ReCAST Disparity Impact Statement
Mecklenburg County Public Health

A. Community Focus

Charlotte, NC has experienced demonstrations of mass protest and civil unrest - including acts of vandalism, looting and violence – sparked by two unrelated fatal shootings of African-American men by members of the Charlotte-Mecklenburg Police Department (CMPD). The most violent was in September 2016 when, following the shooting of Keith Lamont Scott, crowds of predominately African American residents took to the streets in protest. These protests spanned several days resulting in the imposition of a city-wide curfew, the governor declaring a state of emergency and ordering the National Guard and State Highway Patrol to help CMPD respond to the unrest.

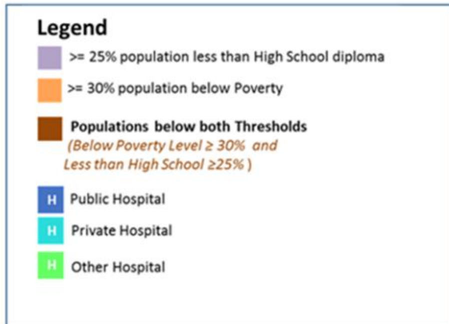
These events spurred positive responses in many quarters. The City of Charlotte committed itself to increasing affordable housing; in November 2018 citizens passed a $50 million bond issue; an increase from the normal $15 million. CMPD developed a strategic plan based on recommendations from the President's Task Force on 21st Century Policing. There have been an ongoing series of *Bridging the Difference* seminars, with newly added emphasis of preparing for the 2020 Republican National Convention.

This incident greatly increased community awareness of the disparities in opportunity, wealth, education, housing and health. Some are a legacy of segregation; others the result of economic changes that have reduced manufacturing jobs with a service economy requiring higher levels of education and training. Clarity around these issues followed the release of the *Leading on Opportunity Report*, the result of a multi-sector, community-based research effort exploring the multiple, complex issues that impact generational poverty and access to opportunity. Using input from national experts and "community listening" events the report identified Early Care and Education, College and Career Readiness and Child and Family Stability as the interrelated determinants most likely to have the greatest influence on an individual's opportunity trajectory. It also recognized the cross-cutting influence of segregation and social capital.

Evidence for these disparities is seen in the data. Race, poverty and segregation are closely related. When mapping health data, a crescent shaped area consisting of six zip codes (28205, 28206, 28208, 28212, 28216 and 28217) show poor health outcomes including high rates of poverty, uninsured populations and death from chronic diseases. These zip codes form a Public Health Priority Area (PHPA) and include over 210,000 residents (one fifth of the total county population). The PHPA represents a broad area containing numerous census tracts and diverse communities with unique service needs. In addition, the Harvard-developed "Chetty Study" showed a child born into poverty had a less than 5% chance of ever moving into the top fifth of income earners.

