number of properties with a smoke-free policy	A database of MUH properties with a policy will be established as a baseline	July 2014
<b>Build support for incremental steps toward smoke-free MUH policies</b>	BCDH; CTGP	Increased community support for smoke-free MUH properties	At least three additional key community stakeholders are engaged in these initiatives	July 2014

**Goal 3: Prevent and reduce tobacco use among youth and young adults by increasing compliance with regulations**

**Strategy 3.1: Compliance with tobacco regulations among institutions that serve youth**

**Objective 3.1.1:**

Increase the number of stores that are in compliance with the Synar Amendment (restricting minor's access to tobacco products)

**Indicator:** Number of stores that are in compliance with the Synar Amendment

**Objective 3.1.2:**

Assure that all City and County Schools meet the requirements of teaching the "Alcohol, Tobacco and Other Drugs" Strand of the NC Healthful Living Essential Standards – for grades 3-9

**Indicator:** Percentage of City and County Schools that meet the requirements of teaching the "Alcohol, Tobacco and Other Drugs" Strand of the NC Healthful Living Essential Standards – for grades 3-9

**Objective 3.1.3:**

Increase compliance with 100% Tobacco Free School policies

**Indicator:** Number of schools that make changes to support 100% TF School policies

**Strategy Background**

**Source:**



The Guide to Community Preventive Services; Centers for Disease Control and Prevention (CDC); [www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)

“Healthful Living Essential Standards” - [Standard Course of Study](http://www.ncpublicschools.org/acre/standards/new-standards/); North Carolina Department of Public Instruction; <http://www.ncpublicschools.org/acre/standards/new-standards/>

**Evidence Base:** Community mobilization with additional interventions to restrict minors’ access to tobacco products. These are community-wide interventions aimed at focusing public attention on the issue of youth access to tobacco products and mobilizing community support for additional efforts to reduce that access. The Community Guide 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.

The Standard Course of Study adopted by the North Carolina Department of Public Instruction describes the subjects and course content that is taught in North Carolina public schools, and the assessments and accountability model used to evaluate student, school and district success. The Accountability and Reform Effort (ACRE) identifies what students should know and clearly measures whether students are on track for success after high school. It is time for a new generation of K-12 school curricula, student assessment, and school accountability. In 2008, following extensive input from the Blue Ribbon Commission on Testing and Accountability, the State Board of Education crafted the Framework for Change - 27 recommendations to dramatically change the scope of the Standard Course of Study, assessments, and accountability.

**Type of Change:** Policy

**Partner Agencies**

**Lead:** ARP, Asheville City Schools, Buncombe County Schools

**Collaborating:** TBD

**Supporting:** BCDH

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Provide merchant education in stores to decrease minors access to tobacco products (in accordance with a federal-state partnership program [Synar Amendment] aimed at ending illegal tobacco sales to minors)</b>	ARP; educational materials	Increased number of stores complying with Synar Amendment	Partner documentation	July 2014
<b>Complete an environmental</b>	ARP;	Increased number of	Partner documentation	July 2014

scan in each store visited (to look for tobacco product placement, location of tobacco signage, number of signs in store, etc.)	Environmental scan tool	stores complying with Synar Amendment		
Encourage merchants to move ads away from eye level of children	ARP	Merchants move ads out of direct site of children	Partner documentation	July 2014
Hold merchant events to educate about Synar Amendment	ARP	Increased number of stores complying with Synar Amendment	Partner documentation	July 2014
Teach the “Alcohol, Tobacco and Other Drugs” strand of the NC Healthful Living Essential Standards – for grades 3-9	Asheville City Schools; Buncombe County Schools	Increase the percentage of schools that meet requirements.	Partner documentation	July 2014
Support all schools in the Asheville and Buncombe County School Systems in complying with 100% Tobacco Free School policies (ex. post signage, school announcements, letters to parents, etc.)	Asheville City Schools; Buncombe County Schools; BCDH	Additional signage and support offered to increase compliance with 100% TFS policies	Additional signage posted at least 3 schools	June 2014

#### Goal 4: Increase public will for tobacco-related policy and environmental changes

**Strategy 4.1:** Influence community culture/norms around tobacco use

**Objective 4.1.1:**

Increase # of mass media campaigns that support policy and environmental changes

**Indicator:** Number of mass media campaigns that are published or aired

**Objective 4.1.2:**

Increase communications with community leaders and community members (such as elected officials). Celebrate our and others’ successes and advance understanding of those successes.

**Indicator:** Number of communications with community leader and community members

## Strategy Background

### Source:

[Guide to Community Preventive Services](http://www.thecommunityguide.org/tobacco/index.html); Centers for Disease Control and Prevention (CDC); [www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)

**Evidence Base:** Mass reach health communication interventions target large audiences through television and radio broadcasts, print media (e.g., newspapers), out-of-home placements (e.g., billboards, movie theaters, point-of-sale), and digital media to change knowledge, beliefs, attitudes, and behaviors affecting tobacco use. The Community Guide recommends mass-reach health communications interventions. These interventions are based on strong evidence of effectiveness in decreasing the prevalence of tobacco use, increasing cessation and use of available services such as quitlines, and decreasing initiation of tobacco use among young people. Evidence was considered strong based on findings from studies in which television was the primary media channel (Community Guide).

**Type of Change:** Individual, Interpersonal

### Partner Agencies

**Lead:** BCDH

**Collaborating:** TBD

**Supporting:** CTGP, Mission

### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
<p><b>Place media messages that reach targeted audiences to:</b></p> <ul style="list-style-type: none"> <li>• promote QuitlineNC</li> <li>• promote awareness about secondhand smoke</li> <li>• support smoke-free air policies and laws (ex. place radio, print, TV ads; submit letters to the editor, etc.)</li> </ul>	<p>BCDH; CTGP; Mission; VA Funding for media placement</p>	<p>Build community support for tobacco-free lifestyles and smoke-free environments by placing media messages</p>	<p>15 media messages placed or aired</p>	<p>July 2014</p>
<p><b>Develop and implement a plan to highlight successes and increase communications with key community leaders and members</b></p>	<p>BCDH; CTGP; Mission;</p>	<p>Key community stakeholders engaged in driving initiatives that support tobacco-free lifestyles and smoke-free environments</p>	<p>At least 5 key stakeholders</p>	<p>December 2014</p>

**Strategy 4.2:** Mass media campaigns that target youth and young adults

**Objective 4.2.1:**

Increase the number of mass media campaigns that prevent tobacco use by youth and young adults.

**Indicator:** Number of mass media campaigns that prevent tobacco use by youth and young adults

**Strategy Background**

**Source:**

The Guide to Community Preventive Services; Centers for Disease Control and Prevention (CDC); [www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)

**Evidence Base:** Mass reach health communication interventions target large audiences through television and radio broadcasts, print media (e.g., newspapers), out-of-home placements (e.g., billboards, movie theaters, point-of-sale), and digital media to change knowledge, beliefs, attitudes, and behaviors affecting tobacco use. Intervention messages are typically developed through formative testing and aim to reduce initiation of tobacco use among young people, increase quit efforts by tobacco users of all ages, and inform individual and public attitudes on tobacco use and secondhand smoke. Pictorial warning labels on tobacco packages, an additional channel for the dissemination of health information to tobacco users, were not considered in this review (Community Guide).

**Type of Change:** Individual, Community

**Partner Agencies**

**Lead:** BCDH

**Collaborating:** TBD

**Supporting:** CTGP, Mission

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Place media messages that reach youth and young adults to:</b> <ul style="list-style-type: none"><li>• prevent initiation of tobacco use</li><li>• promote quitting and QuitlineNC</li><li>• promote awareness about secondhand smoke</li><li>• support smoke-free air policies and laws</li></ul> (ex. place radio, print, TV ads; submit letters to the editor, etc.)	ARP; BCDH; CTGP; Mission	Create awareness of the dangers of tobacco use among youth and young adults	5 media messages placed or aired	July 2014

## Works Cited Tobacco Prevention and Cessation:

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U.S. Department of Health and Human Services, Clinical Practice Guideline: Treating Tobacco Use and Dependence: 2008 Update. Accessed 7/30/13 at: : [http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/treating\\_tobacco\\_use08.pdf](http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/treating_tobacco_use08.pdf)

## CHAPTER 4 – PRECONCEPTION HEALTH

### Situational Analysis

#### *Did you know?*

There have been important advances in medicine and prenatal care in recent years. Despite these advances, birth outcomes are worse in the United States than in many other developed countries.

Many babies are born early or have low birth-weight. Among some groups of people, the problems actually are getting worse.

Preconception health and preconception health care can make a difference

*Source:*  
*Center for Disease Control and Prevention*

Preconception health refers to the health of women and men during their reproductive years, which are the years they can have a child. Preconception health helps men and women think about how their behaviors, lifestyles, and medical conditions affect their ability to live healthy lives and to have healthy children (NCDHHS 2010). However, all women and men can benefit from preconception health, whether or not they plan to have a baby one day. Preconception health is about people getting and staying healthy, throughout their lives (CDC<sup>1</sup> 2012). Since several important components of preconception health (chronic disease, physical activity and nutrition, tobacco use, and access to care) are covered extensively in Chapters 2, 3, and 5 of this CHIP plan, this chapter focuses on sexual and reproductive health in Buncombe County.

#### **Sexually Transmitted Disease**

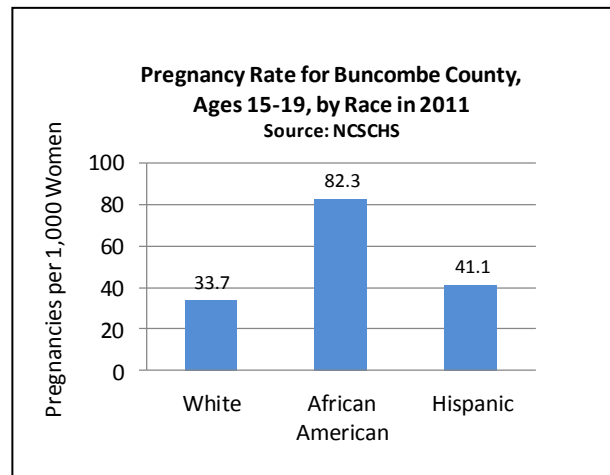
Sexually transmitted diseases (STDs) pose a health threat in Buncombe County. Though most STDs are easily diagnosed and treated, many have no noticeable symptoms. As a result, many infections go undetected. Without treatment, individuals with STDs are at risk of health problems including pelvic inflammatory disease, infertility, increased risk of HIV transmission, preterm birth, and other serious complication for the newborn (WHO 2013).

STDs affect people of all races, ages, and sexual orientations, but some individuals experience greater challenges in protecting their health. Everyone should have the opportunity to make choices that allow them to live healthy lives regardless of their income, education, or racial/ethnic background. The reality is that lack of resources or insurance and challenging living conditions make it more difficult to become and stay healthy, and can lead to circumstances that increase the risk of STDs. African Americans in Buncombe County sometimes face these barriers, which contributes to the especially heavy toll STDs take on this community (CDC<sup>2</sup> 2012). African Americans represent just 6% of the Buncombe County population, yet account for almost a third of all reported chlamydia cases and almost half of all gonorrhea cases (Census 2010; NCDHHS 2011 ). To ensure that everyone in the community has the opportunity to make healthy decisions, it is essential to address both the individual and social factors that contribute to STD risk.

