2008

PUBLIC HEALTH STUDY COMMISSION

MINUTES

NORTH CAROLINA GENERAL ASSEMBLY

Public Health Study Commission

MEMORANDUM

TO: Members, Public Health Study Commission

FROM: Senator William Purcell, Co-Chair
Representative Bob England, Co-Chair

SUBJECT: Meeting Notice

The Public Health Study Commission will meet on the following date:

DAY:	Tuesday
DATE:	February 26, 2008
TIME:	10:00 – 1:00
LOCATION:	Room 544, LOB

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives (see attached map). The cost for visitor parking is $1.00 per hour or $8.00 per day and may be reimbursed with a parking receipt submitted with your travel reimbursement form.

If you have any questions concerning this meeting, please contact Lisa Brown at 919-733-5749 or Lorraine Blake at 919-733-5953. If you cannot attend, please contact Lorraine Blake, 919-733-5953.

Agenda

Public Health Study Commission

Tuesday, February 26, 2008
10:00 a.m. – 1:00 p.m.
Room 544, LOB

I. Welcome and Introductions
Senator Bill Purcell, Co-Chair
Representative Bob England, Co-Chair

II. Comments on the Public Health Task Force 2008 State of the State's Health
Secretary Dempsey Benton, Department of Health and Human Services
Dr. Leah Devlin, State Health Director, Department of Public Health

III. Chronic Disease
Dr. Marcus Plescia, Chronic Disease and Injury Section Chief, Department of Public Health

IV. Communicable Disease and Preparedness
Dr. Jeff Engel, Epidemiology Section Chief
Dr. John Butts, Chief Medical Examiner, Department of Public Health

V. Children and Families
Dr. Kevin Ryan, Women's and Children's Health Section Chief, Department of Public Health

VI. Core Public Health and Finance
Dr. Steve Cline, Deputy State Health Director, Department of Public Health
Dr. Rosemary Summers, Orange County Health Director

VII. Discussion of Next Steps

VIII. Adjourn

PUBLIC HEALTH STUDY COMMISSION
FEBRUARY 26, 2008
MINUTES

The Public Health Study Commission met on Tuesday, February 26, 2008 in Room 544 of the Legislative Office Building. Present were Cochairs Senator William Purcell and Representative Bob England. Committee members present were: Representatives Alma Adams, William Current, Verla Insko and Carolyn Justus: public members Dr. Edward Baker, Director of the NC Institute for Public Health; Beth Lovette, Health Director Wilkes County; Ms. Anne Thomas, Health Director Dare County; Dr. Ronald Levine, former State Health Director and present member of the Commission for Public Health; and Dr. Leah Devlin, State Health Director, who is an ex-officio member of the Commission.

Cochairman Senator Purcell called the meeting to order and committee members introduced themselves. Shawn Parker, analyst with the Research Division of the General Assembly and staff to this Commission, explained the statute creating the Commission (Attachments I & I a). Also staffing the committee is Ben Popkin, attorney with the Research Division and Susan Barham, research assistant. Lisa Brown and Becky Hedspeth will serve as the clerks to the Commission.

The Commission was created by General Statute 120-195 and spells out that the "Commission shall examine the public health system to determine its effectiveness and efficiency in assuring the delivery of public health services to the citizens of North Carolina". Duties of the Commission, per General Statute 120-196, are "to study the availability and accessibility of public health services to all citizens throughout the State".

Meetings are held upon the call of the cochairs. The Commission shall report to the General Assembly, the Governor, and the Lieutenant Governor the results of its study and recommendations. Senator Purcell then asked Dr. Devlin if any updates regarding duties regarding duties are needed for the Statute. She responded that the flexibility is there to meet needs as they arise.

Dempsey Benton, Secretary of the Department of Health & Human Services and chair of the Public Health Task Force 2008, gave opening remarks commending the Final Report of the North Carolina Public Health Task Force 2008 (Attachment II) and its recommendations. He spoke about the many stakeholders participating for the third time in this unique planning effort and reported that in years 2004 and 2006 significant progress was made, and those are outlined in the beginning of the 2008 Report. The Report contains current recommendations, many of which continue to build on the work that has been undertaken but not yet completely accomplished. There were four committees working on this 2008 Report under the guidance of an Executive Committee: Strengthen Core Public Health, Chronic

Disease & Injury, Healthy Children & Families, And Communicable Disease & Preparedness.