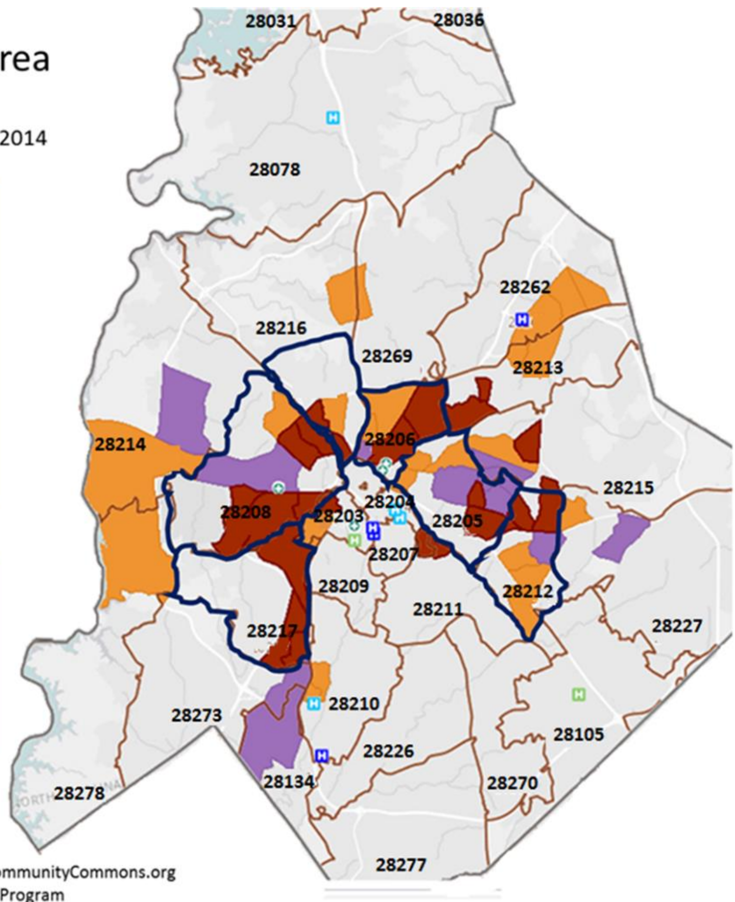
2016 Public Health Priority Area Mecklenburg County, NC

Data Source: American Community Survey, 2010-2014



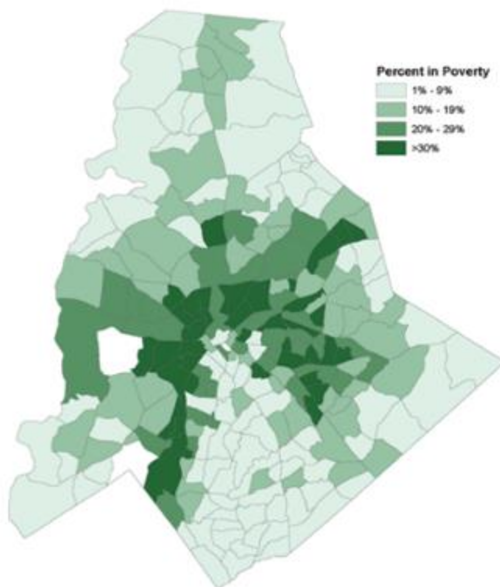
What Does This Map Tells Us?

Two key social determinants, poverty and education, have a significant impact on health outcomes. This map displays where vulnerable populations live by overlapping census tracts with high concentrations of poverty alongside those with low educational attainment.

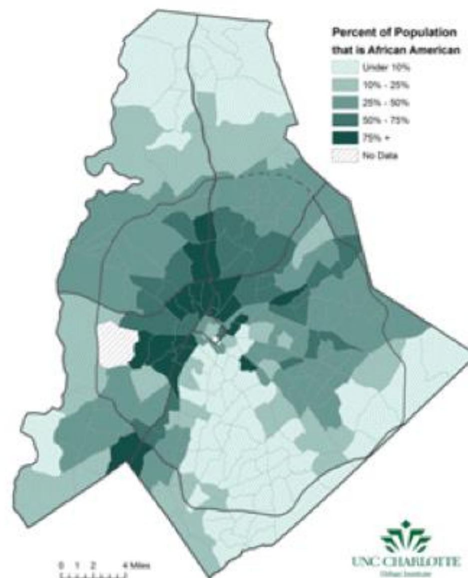


Mapping: Community Health Needs Assessment, located on CommunityCommons.org
Prepared by Mecklenburg County Public Health, Epidemiology Program

Segregation by Poverty



Segregation by Race (African-American)



In response to this data and stakeholder feedback **ReCAST Mecklenburg County** will use resources made available by SAMHSA through a systems approach to build “relational wealth” (having supports in family and community that create connectedness and ability to manage trauma), increase resilience, and support advancement in economic opportunity in our community that will lead to sustained improvements in community connectivity and wellness. Through leveraging current activities, enhancing coordination among partners and engaging the community Mecklenburg ReCAST will utilize the Collective Impact approach (see illustration) to promote resiliency, well-being, and community healing for high risk youth, families and communities. This effort will work to create improved behavioral health, empowered community residents, reductions in trauma and violence, and sustained community change.