## Unintended Pregnancies

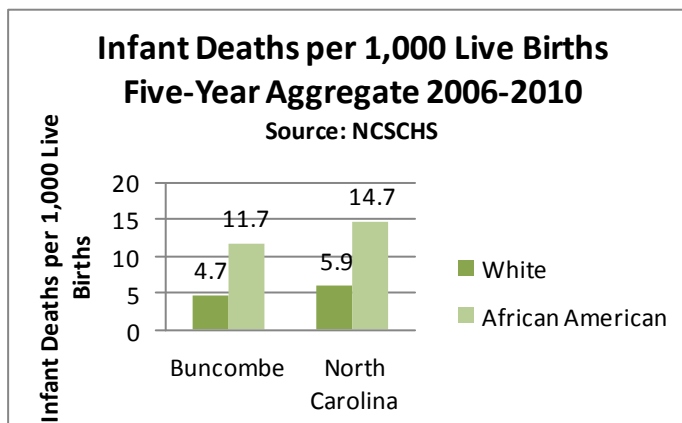
No one expects an unplanned pregnancy. But it happens often and is a barrier to efforts to give every child in Buncombe County the best start possible. Approximately 43% of births in North Carolina are the result of unintended pregnancies (pregnancies that are desired later or not at all) (NCSCS<sup>1</sup> 2011). Couples with unintended pregnancies may have risk factors or be engaging in behaviors that put their own health and the health of the pregnancy at risk. Unintended pregnancy has been associated with poor outcomes such as late entry into prenatal care, low birth weight, and child abuse and neglect (Brown 1995). Nearly half of new mothers in North Carolina reported that they were not trying to get pregnant at the time of conception but were not doing anything to keep from getting pregnant (NCSCS 2008).

African American and Hispanic women in Buncombe County have significantly higher pregnancy rates than white women, suggesting potential opportunities for preconception health efforts. The racial and ethnic gap is even greater in teen pregnancies, despite the decreasing rates of teen pregnancy for the Buncombe County on average. The large majority of teen pregnancies are unintended.



## Infant Mortality

Too many babies are dying in Buncombe County. While the rate of infant deaths has been declining (reaching 5.2 deaths per 1,000 live births in 2011), many of these deaths are still preventable (NCSCS<sup>2</sup> 2011). Buncombe County's infant mortality rate is largely attributable to premature births and low birth weights. Each year in Buncombe County, one in seven babies is born too early, and the number is rising (NCSCS 2013). Prematurity and low birth weight are often connected to the health of the parents before they become pregnant, so we must concentrate on making sure parents have adequate knowledge about healthy choices and practices before pregnancy. Infant mortality is an issue that affects the county across racial and socio-economic lines but some of our communities suffer more than others. African-American



infants in Buncombe County are 2.4 times more likely to die before the age of one than white infants, mirroring a pattern across the state (NCSCS<sup>2</sup> 2011). Significant disparities in birth outcomes and women's health have persisted for generations across North Carolina (NCDHHS 2010). Working to help all women and all men be healthy before, during, and after pregnancy is the best way to save babies' lives and improve the health of our community.

## Spotlight on Success

### Making Proud Choices!

Buncombe County Health and Human Services (BCHHS) is participating in a three year *Institute on the Prevention of Teen Pregnancy and Sexually Transmitted Infection*. The Institute is comprised of five state jurisdictions and Buncombe, Wake and Wilson counties and aims to reduce teen pregnancy and sexually transmitted infection (STI) with youth in foster care by utilizing an evidence-based curriculum along with strategic change management efforts within the agency and community that address the unique needs of this population. This project is in association with The National Campaign to Prevent Teen and Unplanned Pregnancy, the American Public Human Services Association (APHSA), and its affiliate, the National Association of Public Child Welfare Administrators (NAPCWA), with support from the Annie E. Casey Foundation.

BCHHS and strategic community partners are working together to implement *Making Proud Choices!*, an evidence-based program that provides youth with the knowledge, confidence, and skills necessary to reduce their risk of STIs, HIV, and pregnancy. The curriculum was adapted to address the specific concerns of youth in foster care; however, the curriculum is not restricted for use only with this population. The adapted curriculum includes LGBT youth inclusion; greater focus on birth control, broader sexuality issues and healthy relationships; and case studies, discussions and role plays that are tailored to youth in foster care. A diverse group of facilitators from community organizations were trained to deliver the program to the community, beginning with foster care youth. Thirty-five foster youth successfully completed the sessions held in May. Caregivers were also given a chance to experience the *Making Proud Choices!* curriculum and provided valuable positive feedback about the program. Participant response indicated that the topics and

information shared in *Making Proud Choices!* is critical to a successful decision-making path for teenagers when they are in their formative years. Future efforts include expanding the program into the community. In addition to the existing programs at Mt. Zion Community Development and the YWCA, the program will be delivered in the Pisgah View Housing community beginning in August.



Parenthood is the leading reason teen girls drop out of school. 50% of teen mothers never finish high school.

One out of every four sexually active teens has an STD.

A child born to a teen mother who has not finished high school and is not married is nine times more likely to be poor than one who has graduated and is married.

Teen girls in foster care are 2.5 times more likely than their peers not in foster care to get pregnant by age 19.

Half of 21- year- old males leaving foster care report they had gotten someone pregnant, versus 19% of their peers who were not in foster care.

41% of foster youth think the reason teen pregnancy is higher among foster youth is because they want to feel loved.

Source: The National Campaign to Prevent Teen and Unplanned Pregnancy



## Partners

Addressing preconception health is complex and will require the collaborative planning, action, and coordination of multiple partners in our community. The following partner agencies and organizations are engaged in efforts to improve preconception health in our community. As new partners are identified, we will continuously work to bring them into the process.

<b>Organizations</b>	<b>Website or Contact Information</b>
Asheville City Schools	<a href="http://www.ashevillecityschools.net/Pages/default.aspx">http://www.ashevillecityschools.net/Pages/default.aspx</a>
Buncombe County Schools	<a href="http://www.buncombe.k12.nc.us">www.buncombe.k12.nc.us</a>
Buncombe County Health and Human Services (BCHHS)- Economic Services	<a href="http://www.buncombecounty.org/Governing/Depts/DSS/Economics/">http://www.buncombecounty.org/Governing/Depts/DSS/Economics/</a>
BCHHS- Family Planning Clinic	<a href="http://www.buncombecounty.org/Governing/Depts/Health/Family.aspx">http://www.buncombecounty.org/Governing/Depts/Health/Family.aspx</a>
BCHHS- Nurse Family Partnership	<a href="http://www.nursefamilypartnership.org/locations/North-Carolina/Buncombe-County-NFP">http://www.nursefamilypartnership.org/locations/North-Carolina/Buncombe-County-NFP</a>
BCHHS – Outreach and Wellbeing	Becky Kessel, MSW <a href="mailto:Becky.Kessel@buncombecounty.org">Becky.Kessel@buncombecounty.org</a>
BCHHS - School Health	<a href="http://buncombecounty.org/Governing/Depts/health/SchoolHealth.aspx">http://buncombecounty.org/Governing/Depts/health/SchoolHealth.aspx</a>
BCHHS- Youth Educators and Advocates for Health (YEAH!)	<a href="mailto:Sara.green@buncombecounty.org">Sara.green@buncombecounty.org</a>
Community Care of Western North Carolina (CCWNC)	<a href="http://www.communitycarewnc.org/">http://www.communitycarewnc.org/</a>
MAHEC Family Medicine	<a href="http://www.mahec.net/resident/fhca_curriculum.aspx#ob">http://www.mahec.net/resident/fhca_curriculum.aspx#ob</a>
Mt. Zion Community Development, Inc.- Project EMPOWER and Project NAF	<a href="http://www.mtzionasheville.org/mt_zion_cdc">http://www.mtzionasheville.org/mt_zion_cdc</a>
North Carolina Preconception Health Campaign/Mission Health	<a href="http://everywomannc.com/about-us/nc-preconception-health-campaign">http://everywomannc.com/about-us/nc-preconception-health-campaign</a>
Planned Parenthood Health Systems	<a href="http://www.plannedparenthood.org/health-center/centerDetails.asp?f=2626&amp;a=90860&amp;v=details">http://www.plannedparenthood.org/health-center/centerDetails.asp?f=2626&amp;a=90860&amp;v=details</a>
Western North Carolina AIDS Project (WNCAP)	<a href="http://wncap.org/">http://wncap.org/</a>
Western North Carolina Community Health Services (WNCCHS)	<a href="http://www.wncchs.org/">http://www.wncchs.org/</a>
YWCA- MotherLove program	<a href="http://www.ywcaofasheville.org/site/c.7oIEJQPxGeISF/b.8131583/k.2A86/MotherLove.htm">http://www.ywcaofasheville.org/site/c.7oIEJQPxGeISF/b.8131583/k.2A86/MotherLove.htm</a>

## Preconception Health Plan

### Vision of Impact

All men and women of reproductive age, regardless of pregnancy status or desire, have the knowledge, empowerment and ability to choose healthy behaviors within a community which supports those behaviors. This will lead to improved health outcomes for women, newborns and families.



- All men and women of reproductive age have an informed, comprehensive reproductive life plan and are supported in their plan.
- All pregnancies are intended and planned.
- All men and women of reproductive age have access to health care and are screened and receive evidence-based interventions prior to pregnancy to improve birth outcomes.
- All men and women receive interconception care to reduce their risks for adverse outcomes in subsequent pregnancies.

*Adapted from the Center for Disease Control and Prevention, the Global Action Report on Preterm Birth and the Action Plan for the National Initiative on Preconception Health and Health Care 2012-2014 Plan*

State and National Objectives:	Baseline/Indicator Source
<b>Healthy NC 2020 Objective:</b> Decrease the percentage of pregnancies that are unintended [2010 NC Baseline: 45.2%; 2020 Target: 30.9%]	PRAMS
<b>Healthy NC 2020 Objective:</b> Reduce the infant mortality rate (per 1,000 live births) [2006-2011 BC Baseline: 5.2; 2020 Target: 6.3]	5-year aggregate NCSCHS
<b>Healthy NC 2020 Objective:</b> Reduce the infant mortality racial disparity between whites and African Americans [2011 BC Baseline: 2.5; 2020 Target: 1.92 ]	5-year aggregate NCSCHS
<b>Healthy NC 2020 Objective:</b> Reduce the percentage of positive results among individuals aged 15 to 24 tested for chlamydia [2010 BC Baseline: 9.9%; 2020 Target: 8.7% ]	NC SCHS
<b>Healthy NC 2020 Objective:</b> Reduce the rate of new HIV infection diagnoses (per 100,000 population) [2020 Target: 22.2 ]	NC DHHS
<b>Healthy People 2020 Objective:</b> Reduce low birth weight (LBW) [2007-2011 BC Baseline: 8.0%; 2020 Target: 7.8% ]	5-year aggregate NCSCHS
<b>Healthy People 2020 Objective:</b> Reduce preterm births. [2007-2011 BC Baseline: 14.7%; 2020 Target: 11.4% ]	5-year aggregate NCSCHS

<p><b>Healthy People 2020 Objective:</b> Reduce pregnancies among adolescent females aged 15-17  [2011 BC Baseline: 19.9 pregnancies per 1,000; 2020 Target: 10% improvement]</p>	<p>NCSCHS</p>
<p><b>Healthy People 2020 Objective:</b> Reduce pregnancies among adolescent females aged 18-19  [2011 BC Baseline: 66.3 pregnancies per 1,000; 2020 Target: 10% improvement]</p>	<p>NCSCHS</p>

**Goal 1: Increase awareness of the importance of health before pregnancy**

**Strategy 1.1:** Preconception health trainings for health care providers

**Objective 1.1.1:**

Conduct preconception health trainings using evidence-based curriculum for 250 public and private health care providers

**Indicator:** Number of evidence-based preconception health trainings provided to providers

**Strategy Background**

**Source:**

North Carolina Preconception Health Campaign Young Mom’s Connect program:  
<http://everywomannc.com/public-health-programs/north-carolina-programs/young-moms-connect>

**Evidence Base:** This strategy is aligned with the CDC’s recommendation to improve preconception health and health care by integrating preconception health risk assessment and education into primary care visits (CDC 2006). Young Moms Connect is an evidence-based curriculum intended to train health care providers on five maternal health best practices: early entry and effective utilization of prenatal care; establishment and utilization of a medical home (for non-pregnant women); reproductive life planning (including access and utilization of family planning services); tobacco cessation counseling using the 5 A’s approach; and promotion of healthy weight (March of Dimes North Carolina Preconception Health Campaign 2012).