Dr. Leah Devlin, State Health Director, addressed the Commission regarding the three points for the meeting today: (1) what is the state of health in North Carolina? She stated that North Carolina ranks very low on all health indicators and that our goal should be to become the healthiest State in the nation and that we should attempt to accomplish this by 2020. (2) What are the investments in the public health governmental system? (3) What are the recommended priorities for the future? She referenced Attachments III and IV and noted that major health risks are tobacco, obesity (particularly in children), and physical inactivity, with the solution being prevention, the focus of this meeting. Tobacco use, obesity, and physical inactivity cost our State $25.82 billion annually in health care costs. Dr. Devlin then referenced Ten Essential Services: 1. monitor the health of North Carolinians; 2. identify and investigate health problems; 3. inform and educate North Carolina citizens about health issues; 4. organize community partnerships to solve health problems; 5. develop policies and plans that support health programs; 6. enforce laws and regulations that protect health and safety; 7. connect North Carolina citizens to needed health services; 8. assure the ability to recruit and retain an adequately trained public health workforce; 9. measure the effectiveness and quality of health services; and 10. Identify new solutions to health problems.

The next presenter was Dr. Marcus Plescia, of the Department of Public Health, Chronic Disease and Injury Section Chief, who reported on the work of the Chronic Disease prevention committee. Attachments V & V (a) contain information shared by him. The needs identified by this committee are obesity and tobacco control, support for chronic disease management, support for public health surveillance, and expansion of statewide dental health services.

Dr. Jeff Engle, Department of Public Health, Epidemiology Section Chief, was the next presenter reporting on the Highlights of Public Health Priorities (pp. 2 & 3 of Attachment V). These are needs identified under Communicable Disease and Preparedness: needs within the State Medical Examiner System; shoring up local Epi teams; raising eligibility for the AIDS Drug Assistance Program; and legislation to improve public health preparedness and response.

Dr. Kevin Ryan, the Department of Public Health, Women's and Children's Health Section Chief, presented on Healthy Families (pp. 4-5 of Attachment V). The priorities include Every Child Succeeds, with a focus on school nurses, Universal Vaccinations, improving birth outcomes, and expansion of statewide dental health services.

Dr. Rosie Summers, Orange County Health Director, presented next (pp. 7-9 of Attachment V) on Core Public Health & Finance. Dr. Summers referenced the

recommendation from this committee: increasing the capacity of Local Health Departments to provide the 10 essential public health services statewide.

Dr. Steve Cline, Department of Public Health, Deputy State Health Director, addressed the area of resources for these needs (p. 9 of Attachment V): increasing the tobacco tax to the national average of $1.09 per pack; seeking legislation to enable local authorities to set fees for food and lodging inspections; legislatively creating a permanent sustainable funding source for the Universal Vaccine Program; correcting the fee adjustment process for Local Health Departments and Child Development Service Agencies; and adjusting the newborn screening fee to support adding cystic fibrosis screening. In summing up the Report, he stated this is a 2-year roadmap with 21 broad recommendations, more than 50 specific program recommendations and activities, with over $100,000 in recommended funding. He acknowledged that this goal cannot be reached in a year, nor can state government alone accomplish the goal. The priorities and focus areas are (1) the ten public health essential services (2) a reduction in childhood obesity; (3) school health focus on school nurses; (4) immunizations; and (5) public health preparedness, focusing on support for the Chief Medical Examiner and the medical examiner system in North Carolina in general.

Senator Purcell called for questions from the Commission members. Representative Adams asked for the nurse/student ratio to be repeated. Dr. Devlin responded that currently the ratio is 1/1200 and the goal is 1/750. She then asked about the N.C. Tobacco Cessation "Quit Line" and was told this has been a very cost effective initiative. Representative Insko asked about best practice treatments versus evidence-based practices. Dr. Plescia stated that the best practice approach is not only being used in North Carolina, but seems to be the national approach to dealing with obesity issues. Representative Insko then asked whether school nurses are involved in the teaching program of the school health programs. Dr. Devlin stated that varies from school to school and district to district, but that the nurses are there to provide services to the children, rather than to teach, although most nurses are on the School Health Advisory Council. Representative Insko then asked if school-based health clinics could be a medical home for the uninsured, with Dr. Devlin responding yes that they can be and that there are 28 or so for which the State provides funding. Representative Justus asked the status of the emergency volunteer practice act. Ms. Devlin stated this is a new piece of legislation. Representative Justus then asked that any proposed legislation be emailed to members prior to a meeting where such will be considered. Representative Currant asked about the status of the dental hygienists program. Dr. Devlin said there are currently 50 dental health hygienists in North Carolina, with many of those covering more than one county; however, there are still deficiencies within the program. Representative Current then asked how we are doing with fluoridation, with Dr. Devlin responding this is done in all municipalities of 10,000 and greater; but there is a recent concern about one community, Brevard, that voted to stop fluoridation of water (with Dr. Devlin stating also that there are current conversations going on in Buncombe about the need for fluoridation). Dr. Levine expressed his concern about this and asked if

the Commission on Public Health, of which Dr. Levine is a member, has current authority to consider this fluoridation issue. He expressed his interest in our legal staff looking at this area.