A purpose of Mecklenburg ReCAST is to engage the community in developing a focused approach to the goals of building a resilient and connected community by creating a system of coordinated and integrated initiatives and programs. This will serve as a common ground for: creating community change through participatory approaches that promote community and youth engagement and leadership development; creating a community-wide understanding of trauma and its effect on individuals, families and neighborhoods; creating more equitable access to a trauma-informed community’s behavioral health resources; strengthening integration of behavioral health services and other community systems; and ensuring program resources are culturally specific and developmentally appropriate.

The chart below reflects the proposed number of individuals to be reached during the grant period and all identified sub populations in the grant service area.

2012-2106 Population*								
PHPA and Mecklenburg County								
	PHPA		NUMBER TO BE REACHED					
Total Population	**217,314**		**FY1**	**FY2**	**FY3**	**FY4**	**FY5**	**TOTAL**
Racial/Ethnic Groups	**Popula-tion in PHPA**	**% of PHPA Popula-tion**						
Hispanic-Latino	37,840	17.4%	5,676	5,846	6,080	6,445	6,896	30,943
African American-Black	110,766	51.0%	16,615	17,113	17,798	18,866	19,998	90,390
Asian American	12,137	5.6%	1,821	1,875	1,950	2,067	2,212	9,925
Native Hawaiian-Pacific Islander	423	0.2%	63	65	68	72	77	346
American Indian-Alaskan Native	423	0.2%	63	65	68	72	77	346
White Non-Hispanic	49,873	22.9%	7,481	7,705	8,014	8,494	9,089	40,783
Two or more Races	5,380	2.5%	807	831	864	916	980	4,399
Other Race	472	0.2%	71	73	76	80	86	386
Youth Age Groups								
Age 0-4	17,737	8.2%	2,661	2,740	2,850	3,021	3,232	14,504
Age 5-9	16,865	7.8%	2,530	2,606	2,710	2,872	3,074	13,791
Age 10-14	13,356	6.1%	2,003	2,064	2,146	2,275	2,434	10,922
Age 15-19	11,977	5.5%	1,797	1,850	1,924	2,040	2,183	9,794
*Source: 2012-2016 American Community Survey, US Census								

A Quality Improvement Plan Using Our Data

Standards for ReCAST activities will be drawn from the HHS *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care* and those of the North Carolina Institute for Public Health's *Guidelines for Local Public Health Accreditation.* These

include, under the standard of Agency Core Functions and Essential Services, Benchmarks 19: *The local health department shall take actions to include linguistically and culturally representative persons in planning and implementing programs intended to reach underserved population groups;* 21: *The local health department shall assure that the program planning and implementation involve community health advocates that represent populations being served in the local health department*; and 27: *the local health department shall evaluate all services it provides for effectiveness in achieving desired outcomes.*

All ReCAST initiatives will be guided by the principles of inclusion, diversity and equity, including governance structure, hiring of staff, contracting with community organizations and interactions with program beneficiaries. Selection of evidence-based and evidence-informed interventions will be based on criteria that include cultural sensitivity and appropriateness. ReCAST Mecklenburg will be guided by the principle that communities "closest to the pain" become decision makers, have their voices heard, and challenge trauma's underlying conditions.

Using an "equity lens" and with a commitment to preventing trauma and enhancing community resilience, ReCAST Mecklenburg will maintain a focus on development and implementation of sustainable policies that effectively address the social determinants of health which are the root causes of community trauma.