**Type of Change:** Individual, Community

**Partner Agencies**

**Lead:** North Carolina Preconception Health Campaign

**Collaborating/Supporting:** TBD

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Identify providers interested in trainings</b>	-NC preconception health campaign staff time	-Roster of interested providers will be developed	-Review of deliverable	May 2013
<b>Provide trainings to providers</b>	-NC preconception health campaign staff time -Provider staff time -Training materials -Training space	-New providers will be trained on integrating preconception health into their practice	- Training will be held - Evaluation of Training	May 2013
<b>Create an evaluation plan for provider trainings</b>	- NC preconception health campaign staff time	-Established an evaluation protocol for provider trainings	-Review of deliverable	May 2013

**Strategy 1.2:** Preconception health trainings for consumers

**Objective 1.1.2:**

Conduct preconception health trainings using evidence-based curriculum for 463 consumers in 24 counties in Western NC

**Indicator:** Number of evidence-based preconception health trainings provided to consumers

**Strategy Background**

**Source:**

North Carolina Preconception Health Campaign Young Moms Connect program:  
<http://everywomannc.com/public-health-programs/north-carolina-programs/young-moms-connect>

**Evidence Base:** This strategy is aligned with the CDC’s recommendations to improve preconception health and health care by increasing public awareness of the importance of preconception health behaviors and preconception care services (CDC 2006). Through Young Moms Connect, preconception health materials have been developed and compiled. These materials include consumer-appropriate material that addresses the establishment and utilization of a medical home (for non-pregnant women), reproductive life planning (including access and utilization of family planning services), tobacco cessation counseling using the 5 A’s approach, and promotion of healthy weight (March of Dimes North Carolina Preconception Health Campaign 2012). These materials are distributed online and through trainings.

**Type of Change:** Individual

**Partner Agencies**

**Lead:** North Carolina Preconception Health Campaign  
**Collaborating/Supporting:** TBD

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Identify consumers interested in trainings</b>	-NC preconception health campaign staff time	-Roster of interested consumers will be developed	-Review of deliverable	May 2013
<b>Provide trainings to consumers</b>	-NC preconception health campaign staff time -Training materials -Training space	-Consumers will have increased knowledge preconception health	- Training will be held - Evaluation of Training	May 2013
<b>Create an evaluation plan for consumers trainings</b>	- NC preconception health campaign staff time	-Established an evaluation protocol for consumer trainings	-Review of deliverable	May 2013

**Strategy 1.3:** Community ambassador peer trainings in preconception health**Objective 1.3.1:**

Train ten community ambassadors (lay health educators) to train their peers in preconception health

**Indicator:** Number of community ambassadors trained in preconception health

**Strategy Background****Source:**

North Carolina Preconception Health Campaign- The Community Ambassador Program  
<http://everywomannc.com/about-us/nc-preconception-health-campaign>

**Evidence Base:** There is evidence indicating the effectiveness of lay community health workers (LCHWs) in several areas related to preconception health. A Cochrane literature review documented the effectiveness of lay health worker programs for increasing immunization uptake, promoting breastfeeding, and reducing morbidity and mortality as the result of childhood illnesses (Lewin et al 2005). The CDC has compiled examples of the growing body of evidence documenting the effectiveness of LCHWs in diabetes care and education efforts (CDC 2011). LCHWs are a component of the CDC’s National Breast and Cervical Cancer Early Detection Program. LCHWs have also been shown to be effective in increasing breast and cervical cancer screening in several different populations of women (Bird et al. 1998, Fernández et al 2009).

**Type of Change:** Individual, Community

**Partner Agencies**

**Lead:** North Carolina Preconception Health Campaign

**Collaborating/Supporting:** TBD

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Identify suitable community ambassadors	-NC preconception health campaign staff time	-Roster of appropriate ambassadors a will be developed	-Review of deliverable	May 2013
Create evaluation plan for trainings for ambassadors and the peer trainings they will lead	- NC preconception health campaign staff time	-Established an evaluation protocol for ambassador trainings and their peer trainings	-Review of deliverable	May 2013
Hold training for ambassadors	-NC preconception health campaign staff time -Training materials -Training space	-Ambassadors will have increased knowledge preconception health and skills to provide peer trainings	- Training will be held - Evaluation of Training	May 2013
Track trainings that ambassadors hold	-NC preconception health campaign staff time -Tracking sheets	- Each ambassador will have held trained 25 peers	-Tracking sheet and database	May 2013

## Goal 2: Increase reproductive health education and awareness among teens

### Strategy 2.1: Making Proud Choices! curriculum

#### Objective 2.1.1:

Increase the number of teens completing the Making Proud Choices! curriculum.

**Indicator:** Number of teens completing the Making Proud Choices! curriculum

### Strategy Background

#### Source:

Resource Center for Adolescent Pregnancy Prevention- Making Proud Choices! Program  
<http://recapp.etr.org/recapp/index.cfm?fuseaction=pages.ebpDetail&PageID=128>

**Evidence Base:** The Making Proud Choices! curriculum is recommended by the NC DHHS Pregnancy Prevention Program and meets the CDC-designated "Best Evidence" criteria. Randomized control trials have shown significant positive attitude and behavior changes among teens who received the curriculum up to four years post-intervention (Jemmott et al. 1998). A modified curriculum for teens in foster care is currently being piloted and evaluated in five states, including in Buncombe County.

**Type of Change:** Individual, family, community

#### Partner Agencies

**Lead:** BCHHS, Mt. Zion Community Development, Inc- Project EMPOWER, YWCA- MotherLove

**Collaborating/Supporting:** TBD

#### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to discuss variations on curriculum and evaluation methods	-Staff time - Partner staff time - Meeting space	-establish difference in curriculum - comparison of evaluation methods -plan set for common evaluation tool	-Meeting held - plan set for creation of common evaluation tool	October 2013
Create a common evaluation tool	-Staff time -Partner staff time -materials for evaluation tools (paper, printing)	-creation of a common evaluation tool	-Review of deliverable	November 2013
Convene partner to determine which teens are being served and ways to reach more/ target high risk teens between the programs	-Staff time - Partner staff time - Meeting space	-establishment of an action plan to serve the most teens through the three programs	-review of deliverable	January 2013

**Strategy 2.2:** Promotional and educational activities by youth peer educators

**Objective 2.2.1:**

Increase the number of promotional and educational activities by Y.E.A.H. leaders at high school and community events

**Indicator:** Number of high schools with promotional activities by Y.E.A.H  
Number of community events with promotional activities by Y.E.A.H

**Strategy Background**

**Source:** N/A

**Evidence Base:** Y.E.A.H. is modeled after the CDC-funded Gaston Youth Connected’s Teen Action Council which combines the Youth Empowerment Model with peer-to-peer education (<http://gastonyouthconnected.org/>; <http://www.youthempoweredolutions.org/>). The research on peer education programs resulting in the prevention of pregnancy is mixed (Resource Center for Adolescent Pregnancy Prevention). However, research suggests that people are more likely to hear and internalize messages, and have corresponding attitude and behavior changes, if they identify the speaker as similar to them (Milburn 1995). A number of studies have demonstrated that young people’s health behaviors around sexuality are influenced by their peers. (Sloane and Zimmer 1993; DiClemente 1992). Peer educators model positive youth behavior, affecting social norms and support healthy decisions about sex (DiClemente 1993). An extensive literature review is available at: <http://www.advocatesforyouth.org/publications/444?task=view>.

**Type of Change:** Individual, Community

**Partner Agencies**

**Lead:** BCHHS- Y.E.A.H.

**Collaborating:** TBD

**Supporting:** Asheville City Schools, Buncombe County Schools

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Recruit applicants	Staff time	Representation from all high schools	Roster of YEAH members	September 2013
Provide orientation and training	Staff time and training materials	Increased knowledge and skills	Training log and evaluation	October 2013
Conduct youth-driven activities to engage youth in advocacy for behavior and policy change	Staff time; community partner time; YEAH leader time	high schools with promotions implemented by YEAH members presentations to key leaders	Campaigns/outreach conducted in high schools and community	June 2013



**Strategy 2.3:** Growth and development and reproductive health and safety curriculum in schools

**Objective 2.3.1:**

Implement the growth and development and reproductive health and safety curriculum (Healthful Living Essential Standards) in all Asheville City and Buncombe County Schools

**Indicator:** Percentage of Asheville and Buncombe County schools that have implemented the growth and development and reproductive health and safety curriculum (Healthful Living Essential Standards)

## Strategy Background

**Source:**

Buncombe County Schools Curriculum Outlines:

<http://www.buncombe.k12.nc.us/Page/27487>

Asheville City Schools Curriculum Outlines:

<http://www.ashevillecityschools.net/depts/student-services/Pages/Safe%20and%20Drug-Free%20Schools.aspx>

**Evidence Base:** The Reproductive Health and Safety Education curriculums are in compliance with the Healthy Youth Act integrating abstinence messaging with comprehensive sex education. Evidence shows that students who complete sexuality education in general wait longer to have sex than students who have no sexuality education. Furthermore, when students do become sexually active, those who complete comprehensive sexuality education are more likely to use condoms and/or contraceptives than students who have no sexuality education or who only receive abstinence-only education (Kohler 2008; Kirby 2008, Chin 2012). While the curricula for Buncombe County and Asheville City Schools have been adapted for these specific student populations, they include activities from evidence-based curricula such as Safe Dates and Making Proud Choices! (<http://www.hazelden.org/web/go/safedates>; <http://recapp.etr.org/Recapp/index.cfm?fuseaction=pages.ebpDetail&PageID=128>).

**Type of Change:** Individual, Community

**Partner Agencies**

**Lead:** Asheville City Schools, Buncombe County Schools

**Collaborating:** BCHSS- School Nurses, WNCAP, Our Voice, HelpMate

**Supporting:** TBD

## Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
<b>Provide Growth and Development Curriculum to 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> graders</b>	-Asheville City and Buncombe County staff and health educator time -School Nurse staff time -Activity resources	- All 4 <sup>th</sup> -6 <sup>th</sup> graders will receive the curriculum	- Records from Asheville and Buncombe County Schools	June 2014
<b>Provide Reproductive Health and Safety Curriculum to 7<sup>th</sup>, 8<sup>th</sup> and 9<sup>th</sup> graders</b>	-Asheville City and Buncombe County staff and health educator time -School Nurse staff time -Activity resources	- All 7 <sup>th</sup> -9 <sup>th</sup> graders will receive the curriculum	- Records from Asheville and Buncombe County Schools	June 2014

### Goal 3: Increase access to reproductive health services

**Strategy 3.1:** Expedited protocol for birth control prescription

**Objective 3.1.1:**

Increase number of practices that use a protocol for expedited birth control prescription

**Indicator:** Number of practices using an expedited birth control prescription

### Strategy Background

**Source:** N/A

**Evidence Base:** Expedited protocol for birth control prescriptions allows patients to begin using birth control more quickly through two different means. One is "quick-start," which allows women to begin using hormonal contraceptives on the day that they visit their provider's office, instead of waiting until a certain point in their menstrual cycle. Protocols that require a woman to wait until the next menses to start hormonal contraceptives have been found to be medically unnecessary and an obstacle to contraceptive initiation. Immediate initiation of a birth control method has been shown to improve short-term continuation of oral contraceptive pills and improved adherence to Depo Provera shot continuation leading to fewer pregnancies (Westoff et al 2007; Vaughn et al 2007).

The second part of expedited birth control prescriptions is requiring only a counseling session to get a birth control prescription. Neither the World Health Organization nor the American College of Obstetrics and Gynecology requires a pelvic exam in advance of birth control prescriptions. Evaluation of programs that offer hormonal contraception and optional pelvic exam found that lower expense and prompt appointment of non-exam visits were reported as very important to patients (Harper 2001; Armstrong 2012)

**Type of Change:** Individual, Policy

**Partner Agencies**

**Lead:** BCHHS Family Planning Clinic, MAHEC Family Medicine, Planned Parenthood

**Collaborating/Supporting:** TBD

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Convene partners to continue work on shared measures and roles/responsibilities</b>	-Staff time -Partner staff time	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
<b>Convene partners to develop system for managing data</b>	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	October 2013
<b>Convene partners discuss to detailed action item discussed as workgroup meeting including:</b> <ul style="list-style-type: none"> <li>- Survey practices in the area to see what BC prescription protocols are being used</li> <li>- Create a document to share the expedited BC prescription protocol</li> <li>- Hold a question and answer panel of the clinics already implementing this protocol</li> </ul>	-Staff time -Partner staff time	Detailed action plan will be established	Review of deliverable	October 2013

**Strategy 3.2:** Enrollment of eligible women in the Be Smart Family Planning Medicaid Waiver

**Objective 3.2.1:**

Increase referrals to Be Smart Family Planning Medicaid Waiver

**Indicator:** Number of women referred to Be Smart Family Planning Medicaid Waiver

**Strategy Background**

**Source:**

NC Be Smart Family Planning Program

<http://www.ncdhhs.gov/dma/medicaid/familyplanning.htm>

**Evidence Base:** This strategy is aligned with the CDC’s recommendation to improve preconception health and health care by increasing health insurance coverage for women with low incomes to improve access to preconception care (CDC 2006). Analyses of Behavioral Risk Factor Surveillance System data found that lack of health insurance is associated with reduced use of prescription contraceptives (Culwell and Feinglass 2007). Waivers that expand Medicaid eligibility for family planning coverage allow more women to have health insurance coverage for contraceptive services. Evaluations of these programs found that Medicaid eligibility expansion waivers lowered average annual birth rates in all states (Lindrooth and McCullogh 2007).