There being no further business before the Commission, Senator Purcell announced that the Commission would meet on March 25th at 10:00 a.m. in Room 544 of the Legislative Office Building and again on April 22 at 10:00 a.m., also in Room 544 of the Legislative Office Building.

Respectfully submitted,

Becky Hedspeth
Becky Hedspeth
Committee Clerk

William R Purcell
Senator William R. Purcell, M.D.
CoChairman

Representative Bob England
CoChairman

Attachment 1

Article 22.

The Public Health Study Commission.

§ 120-195. Commission created; purpose.

There is established the Public Health Study Commission. The Commission shall examine the public health system to determine its effectiveness and efficiency in assuring the delivery of public health services to the citizens of North Carolina. (1993 (Reg. Sess., 1994), c. 771, s. 2.1, 8.1; 1995, c. 358, s. 6; c. 437, s. 4; c. 467, s. 3; c. 507, s. 23A.6(b).)

§ 120-196. Commission duties.

The Commission shall study the availability and accessibility of public health services to all citizens throughout the State. In conducting the study the Commission shall:

(1) Determine whether the public health services currently available in each local health department conform to the mission and essential services established under G.S. 130A-1.1;

(2) Study the workforce needs of each local department, including salary levels, professional credentials, and continuing education requirements, and determine the impact that shortages of public health professional personnel have on the delivery of public health services in local health departments;

(3) Review the status and needs of local health departments relative to facilities, and the need for the development of minimum standards governing the provision and maintenance of these facilities;

(4) Propose a long-range plan for funding the public health system, which plan shall include a review and evaluation of the current structure and financing of public health in North Carolina and any other recommendations the Commission deems appropriate based on its study activities;

(5) Conduct any other studies or evaluations the Commission considers necessary to effectuate its purpose; and

(6) Study the capacity of small counties to meet the core public health functions mandated by current State and federal law. The Commission shall consider whether the current local health departments should be organized into a network of larger multidistrict community administrative units. In making its recommendations on this study, the Commission shall consider whether the State should establish minimum populations for local health departments, and if so, shall recommend the number of and configuration for these multicounty administrative units and shall recommend a series of incentives to ease county transition into these new arrangements. (1993 (Reg. Sess., 1994), c. 771, s. 2.1; 1995, c. 507, s. 23A.6(a), (b); 1997-502, s. 11.)

§ 120-197. Commission membership; vacancies; terms.

(a) The Commission shall consist of 17 members, one of whom shall be the State Health Director. The Speaker of the House of Representatives shall appoint seven members, two of whom shall be selected from among the following: the UNC School of Public Health, the North Carolina Primary Care Association, the North Carolina Home Care Association, the North Carolina Pediatric Society, and the North Carolina Citizens for Public Health. Five of the Speaker's appointees shall be persons who are members of the House of Representatives at the time of their appointment, one of the five being the Representative who chairs the House standing committee related to health matters. The President Pro Tempore of the Senate shall appoint seven members, two of whom shall be selected from among the following: the North Carolina Health Directors' Association, the North Carolina Public Health Association, the Association of Public Health Nurses, the North Carolina Environmental Health Supervisors' Association, and the North Carolina Association of Public Health Educators. Five of the President Pro Tempore's appointees shall be persons who are members of the Senate at the time of their appointment, one of the five being the Senator who chairs the Senate standing committee related to health matters. The Governor shall appoint one member from either the North Carolina Medical Society or the North Carolina Hospital Association. The Lieutenant Governor shall appoint one member from either the North Carolina Association of County Commissioners or the Association of North Carolina Boards of Health.

(b) Vacancies shall be filled by the official who made the initial appointment using the same criteria as provided by this section. All initial appointments shall be made within one calendar month from the effective date of this Article.

