

COMMUNITY HEALTH ACTION PLAN

IDENTIFYING INFORMATION

County: Durham	Partnership: Partnership for A Healthy Durham	Period Covered: 2005-2010
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LOCAL PRIORITY ISSUE	LOCAL COMMUNITY OBJECTIVE	POPULATION(S)
<p>Local priority issue: Reduce Infant Mortality</p> <p>Was this issue described in your county's most recent Community Health Assessment? (please answer "yes" or "no") Yes</p> <p>List other sources of information about this priority issue: State Center for Health Statistics Local vital records information (birth & death certificates) DCHD patient records Issue reports (e.g., US DHHS Maternal, Infant, and Child Health Progress Review, NC Healthy Start Foundation)</p>	<p>By: 2010</p> <p>Objective:</p> <ol style="list-style-type: none"> 1) Reduce infant deaths in African American families within the first year of life by 25% 2) Reduce the incidence of low birth weight among African Americans by 25% <p>Original Baseline:</p> <ol style="list-style-type: none"> 1) 5-year infant mortality rate of 7.4 overall, 2003 minority rate of 7.4. 2) CY 2003 LBW (<2500 grams) overall %: 9.3, minority %: 13.5. 3) CY 2003, overall % of pregnant smokers: 3.7%, minority percent: 6.4. <p>Date and source of original baseline data: 2004 State Center for Health Statistic report (BABY book, 2003; Infant Mortality statistics</p> <p>Updated information (Continuing Objective only): N/A</p> <p>Date and source of updated information:</p>	<p>Local population(s) experiencing disparities in relation to this local objective: African American families</p> <p>Describe the local population(s) that will benefit: African American families</p> <p>Total number in population: 236,781 (Population of county)</p> <p>Number you plan to reach: 93,528 (African American family population), 31,406 (projected African American female population in childbearing age)</p>

NC 2010 FOCUS AREA AND HEALTH OBJECTIVE ADDRESSED

<p>Focus Area: Infant Mortality</p> <p>Health Objective: Reduce overall infant mortality; reduce disparity between white and minority populations</p>

INTERVENTIONS/TIMEFRAME (insert extra rows as needed)	COMMUNITY PARTNERS Roles and Responsibilities	SETTING(S)	EVALUATION PLAN & PROGRESS TO DATE
<p>A. In order to secure the active involvement of the priority population(s), our Partnership will:</p> <ul style="list-style-type: none"> • Continue Infant Mortality Task Force (IMTF) composed of target population members and interested professionals. (Current membership is 50% community members, primarily from the target group). • Support the Lay Health Advisor Initiative; expand throughout the target community. (Ongoing strategy through 2010) • Invite all Lay Health Advisors to participate in the IMTF (Ongoing strategy through 2010) • Include infant mortality information in Community Report card that will be widely 	<p>DCHD (Health Ed. Division, Maternal Health Program): Staff Infant Mortality Task Force, train Lay Health Advisors, identify women with poor outcomes</p> <p>Infant Mortality Task Force (Coordinate community involvement, mobilize community action, make policy or practice recommendations)</p>	<p>DCHD (IMTF meetings)</p> <p>Neighborhoods</p>	<p>Progress to date:</p> <ul style="list-style-type: none"> • Quarterly IMTF meetings with community representation • Active Lay Health Advisors who provide input on all infant mortality reduction actions • Routine prenatal record reviews (DCHD patients) and birth certificate reviews for maternal risk factors

Office of Healthy Carolinians, Division of Public Health, NC Department of Health and Human Services
(Revised 1/04)