**Type of Change:** Individual, Community

**Partner Agencies**

**Lead:** BCHHS Family Planning Clinic and Economic Services

**Collaborating:** CCWNC

**Supporting:** TBD

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to explore the practice and recording of Medicaid referrals in different organizations	-Staff time -Partner staff time	-comparison of Medicaid referral practice and recording -plan developed for shared measurement system	-meeting held - review of deliverable	October 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	November/ December 2013

**Strategy 3.3:** School nurse family planning/STI case management

**Objective 3.3.1:**

Increase the number of youth using BCHHS Family Planning Clinic

**Indicator:** Number of youth using BCHHS Family Planning Clinic

**Strategy Background**

**Source:** N/A

**Evidence Base:** Research has shown that adherence to birth control decreases several months post prescription and discontinuation is common (Westoff et al 2007). Consistent use of any

contraceptive method remains a challenge for many sexually active adolescents in particular (American Academy of Pediatrics 2007). This pilot program uses case management from school nurses to in order prevent pregnancy though improved adherence to birth control among sexually active adolescents. School nurses in Buncombe County have historically provided pregnancy case management which has been shown to reduce subsequent pregnancies among parenting teens (Guidry 1989; Brindis and Philliber 1998). Preliminary evaluations of clinic-linked case management programs have shown promising results, including increased consistent condom and hormonal contraceptive use among teen girls at high risk for a first pregnancy (Sieving et al. 2013).

**Type of Change:** Individual, Community

**Partner Agencies**

**Lead:** BCHHS- High School Nurses, BCHHS- Family Planning Clinic

**Collaborating/Supporting:** TBD

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Receive school approval	-Staff time	-Receive school approval	- Existence of approval	August 2013
Identify and select nurses act as case managers	-Staff time	- Nurses will be selected to be trained	- Nurses selected	August 2013
Train nurses in case management	-Staff time -Nurse staff time -Training materials	-Nurses will receive case management train and be prepared to being having a case load	- Training post-test and evaluation	September 2013
Track students participation in case management	-Nurse staff time -Tracking forms	- Record of the reach of the case management	-review of deliverable	June 2014

**Strategy 3.4:** Women's healthcare at methadone clinics

**Objective 3.4.1:**

Increase the use of contraception, including long acting reversible contraception, among female clients of the Mountain Area Recovery Center

**Indicator:** The percentage of female clients at the Mountain Area Recovery Center who desire family planning that have are using contraception

**Objective 3.4.2:**

Increase the use of folic acid among female clients of the Mountain Area Recovery Center

**Indicator:** The percentage of female clients at the Mountain Area Recovery Center taking a multivitamin

## Strategy Background

**Source:** N/A

**Evidence Base:** A study of women attending opioid treatment programs found unaddressed reproductive health issues, particularly around contraception. The study found: high pregnancy rates (with almost a third of women reporting six or more pregnancies); high rates of miscarriage, termination and stillbirth compared with national data; and poor uptake of contraception (with only half of sexually active women not wanting to get pregnant using a method) (Black et al. 2012). An article in *Advances in Preventive Medicine* on designing interventions for women who inject drug recommends low-cost and accessible sexual and reproductive healthcare programs targeted at women who use drugs and often have insufficient access to care (Pinkham et al. 2012). Most current opioid treatment programs involve referral to external women’s health services, but an integrated model of care may increase access and better address the unmet contraceptive needs of these women.

**Type of Change:** Individual, community

### Partner Agencies

**Lead:** MAHEC , BCHHS Family Planning Clinic

**Collaborating/Supporting:** TBD

### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to explore ways to increase appointments and decrease the no-show rates	-Staff time -Partner staff time -Meeting space	-Development of an action plan for increasing appointment and decreasing no-show rates.	-Review of deliverable	October 2013
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Partner staff time	-Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	-Shared measures, roles and responsibilities posted in online CHIP document	October 2013
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	-Data management and accountability system and timeline for strategy developed	-Internet-based system established	November 2013

**Strategy 3.5:** Integrated Targeted HIV and STD Testing Services (ITTS)

**Objective 3.5.1:**

Increase the number of clients tested for HIV and other STDs in targeted testing settings

**Indicator:** Number of HIV, hepatitis C, syphilis, Chlamydia, gonorrhea tests

**Objective 3.5.2:**

Increase the proportion of individuals that are aware of their infection status

**Indicator:** Number of individuals tested

## Strategy Background

**Source:** Program Collaboration and Service Integration: Enhancing the Prevention and Control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis in the United States

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), White Paper, 2009

[http://www.cdc.gov/nchhstp/programintegration/docs/207181-C\\_NCHHSTP\\_PCSI%20WhitePaper-508c.pdf](http://www.cdc.gov/nchhstp/programintegration/docs/207181-C_NCHHSTP_PCSI%20WhitePaper-508c.pdf)

**Evidence Base:** The CDC's Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection emphasize the importance of program collaboration and service integration and should be used as a model for state and local organizations (NCHHSTP White Paper, 2009). The CDC's NCHHSTP, page 7, defines program collaboration and service integration as a "mechanism for organizing and blending interrelated health issues, activities, and prevention strategies to facilitate comprehensive delivery of services".

The Integrated Target Testing Services (ITTS) is committed to an integrated approach and relies on program collaboration and service integration. The rationale for ITTS program collaboration is to maximize the benefits participants receive from prevention services such as STD testing by maximizing opportunities to screen, test, and treat those in need of these services. Through program collaboration ITTS can broaden its mission and provide HIV counseling, testing and referral services to high-risk, hard to reach populations in community settings, increase participation in STD testing, and increase the numbers of those who know their status.

**Type of Change:** Individual, community

## Partner Agencies

**Lead:** Western North Carolina AIDS Project (WNCAP), BCHHS STD clinic, Disease Control Outreach

**Collaborating/Supporting:** Universities and Colleges in Western North Carolina, Homeless Support Agencies, Community Centers, Substance Abuse Clinics in Western North Carolina

## Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to explore ways to	-Staff time -Partner staff time -Meeting space	-Development of an action	-Review of deliverable	
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Partner staff time	-Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	-Shared measures, roles and responsibilities posted in online CHIP document	
Convene partners to develop system for managing data	-Staff time -Lead and select collaborating/supporting partners	-Data management and accountability system and timeline for strategy developed	-Internet-based system established	

## Goal 4: Increase opportunities for interconception care

### Strategy 4.1: Case management, nursing assessment and care plans for pregnant and postpartum women

#### Objective 4.1.1:

Maintain a case load of 125 first time mothers receiving nursing care and education using the Nurse Family Partnership model to fidelity

**Indicator:** Number of first time mother receiving case management through NFP

#### Objective 4.1.2:

All high risk Medicaid-covered births receive case management during pregnancy

**Indicator:** Percentage of high-risk mother with Medicaid coverage receiving case management

#### Objective 4.1.3:

Provide 40 African-American women per year with case management and education through the Healthy Beginnings Program

**Indicator:** Number of women receiving case management through Project NAF

#### Objective 4.1.4:

Provide 30 pregnant or parenting students per year with case management and education, and an additional 50 parenting students with the education using the Love Notes Curriculum

**Indicator:** Number of students receiving case management and education though the



## Strategy Background

### Source:

Nurse Family Partnership: <http://www.nursefamilypartnership.org/locations/North-Carolina/Buncombe-County-NFP>

Project NAF: [http://www.mtzionasheville.org/mt\\_zion\\_cdc](http://www.mtzionasheville.org/mt_zion_cdc)

Mother Love:

<http://www.ywcaofasheville.org/site/c.7oIEJQPxGeISF/b.8131583/k.2A86/MotherLove.htm>

**Evidence Base:** There is strong evidence of the effectiveness of case management in pregnant and postpartum women improving maternal outcomes. Three large randomized control trials and numerous follow-up studies have found the Nurse Family Partnership program to decrease high risk pregnancies and unintended pregnancies. It has also been found to result in longer intervals before subsequent pregnancies (<http://www.nursefamilypartnership.org/proven-results/published-research>). MotherLove’s one-on-one sessions are guided by the evidence-based Partners for a Healthy Baby, which is shown to improve birth outcomes (<https://cpeip.fsu.edu/PHB/>). The group sessions are based on an adaptation of evidence-based Love U2: Relationship Smarts PLUS program, shown to increase knowledge of and develop skills for making good decisions about forming and maintaining healthy relationships (Adler-Baeder et al 2007). Project NAF is guided by the North Carolina Division of Public Health’s Healthy Beginnings program.

**Type of Change:** Individual, Family, Community

### Partner Agencies

**Lead:** BCHHS Nurse Family Partnership, Mt. Zion- Project NAF, YWCA- MotherLove Program

**Collaborating:** CCWNC OB Case Management

**Supporting:** TBD

### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	Staff time Working group participants	Shared measures identified and clarified roles and responsibilities for moving work on strategy forward	Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013
Convene partners to develop system for managing data	Staff time Lead and select collaborating/supporting partners	Data management and accountability system and timeline for strategy developed	Internet-based system established	Oct/November 2013
Develop detailed action plan for each	Staff time	Strategy level action plans developed	Action plans posted in online CHIP document	Oct/November 2013

strategy	Working group participants			
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### Strategy 4.2: Post-partum visits

#### Objective 4.2.1:

Increase the number providers participating as a Pregnancy Medical Homes.

**Indicator:** Number of providers participating in pregnancy medical homes

#### Objective 4.2.2:

Increase the percentage of women with Medicaid covered births attending their postpartum visits

**Indicator:** Increase the percentage of women with Medicaid covered births attending their postpartum visits

## Strategy Background

### Source:

Community Care of North Carolina- Pregnancy Medical Home Overview  
<http://commonwealth.communitycarenc.org/toolkit/15/default.aspx>

**Evidence Base:** This strategy is aligned with the CDC's recommendation to improve preconception health and health care by increasing interconception care. The CDC report identifies postpartum visits as an opportunity promote interconception health (CDC 2006). The pregnancy medical home, based on the successful implementation of the primary care medical home model, requires an evidence-based postpartum visit including, at a minimum, a depression screen using a validated instrument, addressing the patient's reproductive life plan, and a referral for ongoing care beyond the maternity period. (Community Care of North Carolina 2011). The model also provides \$150 incentives to the physicians for conducting each evidence-based postpartum visit. The effectiveness of this pilot incentive is being evaluated.

**Type of Change:** Individual, Policy

### Partner Agencies

**Lead:** CCWNC- Pregnancy Medical Homes, BCHHS- Nurse Family Partnership

**Collaborating:** TBD

**Supporting:** Mt. Zion- Project NAF?, YWCA- MotherLove Program?

### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Partner staff time	-Shared measures identified and clarified roles and responsibilities for moving work on	-Shared measures, roles and responsibilities posted in online CHIP document	Sept/October 2013

		strategy forward		
<b>Convene partners to explore tracking and methods of follow-up for missed post-partum visits</b>	-Staff time -Lead and select collaborating/supporting partners	-creation of a detailed action plan for measuring post-partum visits	-review of deliverable	November 2013
<b>Convene partners to develop system for managing data</b>	-Staff time -Lead and select collaborating/supporting partners	-Data management and accountability system and timeline for strategy developed	-Internet-based system established	December 2013

### Strategy 4.3: Integrated interconception care

#### Objective 4.3.1:

Evaluate the IMPLICIT program's integration of interconception care into well-child visits by 2015.