(c) Legislative members appointed by the Speaker and the President Pro Tempore shall serve two-year terms. The public members initially appointed by the Speaker and the President Pro Tempore shall each serve a three-year term. The members initially appointed by the Governor and the Lieutenant Governor shall each serve a one-year term. Thereafter, the terms of all Commission members shall be for two years. (1993 (Reg. Sess., 1994), c. 771, s. 2.1, 8.1; 1995, c. 358, s. 6; c. 437, s. 4; 467, s. 3; c. 507, s. 23A.6(b).)

§ 120-198. Commission meetings.

The Commission shall have its first meeting not later than 60 days after the sine die adjournment of the 1993 General Assembly at the call of the President Pro Tempore of the Senate and the Speaker of the House of Representatives. The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each appoint one legislative member of the Commission to serve as cochair. The Commission shall meet upon the call of the cochairs. (1993 (Reg. Sess., 1994), c. 771, s. 2.1, 8.1; 1995, c. 358, s. 6; c. 437, s. 4; c. 467, s. 3; c. 507, s. 23A.6(b).)

§ 120-199. Commission reimbursement.

The Commission members shall receive no salary as a result of serving on the Commission but shall receive necessary subsistence and travel expenses in accordance

with G.S. 120-3.1, 138-5, and 138-6, as applicable. (1993 (Reg. Sess., 1994), c. 771, ss. 2.1, 8.1; 1995, c, 358, s. 6; c. 437, s. 4; c. 467, s. 3; c. 507, s. 23A.6(b).)

§ 120-200. Commission subcommittees; non-Commission membership.

The Commission cochairs may establish subcommittees for the purpose of making special studies pursuant to its duties, and may appoint non-Commission members to serve on each subcommittee as resource persons. Resource persons shall be voting members of the subcommittee and shall receive subsistence and travel expenses in accordance with G.S. 138-5 and G.S. 138-6. (1993 (Reg. Sess., 1994), c. 771, s. 2.1, 8.1; 1995, c. 358, s. 6; c. 437, s. 4; c. 467, s. 3; c. 507, s. 23A.6(b).)

§ 120-201. Commission authority.

The Commission may obtain information and data from all State officers, agents, agencies, and departments, while in discharge of its duties, under G.S. 120-19, as if it were a committee of the General Assembly. The Commission also may call witnesses, compel testimony relevant to any matter properly before the Commission, and subpoena records and documents, provided that any patient record shall have patient identifying information removed. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Commission as if it were a joint committee of the General Assembly. In addition to the other signatures required for the issuance of a subpoena under this section, the subpoena shall also be signed by the cochairs of the Commission. Any cost of providing information to the Commission not covered by G.S. 120-19.3 may be reimbursed by the Commission from funds appropriated to it for its continuing study. (1993 (Reg. Sess., 1994), c. 771, s. 2.1, 8.1; 1995, c. 358, s. 6; c. 437, s. 4; c. 467, s. 3; c. 507, s. 23A.6(b).)

§ 120-202. Commission reports.

The Commission shall report to the General Assembly, the Governor, and the Lieutenant Governor the results of its study and recommendations. The Commission shall submit its written report not later than 30 days after the convening of each biennial session of the General Assembly. (1993 (Reg. Sess., 1994), c. 771, s. 2.1, 8.1; 1995,.c. 358, s. 6; c. 437, s. 4; c. 467, s. 3; c. 507, s. 23A.6(b).)

§ 120-203. Commission staff; meeting place.

The Commission may contract for clerical and professional staff or for any other services it may require in the course of its ongoing study.

The Commission may, with the approval of the Legislative Services Commission, meet in the State Legislative Building or the Legislative Office Building. (1993 (Reg. Sess., 1994), c. 771, s. 2.1; 1995, c. 358, s. 6; c. 437, s. 4; c. 467, s. 3; c. 507, s. 23A.6(b).)

Public Health Study Commission

Chairs:
Representative Bob F. England, MD
Senator William R. Purcell, MD

Attachment I (12)

Creation and Purpose
G.S. 120-195

- The Commission shall examine the public health system to determine its effectiveness and efficiency in assuring the delivery of public health services to the citizens of North Carolina.

Membership

Representative Bob England, MD

Representative Alma Adams
Representative William Current
Representative Verla Insko
Representative Carolyn K. Justus
Dr. Edward Baker
Dr. Evelyn Schmidt
Dr. Ronald Levine
Rev. Reginald Wells

Senator William Purcell, MD

Senator Robert Atwater
Senator Katie Dorsett
Senator James Forrester, MD
Senator Vernon Malone
Ms. Beth Lovette
Ms. Anne Thomas
Dr. Leah Devlin

Duties

G.S. 120-196

To study the availability and accessibility of public health services to all citizens throughout the State.