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distributed throughout Durham in August, 2005.	Lay Health Advisors (Represent viewpoint of target population, solicit interested community members' participation, advocate for policy change locally and state-wide)		Evaluation Plan: <ul style="list-style-type: none"> • Monthly IMTF meeting attendance records • Monthly IMTF minutes demonstrating community involvement • Annual report of Lay Health Advisor activities • Demonstration of use of additional data sources: Trace Vue, SCHS outcome data
B. Continue to promote and support all community efforts targeting women of child-bearing age including: <ul style="list-style-type: none"> • Promote adequate Folic Acid Intake for all women <ul style="list-style-type: none"> o Dissemination of folic acid supplements to women (not pregnant) of childbearing age by Neighborhood Nurses through May, 2008 o Provision of prenatal vitamins to all patients of DCHD Maternity Clinic o Ongoing dissemination of Folic Acid information to the community by WIC staff and DCHD Nutrition Division • Promote smoking Cessation <ul style="list-style-type: none"> o Maternity and Family Planning staff will receive Smoking Cessation Training (5 A's) o Documentation of women attending Maternity and FP clinics are counseled about smoking using 5 A's o Using Lay Health Advisors, women throughout the community will have access to smoking cessation education and materials • Promote SIDS reduction and prevention <ul style="list-style-type: none"> o Ongoing Lay Health Advisor messages to community regarding safe sleep o Ongoing dissemination of Back to Sleep/safe sleep messages by Health Educators, care coordinators, and medical providers • Provide direct one-on-one encouragement for breastfeeding in target populations by these providers: <ul style="list-style-type: none"> o WIC o Prenatal staffs o Maternity Care Coordination o Neighborhood Nursing • DCHD Nutrition Division staff provide community-wide breastfeeding information, with particular emphasis in target neighborhoods through May, 2008 • Support Obesity prevention/reduction efforts (See Obesity Action Plan) • Continue partnerships to provide contraceptive information and services: DCHD Family Planning Clinic, Planned Parenthood, DCHD Maternal Health staff, DCHD Child Service Coordinators 	DCHD: Provide community nutrition education, disseminate folic acid in Neighborhood Nurse project areas, provide Back to Sleep/Safe Sleep education, manage Maternity and Family Planning Clinics LCHC: Provide community and individual nutrition education through WIC program, provide space and infrastructure support for DCHD Maternal Health Program DUMC: Provide breastfeeding and safe sleep messages to patients, assist with smoking cessation training for DCHD staff Planned Parenthood: Collaborate regarding pregnancy spacing issues	Clinics (located at DCHD, LCHC, DUMC) Neighborhood Nursing sites Community and neighborhood events and activities	Progress to date <ul style="list-style-type: none"> • Folic acid promotion in Neighborhood Nurse project • Folic acid promotion by prenatal providers • Breastfeeding support by WIC project • Community-wide breastfeeding promotion as part of Targeted Infant Mortality Reduction project • Smoking reduction information during prenatal care • Opportunity for DCHD prenatal patients to participate in "Baby Steps" smoking reduction research project • Promotion of "Back to Sleep" campaign by Lay Health Advisors, Child Service Coordinators • Counseling in Family Planning Clinic regarding pregnancy spacing • Partnership with Planned Parenthood to increase contraception services Evaluation Plan <ul style="list-style-type: none"> • IM data from SCHS • Other health (smoking, birthweight, etc.) data from SCHS BABY Book • Local data from matched

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			birth/death records <ul style="list-style-type: none"> • Newspaper inserts regarding breastfeeding, folic acid use, and other healthy practices • Data regarding participation in Folic Acid distribution
C. Increase participation of more pregnant and postpartum women and their infants in the WIC program by increasing the number of WIC sites in the county. Number of sites will be expanded by 3 sites by 2010	LCHC WIC: Project will manage expanded sites	Sites to be determined by WIC administration based on community input and agency agreement	Evaluation Plan <ul style="list-style-type: none"> • Increase in number of WIC sites in Durham
D. Continue to evaluate and change practices that decrease patient compliance to prenatal and family planning appointments. <ul style="list-style-type: none"> • Continue support for Centering Model of prenatal care (Ongoing through 2010) • Implement policy changes affecting the initiation of prenatal care at DCHD Maternity Clinic. (Adapted pregnancy test requirement made April, 2005; other changes to be made based on patient, staff, and community feedback) 	LCHC: Provide space for DCHD Maternity Clinic, including extra space for Centering activities DCHD: Manage Maternal Health Clinic	LCHC	Progress to date <ul style="list-style-type: none"> • Centering Model of Prenatal care already in use • Pregnancy test requirement for 1st appointment eliminated Evaluation Plan <ul style="list-style-type: none"> • Participation data for women utilizing Centering • Clinic Flow review • Customer satisfaction surveys • Policy changes • Broken appointment review • Staff report
E. Analyze demographics, barriers to care, underlying risk factors, and environmental issues in families experiencing infant death. <ul style="list-style-type: none"> • Develop of agreement with DUMC for staff review of patient records • Develop systematic review of DCHD patient records • Pursue funding for position to do IM interviews with families • Advocate for statewide legislative changes that would allow health department, hospital, and other appropriate staff, to review fetal and infant deaths records as they occur on an ongoing basis. 	Infant Mortality Prevention Task Force: Receive data reports and assist with analysis and understanding of information presented (i.e., present a community perspective). Develop strategies for a process of IM interviews with families (to be implemented by one of the other partners). Assist with lobbying efforts to local and state representatives. Child Fatality Task Force: Provide de-identified statistical information from infant death records. Write letters of support for lobbying efforts DCHD: Perform systematic prenatal record reviews on Maternity Clinic	Medical records sites Patient Homes	Evaluation Plan: <ul style="list-style-type: none"> • Data reports from record reviews • Family interview design

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	<p>patients, and infant record reviews on Child Service Coordination patients.</p> <p>DUMC: Perform systematic prenatal, perinatal, and nursery record reviews.</p>		