**Indicator:** Existence of a completed evaluation for IMPLICIT program site

### Strategy Background

#### Source:

[www.fmdrl.org/index.cfm?event=c.getAttachment&riid=6083](http://www.fmdrl.org/index.cfm?event=c.getAttachment&riid=6083)

**Evidence Base:** This strategy is aligned with the CDC's recommendation to improve preconception health and health care by increasing interconception care. The incorporation of maternal assessments into well child visits have been found to be achievable and acceptable to women based in a pilot study (Gjerdengen et al. 2009). The four screening areas were chosen based on the literature on multiple interventions suspected of reducing prematurity. The depression pre-screening tool used in the intervention has been validated (Bennett et al. 2008). As a pilot study, the program impact of this program is being evaluated.

**Type of Change:** Individual, Policy

#### Partner Agencies

**Lead:** MAHEC Family Health- IMPLICIT Program

**Collaborating:** TBD

**Supporting:** TBD

#### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Collect continuous quality improvement data for ICC	-IMPLICIT staff time	-Complete pilot project evaluation	- Review of deliverable	Aug 2014

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## CHAPTER 5 – EARLY CHILDHOOD DEVELOPMENT

### Situational Analysis

There are over 13,000 children under the age of five that live in Buncombe County (US Census Bureau 2012). The five years between when a baby is born and when that child shows up for the first day of kindergarten can have lasting impact on that child's later learning, health, and success. The brain is the only organ not fully developed at birth. Therefore, as the First 2000 Days campaign explains, "children's earliest experiences literally determine how their brains are wired; lay the groundwork for future health; and form the foundation of the social and emotional skills needed for academic and workplace success" (First 2000 Days). Since early experiences have such a profound influence on a child's future trajectory, the first five years must be a major focus of our efforts in Buncombe County.

Research shows that high quality early education is a very effective way to improve childhood development. High quality early education has been shown to provide children with important academic and social skills and contribute to higher graduation rates, higher earnings, and better jobs later in life (Schweinhart et al. 2005). The quality of care children receive through regulated care or education programs in Buncombe County has been greatly improved over the last decade. In Buncombe County from 2011 to 2012, 75% of children in regulated early care and education programs were in programs rated as high quality by North Carolina's five-star rating system. This was even higher (88%) for children receiving child care subsidies or other public assistance to help low-income families afford quality early child care or education (North Carolina Partnership for Children 2012).

However, 69% of young children are not enrolled in formalized quality care, including a large portion of children whose families are struggling to make ends meet (First 2000 Days; North Carolina Partnership for Children 2012). The percentage of Buncombe County

### Did you know?

The best investment is in quality early childhood development from birth to five years of age. Investing in the earliest years of life will yield the greatest return. Investment in early childhood programs produces a 7-10% per year return through increased personal achievement and social productivity.

*-The Heckman Equation*

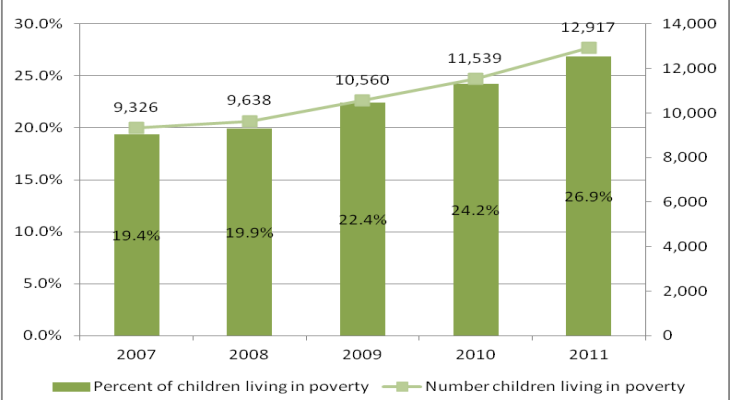
High quality early childhood programs increase graduation rates by as much as 44%.

*-First 2000 Days*

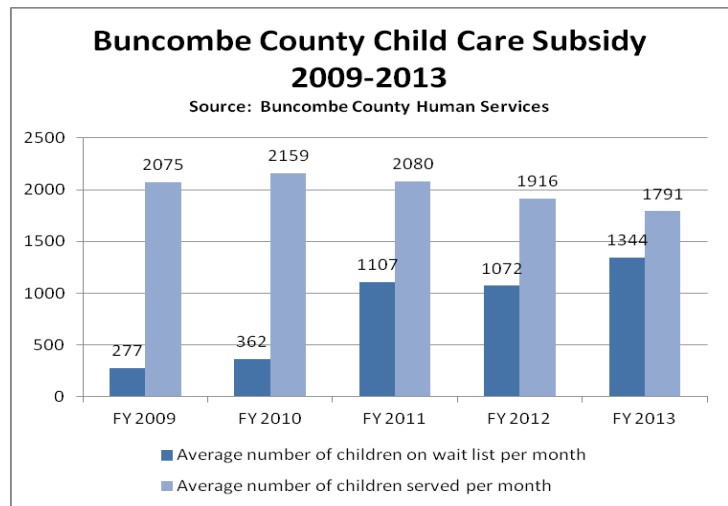
In the first few years of life, 700 new neural connections are formed every second. Early experiences affect the development of the child's brain, and can affect the foundation for learning, health and behavior.

*-Center on the Developing Child, Harvard University, 2008*

**Buncombe Children in living in Poverty 2007-2011**  
Source: US Census Bureau



children living below the federal poverty level has increased over the last several years, reaching 26.9% in 2011 (US Census Bureau 2011). Though child poverty is increasing, the number of children served each month by child care subsidies has decreased. In an average month over the past year, more than 1,300 children under the age of five were on the wait list for a child care voucher (BCHHS 2013). The average wait time for families seeking a childcare subsidy in Buncombe County has increased by over two months since 2011 (CHA 2012). This has contributed to a decrease in Buncombe County children being able to enroll in licensed early care and education programs, which dropped 30% in since 2011 (CHA 2012).



## Spotlight on Success

### Smart Start Champions for Children

One of the most successful efforts in our community to advocate for the needs of young children is the Champions for Children initiative in Buncombe County. Twenty-one local leaders from the community use the messages of the First 2000 Days campaign to emphasize the importance of early child development. Leaders from law enforcement, schools, business, non-profit organizations, government, and citizen and faith communities advocate for the importance of investment in early childhood development during the crucial 2000 days between birth and kindergarten. Champions spread the message of the value of investment in early care and learning to improve health, education, social and economic outcomes for the individual and society. Champions promote the message through public speaking to organizations and groups, writing letters to the editor of the newspaper, contacting and meeting with local legislators, and

promoting the importance of the first 2000 days in their professional and personal networks.



For a list of the local Champions for Children and for more information about the initiative

<http://www.smartstart-buncombe.org/index.php/champions>  
Or contact Program Coordinator Stacey Bailey at (828)407-2057, or via email at [Stacey@smartstart-buncombe.net](mailto:Stacey@smartstart-buncombe.net). For more information about the First 2000 Days campaign please visit [www.first2000days.org](http://www.first2000days.org).

## Success Equation

One in 4 children in Buncombe County lives in poverty. Children in poverty are more likely to experience poorer health, safety, and education outcomes, as well as greater levels of toxic stress, than children from families with more money. In response, the Success Equation works to make our community a place where ALL children can thrive.



In 2010, Children First/Communities in Schools launched a listening project to document the experience of families facing poverty in Buncombe County. In May 2011, Children First/CIS presented the issues raised by the listening session to a broader community summit attended by 120 participants representing local organizations, community leaders, low-income individuals, and interested community members. Out of this summit, an action plan was created and committees were formed to initiate the Success Equation. The 2013 Action Plan focuses on topics identified in the summit: early childhood development; child & family supports; and family economic stability.

The Success Equation inspires and sustains a local movement to reduce the incidence of poverty and its impact on children in Buncombe County through education, collaboration, and public policy advocacy. The Success Equation takes on the following roles:

- **Educator** – reporting poverty data, messaging about poverty’s impact, and inspiring broader dialogue focused on solutions
- **Advocate** – building a local advocacy voice supportive of public policy and investment in effective programs that meet children’s basic needs and place them on a path to success
- **Convener** – connecting individuals, businesses, government, schools, faith communities, and organizations to enhance promising strategies, collaborations, and creative/provocative ideas

The Success Equation worked with regional advocates and local legislators in 2012 to preserve over \$1 million in funding for the child care subsidy program in Western NC counties. The Success Equation (through Children First/CIS) has been a long-time advocate for supporting early childhood education and care. Moving forward the Success Equation will continue to partner with regional advocates to build a strong voice for affordable, quality early childhood education and care. This strategy supports childhood health, safety, and education while helping working parents meet a basic need.



## Partners

Addressing early childhood development is complex and will require the collaborative planning, action, and coordination of multiple partners in our community. The following partner agencies and organizations are engaged in efforts to improve early childhood development in our community. As new partners are identified, we will continuously work to bring them into the process.

<b>Organizations:</b>	<b>Website or Contact Information</b>
Addiction, Recovery, Prevention (ARP)	<a href="http://www.arpnc.org">www.arpnc.org</a>
Asheville Buncombe Community Christian Ministry (ABCCM) - Our Circle	<a href="http://abccm.org/">http://abccm.org/</a>
Asheville City Schools	<a href="http://www.ashevillecityschools.net/Pages/default.aspx">http://www.ashevillecityschools.net/Pages/default.aspx</a>
Asheville City Schools- Asheville City Preschool	<a href="http://www.ashevillecityschools.net/schools/pre/Pages/default.aspx">http://www.ashevillecityschools.net/schools/pre/Pages/default.aspx</a>
Asheville City Preschool- Early Head Start	<a href="http://www.ashevillecityschools.net/schools/pre/Pages/EarlyHeadStart.aspx">http://www.ashevillecityschools.net/schools/pre/Pages/EarlyHeadStart.aspx</a>
Buncombe County Schools	<a href="http://www.buncombe.k12.nc.us">www.buncombe.k12.nc.us</a>
Buncombe County Health and Human Services (BCHHS)	<a href="http://buncombecounty.org/">http://buncombecounty.org/</a>
BCHHS - Innovative Approaches	Melissa Baker <a href="mailto:Melissa.Baker@buncombecounty.org">Melissa.Baker@buncombecounty.org</a>
BCHHS - Nurse Family Partnership (NFP)	<a href="http://www.nursefamilypartnership.org/locations/North-Carolina/Buncombe-County-NFP">http://www.nursefamilypartnership.org/locations/North-Carolina/Buncombe-County-NFP</a>
BCHHS - School Health	<a href="http://buncombecounty.org/Governing/Depts/health/SchoolHealth.aspx">http://buncombecounty.org/Governing/Depts/health/SchoolHealth.aspx</a>
BCHHS - Triple P-Positive Parenting Program	Deanna LaMotte <a href="mailto:Deanna.LaMotte@buncombecounty.org">Deanna.LaMotte@buncombecounty.org</a>
BCHHS - Under Six	Dean Griffin <a href="mailto:Dean.Griffin@buncombecounty.org">Dean.Griffin@buncombecounty.org</a>
Community Care of Western North Carolina (CCWNC)	<a href="http://communitycarewnc.org/">http://communitycarewnc.org/</a>
Community Care of Western North Carolina (CCWNC) - Coordinated Care for Children (CC4C)	<a href="http://www.communitycarenc.com/emerging-initiatives/care-coordination-children-cc4c/">http://www.communitycarenc.com/emerging-initiatives/care-coordination-children-cc4c/</a>