Including:

- **Determine whether the public health services currently available in each county or district health department conform to the mission and essential services;**
- **Study the workforce needs of each county or district health department;**
- **Review the status and needs of local health departments relative to facilities;**
- **Study the capacity of small counties to meet core public health functions mandated by current State and federal law;**
- **Conduct any other studies or evaluation necessary.**

Meetings, Expenses, & Reimbursement

G.S. 120-198

The Commission shall meet upon the call the of the cochairs.

G.S. 120-3.1, 138-5, or 138-6

Commission members shall receive per diem, subsistence, and travel expenses as applicable.

Reports
G.S. 120-202

- The Commission shall report to the General Assembly, the Governor, and the Lieutenant Governor the results of its study and recommendations.

- The written report is to be submitted not later than 30 days after the convening of each biennial session of the General Assembly.

Staff

■ Clerks

Becky Hedspeth

(919) 733-5953

Lisa Brown

(919) 733-5749

■ Staff

Shawn Parker, Staff Analyst

Ben Popkin, Staff Attorney

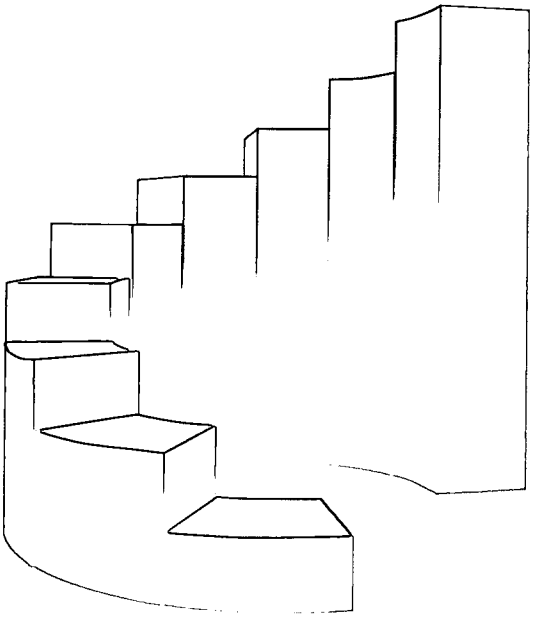
(919) 733-2578

NORTH CAROLINA

Public Health Improvement Plan

Public Health Task Force 2008

FINAL REPORT



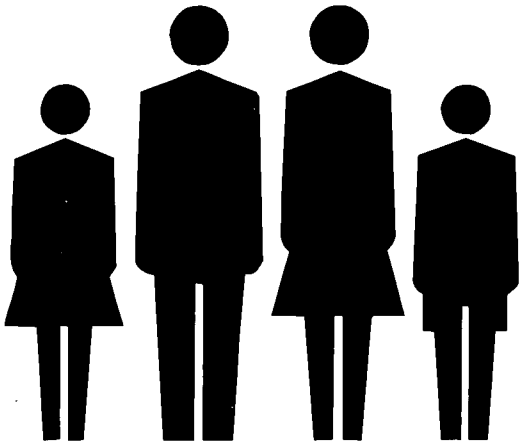
January 2008

NCPH

North Carolina Public Health

Att. 11

Health Profile of North Carolinians: 2007 Update



NC Department of Health and Human Resources
Division of Public Health
State Center for Health Statistics
1908 Mail Service Center
Raleigh, North Carolina 27699-1908
www.schs.state.nc.us/SCHS/

May 2007

Attachment IV

NC Public Health Study Commission – February 26th 2008

"Making North Carolina the Healthiest State"

North Carolina – The Healthiest State in the Nation!

"Making North Carolina the Healthiest State"

Our Conversation today:

- What is the state of health in North Carolina?
- What are the investments in the public health system?
- What are the recommended priorities for the future?