In collaboration with the program evaluators, the three domains of ReCAST will be assessed

Domain	Evaluation	Outcome Implications
Training and Capacity Building	• Pre and Post Testing • Bi-annual assessment of practice implementation • Continuous engagement of community, families, youth	• Development of universal standards and policies regarding Trauma-Informed Practices • Community-wide understanding and use of of resilience tools.
Access to Services	• Ongoing needs assessment; input from community; work teams; executive support • Agreed upon criteria from evaluation team	• Addressing of service gaps in communities. • Strengthening of network of providers with commitment to trauma prevention; health equity; economic mobility
Policy Development	• Ongoing review of policies of department and partnering organizations	• Implementation of *Leading on Opportunity Task Force*

		recommendations (see below). • Support for ReCAST efforts through leveraging of community resources.

B. **Incorporation of CLAS Standards**

The CLAS standards inform the culture of Mecklenburg County Public Health (MCPH). They are evident in our guiding principles, our Strategic Plan and an overarching commitment to health equity that informs all our program and policy decisions. They are also reflected in the North Carolina Public Health Accreditation Standards; MCPH is the largest accredited department in the state.

Mecklenburg ReCAST will incorporate CLAS within the following principles:

Governance, Leadership and Workforce:

A. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

   The commitment to equity, diversity and inclusion is articulated in our Board of County Commissioner approved Strategic Business Plan. In response to the finding of our Community Health Assessment and local BRFSS and YRBS data, we look to "make the healthy choice the easy choice" for all by collaborating with partners to support a Health in All Policies (HiAP) approach to achieve sustainable improvement.

   The County partners with and financially supports community-based organizations that serve the underserved. These include a PrEP pilot to prevent new HIV infections in uninsured, at-risk individuals; , Community Development Grants to support operating costs; the Rosa Parks Farmers Market, a corner store initiative and urban orchards located in food priority areas, etc.

B. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

   All MCHP structures are guided by County human resources policy on Affirmative Recruitment; the Department works with county recruiters to advertise in journals or at institutions where minority populations are more common to recruit staff who will best resemble the population served.

   Our nationally-recognized Village Heart B.E.A.T. program engages the African American and Latino faith communities to address chronic diseases, building the capacity of minority faith-based organizations to address health issues in their communities.

C. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

   Recruitment and promotion efforts are supported by our internal Non-Discrimination/Civil Rights policy, through Health Equity training as part of New Hire Orientation, and through annual completion of the online Diversity Training module by all staff. Department leaders are required to complete the training Health Equity and Inclusion for Managers.

Communication and Language Assistance

A. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

   MCPH has policies/protocols to address accessibility for persons with physical disabilities and Limited English Proficiency. These include Administrative Policies:

   - A-36 Notification Plan for LEP Services
   - A-51 Non-Discrimination, Civil Rights
   - A-53 Signage Policy
   - A-57 Physical Needs of Patients

   In addition, there is access to a Language Line translation service, and the MCPH website features a translation function for seven languages other than English: Spanish, French, German, Korean, Russian, Portuguese and Vietnamese.

   There is active recruitment of linguistically and culturally competent staff who certified for their verbal and written translation skills.

B. Inform all individuals of the availability of language assistance services clearly and in their preferred language verbally and in writing.

   All clients are informed of this availability at every service level, from appointment setting through discharge.

Engagement, Continuous Improvement, and Accountability

A. Conduct ongoing assessments of the organization's CLAS related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

   CLAS-related standards are included in MCPH's quality assurance (QA) and quality improvement (QI) efforts. which are facilitated by the Department's Total Quality (TQ)

team. Quality assurance efforts are led by the team's Practice and Standards Coordinator and quality improvement efforts are led by the team's QI Coordinator. All efforts are supported by two Senior Quality and Training Specialists that facilitate data analysis and visualization to support strategic decision making.

TQ's efforts are ultimately guided by the administrative policies for quality assurance and quality improvements, as well as the Department's QI Plan (QIP).

All MCPH staff, including leadership, are held accountable for the delivery of services that meet the CLAS standards. Accountability is also measured through the Public Health Accreditation Process, where benchmarks 26.1-26.3 requires that "the local health department shall promote diversity in the public health workforce."