Child Abuse Prevention Services	<a href="http://www.childabusepreventionservices.org/Pages/default.aspx">http://www.childabusepreventionservices.org/Pages/default.aspx</a>
Child Care Health Consultation	<a href="http://www.smartstart-buncombe.org/index.php/tatraininglink/healthconsultlink">http://www.smartstart-buncombe.org/index.php/tatraininglink/healthconsultlink</a>
Children First-Communities in Schools	<a href="http://childrenfirstbc.org/">http://childrenfirstbc.org/</a>
Children First-Communities in Schools- Success Equation	<a href="http://childrenfirstbc.org/index.php/thesucsessequation">http://childrenfirstbc.org/index.php/thesucsessequation</a>
Children First-Communities in Schools-Family Resource Center	<a href="http://childrenfirstbc.org/index.php/programs/family-resource-center-at-emma/">http://childrenfirstbc.org/index.php/programs/family-resource-center-at-emma/</a>
Children's Developmental Services Agency of WNC (CDSA)	<a href="http://www.bearly.nc.gov/">http://www.bearly.nc.gov/</a>
Community Action Opportunities	<a href="http://www.communityactionopportunities.org">www.communityactionopportunities.org</a>
Community Action Opportunities- Head Start	<a href="http://www.communityactionopportunities.org/headstart.html">http://www.communityactionopportunities.org/headstart.html</a>
Community Action Opportunities- Life Works	<a href="http://www.communityactionopportunities.org/lifeworks.html">http://www.communityactionopportunities.org/lifeworks.html</a>
FIRST	<a href="http://www.firstwnc.org/">http://www.firstwnc.org/</a>
FIRST- Circle of Parents	
FIRST- Community Parent Resource Center	<a href="http://www.firstwnc.org/cprc.html">http://www.firstwnc.org/cprc.html</a>
FIRST- The Incredible Years	<a href="http://www.firstwnc.org/iypc.html">http://www.firstwnc.org/iypc.html</a>
FIRST- The P.L.A.Y. Project	<a href="http://www.firstwnc.org/projectPlay.html">http://www.firstwnc.org/projectPlay.html</a>
FIRST- The SUNSHINE Project	<a href="http://www.firstwnc.org/sunshine-project.html">http://www.firstwnc.org/sunshine-project.html</a>
Mission Health- Family Support Network	<a href="http://www.missionchildrens.org/education-outreach/family-support-network">http://www.missionchildrens.org/education-outreach/family-support-network</a>
Mountain Area Child & Family Center	<a href="http://www.macfc.org/">http://www.macfc.org/</a>
Mountain Area Child and Family Center- Early Head Start	<a href="http://www.macfc.org/prospective-families/early-head-start-2/">http://www.macfc.org/prospective-families/early-head-start-2/</a>
Mount Zion Community Development, Inc.- Project NAF	<a href="http://www.mtzionasheville.org/mt_zion_cdc">http://www.mtzionasheville.org/mt_zion_cdc</a>
NC Cooperative Extension Buncombe County Center	<a href="http://buncombe.ces.ncsu.edu/">http://buncombe.ces.ncsu.edu/</a>
Pisgah Legal Services	<a href="http://www.pisgahlegal.org/">http://www.pisgahlegal.org/</a>
Smart Start	<a href="http://www.smartstart-buncombe.org/">http://www.smartstart-buncombe.org/</a>

Smart Start- Champions for Children/First 2000 Days Campaign	<a href="http://first2000days.org/">http://first2000days.org/</a>
Smart Start- Child Care Resource & Referral	<a href="http://www.smartstart-buncombe.org/index.php/earlychildhood/tatraininglink">http://www.smartstart-buncombe.org/index.php/earlychildhood/tatraininglink</a>
Smart Start- Play and Learn Groups	<a href="http://www.smartstart-buncombe.org/index.php/fam-programs/famplaynlearn">http://www.smartstart-buncombe.org/index.php/fam-programs/famplaynlearn</a>
Women's Wellbeing and Development Foundation	<a href="http://www.wwd-f.org">www.wwd-f.org</a>
YWCA	<a href="http://www.ywcaofasheville.org">http://www.ywcaofasheville.org</a>
YWCA- Mother Love	<a href="http://www.ywcaofasheville.org/site/c.7oIEJQPxGeISF/b.8131583/k.2A86/MotherLove.htm">http://www.ywcaofasheville.org/site/c.7oIEJQPxGeISF/b.8131583/k.2A86/MotherLove.htm</a>
YWCA- New Choices Program	<a href="http://www.ywcaofasheville.org/site/c.7oIEJQPxGeISF/b.8131585/k.8ECF/New_Choices.htm">http://www.ywcaofasheville.org/site/c.7oIEJQPxGeISF/b.8131585/k.8ECF/New_Choices.htm</a>

## Early Childhood Development Plan

### Vision of Impact

From birth to age five, all children in our community will have safe, nurturing and stimulating relationships and environments to support and guide them to achieve their full potential.



State and National Objectives	Baseline/Indicator Source
<b>Healthy NC 2020 Objective:</b> Decrease the percentage of individuals living in poverty. [2020 Target: 12.5%]	CPS, US Census Bureau
<b>Healthy NC 2020 Objective:</b> Increase the four-year high school graduation rate. [2020 Target: 94.6%]	NC DPI, National Center for Education Statistics
<b>Healthy People 2020 Objective:</b> Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social-emotional development, approaches to learning, language, and cognitive development	National Survey of Children's Health (NSCH), CDC and HRSA/MCH
<b>Healthy People 2020 Objective:</b> Increase the proportion of parents who use positive communication with their child. [2020 Target 76.8%]	National Survey of Children's Health (NSCH), CDC and HRSA/MCH
<b>Healthy People 2020 Objective:</b> Increase the proportion of parents who read to their young child. [2020 Target: 52.6 percent]	National Survey of Children's Health (NSCH), CDC and HRSA/MCH
<b>Healthy People 2020 Objective:</b> Increase the proportion of parents who receive information from their doctors or other health care professionals when they have a concern about their children's learning, development, or behavior. [2020 Target: 52.8 percent]	National Survey of Children's Health (NSCH), CDC and HRSA/MCH
Community Level Objectives	
Percent of low-income children enrolled in early care and education programs (e.g., subsidized child care, Head Start, More at Four, or Title 1 public school pre-kindergarten) [Target: 65 percent]	The North Carolina Partnership for Children, Inc. Performance-Based Incentive System (PBIS)

## Goal 1: Increase availability and sustained access to high quality early care and learning

### Strategy 1.1: Training and technical assistance to support early educators and child-care providers in maintaining and increasing program quality

#### Objective 1.1.1:

Provide 47 technical assistance and training sessions each year

**Indicator:** Number of technical assistance and training sessions provided each year

#### Objective 1.1.2:

Create a common evaluation measure to see outcomes of Technical Assistance by June 2014.

**Indicator:** Existence of a common evaluation measure to see outcomes of Technical Assistance

### Strategy Background

#### Source:

Commonwealth of Pennsylvania: Office of Child Development and Early Learning. Early Childhood Education Teacher Quality: Recognizing High Quality Core Content in Pennsylvania. <http://www.pakeys.org/uploadedContent/Docs/PD/ECE%20Teacher%20Quality.pdf>

The Early Childhood Technical Assistance Center: Presentation on Participatory Adult Learning Strategies (PALS) made at the Ninth National Early Childhood Inclusion Institute [http://ectacenter.org/~ppts/meetings/inclusionMtg2009/Inclusion\\_PALS\\_PresentationF.ppt](http://ectacenter.org/~ppts/meetings/inclusionMtg2009/Inclusion_PALS_PresentationF.ppt)

**Evidence Base:** Evidence shows that the education and professional development opportunities for early educators can affect the quality of early care programs and learning experiences for children. Practitioner/teacher preparation, both pre-service and in-service has been found to significantly affect program quality (*Commonwealth of PA 2011*). The Perry Preschool longitudinal study documented that highly trained and qualified practitioners providing high quality early learning and developmental experiences for children resulted in long term economic and social benefits as well as less crime involvement for children as they grew into adulthood (Schweinhart et al. 2005).

Participatory Adult Learning Strategies (PALS) is an evidence-based model of providing technical assistance that is being used by Smart Start Child Care Resource and Referral to improve program quality. It uses techniques that have been found effective in promoting practitioner adoption of different kinds of evidence-based early childhood practices. (Dunst and Trivette, 2009).

**Type of Change:** Individual, Community

## Partner Agencies

**Lead:** Smart Start - Child Care Resource & Referral

**Collaborating/Supporting:** Child Care Health Consultation, FIRST- The SUNSHINE Project, Mission Health- Family Support Network, Asheville City Preschool – Early Head Start, Buncombe County Schools, Mountain Area Child and Family Center

## Action Plan

<b>Activity</b> <i>(what is being done?)</i>	<b>Resources Needed</b> <i>(who? how much?)</i>	<b>Anticipated Result</b> <i>(what will happen?)</i>	<b>Result Verification</b> <i>(how will you know?)</i>	<b>Target Date</b> <i>(by when?)</i>
<b>Convene partners to discuss evaluation</b>	-Smart-Start staff planning time and meeting space -Staff time for all partners	Group will meet to discuss how they evaluate TA and measure outcomes. Group will make next steps for creating common evaluation measure.	Meeting will be held. Group will set next steps.	December 2013

### **Strategy 1.2: Advocate for increased investment and ensure access to subsidized child-care through vouchers, NC Pre-K, Early Head Start, and Head Start**

**Objective 1.2.1:** TBD

**Indicator:** TBD

## Strategy Background

### Source:

Professor James Heckman's Website <http://www.heckmanequation.org/>

**Evidence Base:** Two longitudinal studies have shown the long-range impact early childhood education can have on the lives of children. The HighScope Perry Preschool Study examined the lives of 123 children born in poverty and at high risk of failing in school. The findings of this study showed that participants who received a high-quality preschool program had higher earnings, were more likely to hold a job, had committed fewer crimes, and were more likely to have graduated from high school than adults who did not have preschool (Schweinhart et al. 2005). Children from low-income families in the intervention group in the Abecedarian project received full-time, high quality educational intervention in a childcare setting from infancy through age five. The study showed that children who participated in early education scored higher on cognitive tests through age 21; had higher academic achievement in reading and math through young adulthood; completed more years of education and were more likely to attend a four-year college (Campbell et al. 2002).

The Harvard Center for the Developing Child found that work-based income supplements for parents can increase the achievement of some young children from poverty situations. Positive experiences for children before school will lead to better outcomes than remediation programs

as they get older. Although it requires a significant investment, it will be more cost-effective and show a greater return (Center on the Developing Child 2007). The research of James J. Heckman, Nobel Laureate in Economics and expert in the economics of human development, estimates that every dollar invested in early education produces a 7- 10% return on investment through increased personal achievement and social productivity (The Heckman Equation).

**Type of Change:** Community, Policy

**Partner Agencies**

**Lead:** Children First-Communities in Schools, Smart Start- Champions for Children-First 2000 Days Campaign and NC Pre-K, Pisgah Legal Services, Southwestern Child Development Commission, Mountain Area Child and Family Center

**Collaborating/Supporting:** Family Support Network – Parent Advocacy group, Asheville City Preschool – Early Head Start, ABCCM, YWCA, Community Action Opportunities-Head Start

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners	-Meeting date, space and contacts -Materials preparation	-Discuss plan and review and revise objectives as needed and set measurements	-Written objectives and measurements determined and agreed on by partners	December 2013

**Strategy 1.3:** Child care co-ops for low-income families

**Objective 1.3.1:** TBD

**Indicator:** TBD

**Strategy Background**

**Source:** N/A

**Evidence Base:** Developing co-operatives is one way local groups or communities join together to address issues or develop solutions to common needs. According to *Child Care Co-operatives: A Place in Canada's Universal Child Care Plan*, the model recognizes the importance of people and communities in defining their own needs and working together to meet those needs. The co-operative typically depends on parent assistance in the classroom. The model program can foster collaborative and co-operative practices that support healthy childhood development and early learning, particularly among participants who may not have access to other early child education programs. The model also provides opportunities to meet other parents and their children, and allows parents to contribute their skills and abilities to benefit

their child and provide learning opportunity for parents, either informally or through more structured training that may be available to parent members. Depending on how the child care co-operative is organized, it can also provide access to experts on child development and early care and education (The Canadian Co-operative Association 2006). Child care co-operatives seem like a practical solution for affordable child care for low-income parents. There is a need for research and evaluation to document the benefits of child care co-operatives as an effective approach for young families facing the challenges of the expense of early child care and learning.

**Type of Change:** Individual, Community

**Partner Agencies**

**Lead:** Children First-Communities in Schools

**Collaborating:** ABCCM, Mountain Area Child and Family Center, Community Action Opportunities-Head Start, Women’s Wellbeing and Development Foundation

**Supporting:** Smart Start

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Convene partners to determine feasibility of Child Care Co-ops and how to proceed</b>	-Children First Staff time	Group will meet and explore the feasibility of Child-Care Co-ops and develop ideas/plans	Group will have met and determined next steps	October 2013

**Goal 2: Support and strengthen families**

**Strategy 2.1: Parenting education that supports effective parenting practices, healthy interaction with children, appropriate developmental expectations and provides child development referral resources**

**Objective 2.1.1:**  
 Serve 25% of parents of children aged zero to six within the community with parenting education by 2015

**Indicator:** Percentage of parents of children aged zero to six within the community served by parenting education programs

**Strategy Background**

**Source:**

US Administration for Children and Families, Child Welfare Information Gateway Parenting Education Brief [https://www.childwelfare.gov/pubs/issue\\_briefs/parented/index.cfm](https://www.childwelfare.gov/pubs/issue_briefs/parented/index.cfm)



**Evidence Base:** As parenting can have a large impact on a child’s development, parent education can be instrumental in supporting children’s developmental outcomes and parents’ well-being. Effective parent education programs have been associated with decreased rates of child abuse and neglect, better physical, cognitive and emotional development, increased parental knowledge of child development and parenting skills, and improved parent-child communication (Bunting 2004; Small and Mathers 2006). The parenting education curricula offered in Buncombe vary and many are based on, or informed by, research. Triple P- Positive Parenting Program’s body of evidence is extensive and can be found here: <http://www.pfsc.uq.edu.au/research/evidence/>. The Incredible Years and Nurturing Parenting Programs can be found along with other evidence-based programs on Child Welfare’s registry [https://www.childwelfare.gov/pubs/issue\\_briefs/parented/programs.cfm](https://www.childwelfare.gov/pubs/issue_briefs/parented/programs.cfm).

**Type of Change:** Individual, Family, Community

**Partner Agencies**

**Lead:** Triple P-Positive Parenting Program

**Collaborating/ Supporting:** BC HHS- Nurse Family Partnership, Mt. Zion Community Development, Inc- Project NAF, FIRST– The P.L.A.Y. Project, The SUNSHINE Project and The Incredible Years, Mountain Area Child and Family Center-Early Head Start, Asheville City Preschool-Early Head Start, Smart Start- Play and Learn Groups, ARP -Nurturing Skills and Strengthening Families, Mission Health- Family Support Network, Child Abuse Prevention Services – Parent/Family Skills Training, Love and Logic, Community Action Opportunities- Nurturing Parents Program and Head Start, Cooperative Extension – Parenting Matters, Family & Children in Transition, Women’s Wellbeing and Development Foundation, YWCA – Mother Love, Buncombe County Schools, Child Care Health Consultation, CCWNC

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Strategic Planning meeting</b>	-Full day of staff time for all partners -Triple-P staff planning time	-group will identify priority trainings for the fall	- Training for the fall will be created	July 2013
<b>Compile survey data to create a database of parenting education program</b>	-Triple-P staff time	Creation of a database/manual of parenting education programs offered in the county that will allow organizations and parents to know what is available	-Manual will be created and available online	September 2013
<b>Level 3 Primary Care training will be held</b>	-Triple P grant funding to sponsor training -Triple-P staff time -Staff time for those being trained	- Train interested workers from community organizations in Level 3 primary care curriculum	- Trainings will be held and those trained will pass certification test	September 2013
<b>Level 4 training will be held</b>	-Triple P grant funding to sponsor training -Triple-P staff time -Staff time for those	- Train interested workers from community organizations in Level 4 curriculum	- Trainings will be held and those trained will pass certification test	October 2013

	being trained			
<b>Second Level 3 Primary care training will be held</b>	-Triple P grant funding to sponsor training -Triple-P staff time -Staff time for those being trained	- Train interested workers from community organizations in Level 3 primary care curriculum	- Trainings will be held and those trained will pass certification test	November 2013
<b>Training will be held on curriculum identified by partners as a priority</b>	-Triple P grant funding to sponsor training -Triple-P staff time -Staff time for those being trained	Train interested workers from community organizations in priority curriculum	- Trainings will be held and those trained will pass certification test	February 2014

**Strategy 2.2: Parent support groups in the community for families to help them build on their strengths and enhance social support systems**

**Objective 2.2.1:**

Increase the number of parents served by parenting support groups

**Indicator:** The number of parents served by parenting support groups

**Strategy Background**

**Source:** N/A

**Evidence Base:** According to guidelines established by the Prevent Child Abuse America and National Family Support Roundtable, parent support groups utilize the mutual self-help support model. A trained group facilitator and parent leader facilitate the support groups with open groups meetings most often offered at no cost to any participant. They are driven by parent need and feasibility and provide community resource information that supports healthy family development (Circles of Parents).

The value of parent support groups for children with disabilities and chronic diseases has been explored through research. Support groups provide opportunities for parents to express their feelings, reduce feelings of isolation, and acquire information (Kerr and McIntosh 2000; Law et al. 2002). Evaluations of support groups for a more general population of parents, such as Circle of Parents, have found participants feel supported and connected to other parents, learn how to parent children as they grow, learn about non-violent ways to discipline children, and gain knowledge about meeting family needs from resources and materials that are provided during the support group meetings (Treichel et al. 2002; Gay 2005). Additional research is necessary to evaluate how those parental outcomes impact child development.

**Type of Change:** Individual, Community

**Partner Agencies**

**Lead:** TBD

**Collaborating/Supporting:** ABCCM – Our Circles, Innovative Approaches, Asheville City  
 Preschool- Father’s Group, Smart Start- Play and Learn Groups, Mountain Area Child  
 and Family Center – Mom’s Program, Children First - Family Resource Centers, Success  
 Equation, YWCA – Mother Love and New Choices Program, Community Action  
 Opportunities – Life Works, Mount Zion – Project NAF, Mission Health- Family Support  
 Network, FIRST – Circle of Parents and Community Parent Resource Center, Women’s  
 Wellbeing and Development Foundation

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Create and distribute a survey to all partners about the parent support groups offered</b>	BCHHS staff time	Data collected about the parent support groups in the county	Data will have been collected	December 2013
<b>Compile survey results to create database of parenting support groups</b>	BCHHS staff time	Creation of a database/manual of parenting support groups offered in the county that will allow organizations and parents to know what is available	-Manual will be created and distributed	June 2014
<b>Strategic planning meeting</b>	Staff time from all partners	Group will use the manual to discuss any gaps/ways to research/target specific parents	-Meeting will have been held and next steps determined	August 2014

**Strategy 2.3: Community education and case management/care coordination for families experiencing or at risk for child maltreatment**

**Objective 2.3.1:**

Increase number of Under Six promotional materials distributed and/or displayed

**Indicator:** Number of Under Six promotional materials distributed and/or displayed

**Objective 2.3.2:**

Increase the percentage of families that engage with Under Six services

**Indicator:** Percentage of families that engage with Under Six services

**Objective 2.3.3:**

Decrease the percentage of families accepting Under Six case management who have screened-in CPS reports in the year following closure of the case

**Indicator:** Percentage of families accepting Under Six case management who have screened-in CPS reports in the year following closure of the case

## Strategy Background

### Source:

Child Welfare Information Gateway: Case Management in Child Protection  
<https://www.childwelfare.gov/responding/casemgmt.cfm>

**Evidence Base:** The Child Welfare Information Gateway, run by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, identifies case management as an important component of responding to child abuse and neglect, providing case plans created together by child protection staff and families to identify goals for the family focusing on maximizing children's safety and minimizing their risk of harm (Child Welfare Information Gateway).

Families in great need of support, such as parents experiencing high levels of conflict or violence, have benefited from focused services targeted to the particular sources of their stress, to prevent as well as stop current child maltreatment. Parents at high risk for child abuse have been found to benefit from individualized coaching to increase their awareness of specific child behaviors and to use praise and nonviolent discipline strategies (Center on the Developing Child 2007). Nurse-Family Partnership is an evidence-based prenatal and infancy nurse home visitation and case management program. Evaluations through randomized, controlled trials have found significant reductions in child abuse and neglect among families in the program in comparison to the control group (Olds et al. 1997). The program is recommended by several evidence-based policy groups including Blueprints for Violence Prevention and the RAND Corporation's Promising Practices Network.

**Type of Change:** Individual, Community

### Partner Agencies

**Lead:** Buncombe County HHS – Under Six

**Collaborating/ Supporting:** CCWNC- Coordinated Care for Children, Child Abuse Prevention Services, Pisgah Legal Services, Child Care Health Consultation, BCHHS- Nurse Family Partnership, Triple P

### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene partners to continue work on shared measures and roles/responsibilities	-Staff time -Working group participants	-Shared measures identified and clarified roles and responsibilities for moving strategy	-Shared measures, roles and responsibilities posted in online CHIP document	October 2013

		forward		
<b>Convene partners to develop system for managing data</b>	-Staff time -Lead and select collaborating/supporting partners	-Data management and accountability system and timeline for strategy developed	-Internet-based system established	November 2013
<b>Develop detailed action plan for each strategy</b>	-Staff time -Working group participants	-Strategy level action plans developed	-Action plans posted in online CHIP document	November 2013

**Goal 3: Increase early identification and intervention/treatment of special healthcare and developmental needs**

**Strategy 3.1: High quality trainings for early educators to screen and for health care providers to identify young children with special health care and developmental needs**

**Objective 3.1.1:**

Increase number of educators trained each year

**Indicator:** Number of educators trained in the year

**Objective 3.1.2:**

Increase number of providers trained each year

**Indicator:** Number of providers trained each year

**Objective 3.1.3:**

Increase the number of trainings held each year

**Indicator:** Number of trainings held in the year

**Strategy Background**

**Source:** N/A

**Evidence Base:** Young children with special health care and developmental needs should be identified as early as possible so that interventions can be used to improve the future outlook for the child. Current research on the early development of the brain, as summarized by the Center on the Developing Child at Harvard University, shows the neural circuits, which create the foundation for learning, behavior and health, are most flexible or subject to change during the first three years of life (Center on the Developing Child 2008). There is a need to identify as early as possible infants and toddlers in need of services to ensure that intervention is initiated in a timely manner to maximize benefits for the child. For example, research has found that children whose hearing loss is detected in infancy and who receive treatment services have better language outcomes at age 8 than children whose hearing loss is detected later. More children are in need of services than are presently identified. Research indicates that as many as 13% of birth-to-three year olds have delays that would make them eligible for services, according to

definitions commonly used by the states (The National Early Childhood Technical Assistance Center 2011).

The Health Resources and Services Administration Maternal and Child Health Bureau identified core outcomes for the community-based system of services mandated for all children with special health care needs under Title V, Healthy People 2010, and the President’s New Freedom Initiative. One of the indicators is: Children are screened early and continuously for special health care needs (USDHSS 2013).

According to research, training and support for pediatricians can improve screening rates and practices. The Assuring Better Child Health and Development (ABCD) project, is designed to build developmental screening into pediatric practices and to link pediatricians to referral networks. This project has been shown to increase developmental screening in pediatric offices and has led to the adoption of validated screening tools in the 27 participating states (Zero to Three, 2012).

**Type of Change:** Individual, Community

**Partner Agencies**

**Lead:** TBD

**Collaborating/Supporting:** Children’s Developmental Services Agency, Asheville City Preschool - Early Head Start, Mountain Area Child and Family Center– Early Head Start, Community Action Opportunities-Head Start, Asheville City Schools, Buncombe County Schools, Local Interagency Coordinating Council, Child Care Health Consultation, Innovative Approaches, FIRST – The SUNSHINE Project, Mission Health-Family Support Network

**Action Plan**

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Survey all partners to establish a baseline number of trainings held, educators trained, and providers trained	Staff time	Creation of baseline levels for each indicator	Review of deliverables	October 2013

**Strategy 3.2: Case management/care coordination for children with special health care and developmental needs (CSHCN)**

**Objective 3.2.1:**

Increase number of CSHCN that have medical homes

**Indicator:** Number of CSHCN that have medical homes

**Objective 3.2.2:**

Increase number of practices with standardized treatment for children with asthma or obesity

**Indicator:** Number of practices with standardized treatment for children with asthma or obesity

## Strategy Background

**Source:** N/A

**Evidence Base:** The Maternal and Child Health Bureau of the Health Resources and Services Administration states that “care coordination and case management are terms used interchangeably to describe an array of activities designed to: link families to clinical, social, and other services that affect overall health and well-being; strengthen communication between families and providers; avoid duplication of effort; and improve health outcomes” (USDHSS 2011). This strategy is in alignment with national health goals and with the goals of service providers in Buncombe County. The Maternal and Child Health Bureau has further identified core outcomes for the community-based system of services mandated for all children with special health care needs under Title V, Healthy People 2010, and the President’s New Freedom Initiative. One of the indicators for this outcome is: “Children and youth with special health care needs receive coordinated ongoing comprehensive care within a medical home” (USDHSS 2013). The importance of involving families in care coordination has been recognized as an important aspect of the practice (Antonelli 2009). According to researchers who have reviewed the literature on care coordination, it is important to expand the evaluation of care coordination interventions for children with special health care needs and document the effectiveness of this recommended practice (Wise et al. 2007).

**Type of Change:** Individual, Community, Policy

### Partner Agencies

**Lead:** TBD

**Collaborating:** CCWNC, Innovative Approaches, Children’s Developmental Services Agency of WNC, FIRST, Local Interagency Coordinating Council

**Supporting:** Local Interagency Coordinating Council, Asheville City Schools, Buncombe County Schools, Asheville City Preschool - Early Head Start, Mountain Area Child and Family Center– Early Head Start, Community Action Opportunities-Head Start, BCHHS-Nurse Family Partnership, Child Care Health Consultation, Under Six, Mission Health-Family Support Network

### Action Plan

Activity (what?)	Resources Needed (who? how much?)	Anticipated Result (what will happen?)	Result Verification (how will you know?)	Target Date (by when?)
Convene meeting of partners engaged in care coordination	Meeting space, date and materials	Identify and agree on objectives and measurement	Written objectives and shared measures to capture data	December 2013

## Goal 4: Improve policies, systems and environments for children through advocacy

### Strategy 4.1: Education and advocacy initiatives to reduce the incidence of poverty and its impact on children and early childhood development

#### Objective 4.1.1:

Provide one Child Watch Tour per year

**Indicator:** Provision of a Child Watch Tour each year

#### Objective 4.1.2:

Increase participation in the Child Watch Tour

**Indicator:** Number of participants in the Child Watch Tours

#### Objective 4.1.3:

Increase the number of letter campaigns or appeals to legislators

**Indicator:** Number of letter campaigns or appeals to legislators

### Strategy Background

#### Source:

The Success Equation <http://childrenfirstbc.org/index.php/thesucsessequation/>

**Evidence Base:** Extensive research shows that relative to their non-poor peers, children who grow up under conditions of poverty are more likely to experience learning disabilities and developmental delays, to be less successful in school, less productive as adults in the labor market, and more likely to commit crimes. They suffer high incidences of adverse health and emotional and behavioral problems (Duncan et al. 1994; National Institute Of Child Health And Human Development Network 2005; Whitmore-Schanzenbach et al. 2007). Despite the strong and consistent correlations between poverty and diminished child well-being, relatively few studies have focused on determining the adverse impacts on children of low-income parents as a single factor in comparison to the effects of conditions often associated with poverty, such as decreased parent education and high levels of family stress.

For families experiencing poverty, work-based income supplements for working parents have been demonstrated to increase the achievement of some young children. Studies suggest that these benefits are more likely to occur in the preschool years than when children reach adolescence (Center on the Developing Child at Harvard University, 2007). Two sets of studies have shown that employment-based increases in family income can produce achievement gains in young children. Using data from random-assignment program evaluations of welfare-to-work



initiatives, one study found that earnings supplements that increased family income by \$1,000 to \$1,500 per year were consistently associated with small, positive impacts on the achievement of preschool-aged children. This influence did not hold for adolescents (Duncan and Clark-Kauffman 2006). Another study estimating the impacts of the Earned Income Tax Credit also found small benefits for younger children’s achievement (Dahl and Lochner 2005).

**Type of Change:** Community, Policy

**Partner Agencies**

**Lead:** Children First-Communities in Schools – Success Equation

**Collaborating/Supporting:** Pisgah Legal Services, ABCCM, YWCA, Mountain Area Child and Family Center, Smart Start, Women’s Wellbeing and Development Foundation

**Action Plan**

<b>Activity</b> (what?)	<b>Resources Needed</b> (who? how much?)	<b>Anticipated Result</b> (what will happen?)	<b>Result Verification</b> (how will you know?)	<b>Target Date</b> (by when?)
<b>Partners convene to create advocacy plan</b>	-Staff time -Meeting space	- Partners will meet and create advocacy plan	-Review of deliverable	December 2013
<b>Organize and provide 2014 Child Watch tour</b>	-Staff time -Advertising funds	-community members will attend the Child Watch tour	Child Watch Tour Held	June 2014

**Other strategies in the Early Childhood Development plan include advocacy:**

Goal 1, Strategy 1.2: Advocate for increased investment and ensure access to subsidized child-care through vouchers, NC Pre-K, Early Head Start, and Head Start (includes advocacy for healthy experiences in birth to 5 years)

Goal 2, Strategy 2.3: Community education and case management/care coordination for families experiencing or at risk for child maltreatment (includes advocacy for safe and nurturing environments for young children)

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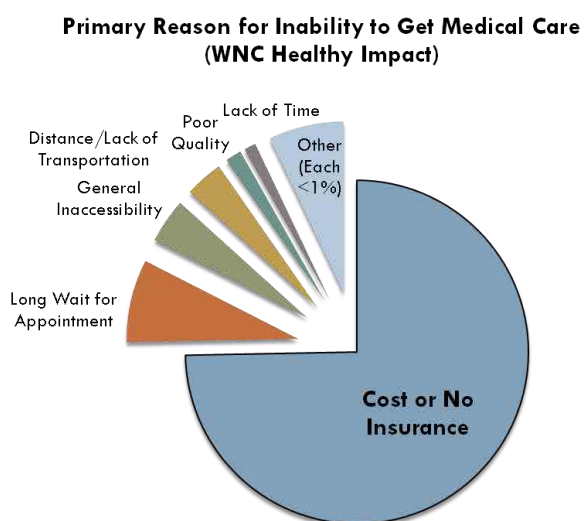
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## CHAPTER 6 – ACCESS TO CARE

### Situational Analysis

The WNC Healthy Impact survey showed mixed results for access to care in Buncombe County. Buncombe County residents were more likely than WNC residents on average to agree that “considering cost, quality, number of options and availability, there is good health care in my county” when asked on the WNC Healthy Impact survey (72% in Buncombe County and 67% across WNC). However, Buncombe County residents on average were also slightly more likely to report that there was a time in the past year that they were unable to get needed medical care (12% in Buncombe County and 11% across WNC). Three quarters of respondents who were unable to get needed medical care cited cost or lack of insurance as the primary reason. Cost or lack of insurance was also the most common reason cited for those unable to get mental health services. Additionally, 15% of Buncombe County residents reported that they were unable to get a desired prescription at some point in the past year.



Access to care is a very complex issue with numerous approaches. Given the current county resources and interests and regional efforts, our work in this area is to focus on increasing connectivity between clinical care and community programs in order to increase the effectiveness and accessibility of the overall system of care in Buncombe County.

## Partners

Addressing access to primary and mental health care is complex and will require the collaborative planning, action, and coordination of multiple partners in our community. The following partner agencies and organizations are engaged in efforts to improve access to care in our community. As new partners are identified, we will continuously work to bring them into the process.

<b>Organizations:</b>	<b>Website or Contact Information</b>
Buncombe County Health and Human Services (BCHHS)	<a href="http://buncombecounty.org/">http://buncombecounty.org/</a>
Community Care of Western North Carolina (CCWNC)	<a href="http://www.communitycarewnc.org/">http://www.communitycarewnc.org/</a>
Community Transformation Grant (CTG)	Jill Simmerman 828-250-6510 <a href="mailto:ctp.region2@gmail.com">ctp.region2@gmail.com</a>
Land-of-Sky Regional Council	<a href="http://www.landofsky.org">www.landofsky.org</a>
Mission Health	<a href="http://www.mission-health.org/">http://www.mission-health.org/</a>
MAHEC	<a href="http://www.mahec.net/">http://www.mahec.net/</a>
WNC Healthy Impact	<a href="http://wnchealthyimpact.com/">http://wnchealthyimpact.com/</a>
YMCA	<a href="http://www.ymcawnc.org/">http://www.ymcawnc.org/</a>
YWCA	<a href="http://www.ywcaofasheville.org">http://www.ywcaofasheville.org</a>

## Access to Care Plan

State and National Objectives	Baseline/Indicator Source
<b>Related Healthy NC 2020 Objective</b> Reduce the cardiovascular disease mortality rate (per 100,000 population)	SCHS, CDC WONDER
<b>Related Healthy People 2020 Objective:</b> Decrease the percentage of adults with diabetes	BRFSS

### Goal 1: Improve the connection between community programs and clinical providers

#### Strategy 1.1: Create workgroup of clinical providers and community program directors to map out and make systems improvements between their fields

##### Objective 1.1.1:

By October, 2013, at least five community programs and five clinical practitioners will be actively engaged with each other in the workgroup

**Indicator:** Number of participants from both fields at meetings

##### Objective 1.1.2:

By December, 2014 there will a measurable decrease in inappropriate ED utilization from baseline

**Indicator:** AHRQ prevention quality indicators within Mission Hospital ED

### Strategy Background

**Source:** <http://patienteducation.stanford.edu/programs/cdsmp.html>

**Evidence Base:** Part of the project will be to identify current programs available in the county, including the evidence-based Chronic Disease Self-Management Program from Stanford University.

**Type of Change:** Community

#### Partner Agencies

**Lead:** Community Transformation Grant, Community Care of Western North Carolina, MAHEC, BCHHS, WNC Healthy Impact

**Collaborating:** Innovative Approaches

**Supporting:** Land-of-Sky Regional Council, YMCA, YWCA

## Action Plan

<b>Activity</b> <i>(what is being done?)</i>	<b>Resources Needed</b> <i>(who? how much?)</i>	<b>Anticipated Result</b> <i>(what will happen?)</i>	<b>Result Verification</b> <i>(how will you know?)</i>	<b>Target Date</b> <i>(by when?)</i>
<b>Convene workgroup to determine full plan</b>	MAHEC and HHS staff time	Full plan created with timeline to outline process for improving connections between clinical and community care	Full plan complete and disseminated	December 2013
<b>Complete inventory of community supports for chronic disease self management (particularly hypertension and high cholesterol)</b>	CTG staff time and resources	The group will have a comprehensive list of the current community programs with which we need to connect clinical providers	Full inventory complete and accessible	July 2013
<b>Assessment of the community navigators in Buncombe County</b>	CTG and HHS staff time	Full list of current navigators	List exists, with all contact and survey results	September 2013

## **CHAPTER 7 – NEXT STEPS**

We will continue to work with a wide range of community partners to modify this CHIP plan in the months and years ahead in Buncombe County. This shared plan will be used by partner organizations to complete agency-specific reporting of roles and responsibilities (e.g., our health department and local hospitals), as well as inform agency strategic plans across the county where appropriate.

This document will be widely disseminated electronically to partner organizations and used as a community roadmap to monitor and evaluate our collective efforts. Dissemination of this document will also include making it publicly available on the Buncombe County website ([www.BuncombeCounty.org/HealthReports](http://www.BuncombeCounty.org/HealthReports)), the WNC Healthy Impact website ([www.WNCHealthyImpact.com](http://www.WNCHealthyImpact.com)), and through local libraries.

Moving forward, the CHIP plan will be updated to provide the framework for the annual State of the County's Health Report, which will be submitted and made publicly available in December 2013.