"Making North Carolina the Healthiest State"

How NC Ranks Nationally:

The United Health Foundation's ***"America's Health Rankings"*** lists North Carolina as:

40th in premature deaths

36th in the nation overall

"Making North Carolina the Healthiest State"

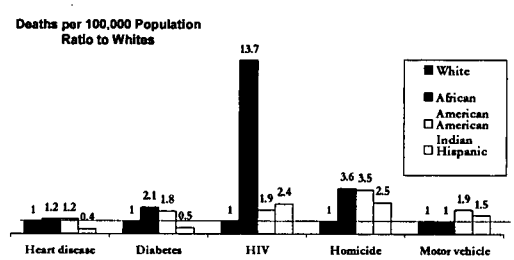
Poorest Health Rankings

North Carolinians are dying younger and have premature morbidity. We rank:

- 44th in infant mortality (America's Health Ranking 2004-2005)
- 38th in percent of adults who report that their activities were limited due to physical health problems (BRFSS 2006)
- 36th in high school tobacco use (BRFSS 2006)
- 45th in child obesity (BRFSS 2006)
- 43th in diabetes (BRFSS 2006)

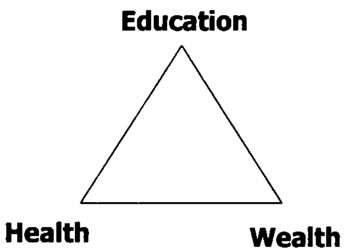
"Making North Carolina the Healthiest State"

Health Disparities: Major Cause of Poor Health Outcomes



Racial and Ethnic Health Disparities in NC. Report Card, 2006. NC DHHS.

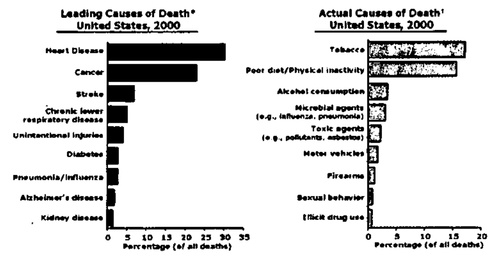
North Carolina Public Health



"Making North Carolina the Healthiest State"

North Carolina Public Health

The Real Threats to our Health



North Carolina Public Health

Major Health Risks:

Tobacco

"Making North Carolina the Healthiest State"

North Carolina Public Health

Major Health Risks:

Obesity

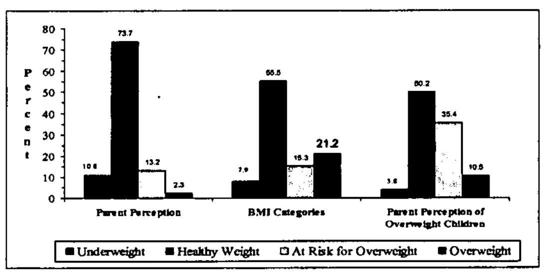
"Making North Carolina the Healthiest State"

1 in 5 N.C. kids overweight

State is 5th-worst in U.S., nationwide obesity study says

North Carolina Public Health

*Parent Perception of Child Weights**



*Agreement (KAPPA Statistics) was 0.32 between calculated BMI categories and parent classification.

Obesity Trends* Among U.S. Adults BRFSS, 1990, 1998, 2006

(*BMI ≥30, or about 30 lbs. overweight for 5'4" person)

http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/

"Making North Carolina the Healthiest State"

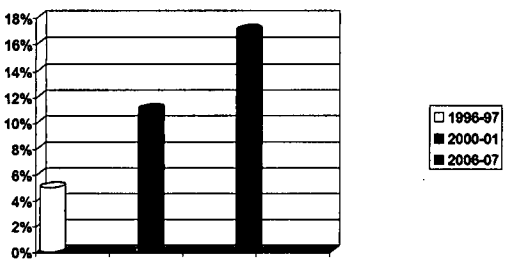
Outstanding Health Ranking –At Risk!

Vaccine Preventable Illness

"Making North Carolina the Healthiest State"

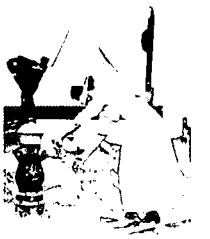
Health of School Age Children

Percent of Students with Chronic Health Conditions Across The Decade



"Making North Carolina the Healthiest State"

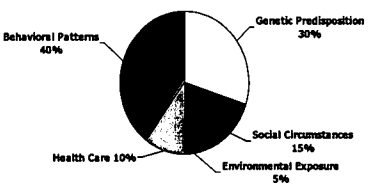
Public Health Preparedness



"Making North Carolina the Healthiest State"

A Solution: Investing in Prevention

- Nationally and in NC the health care system is imbalanced
- Health is influenced by factors in five domains



Determinants of Health and their Contribution to Premature Death- Adapted from McGinnis et al 2002
(As adapted from J. Nick Baird, MD Oct. 2007)

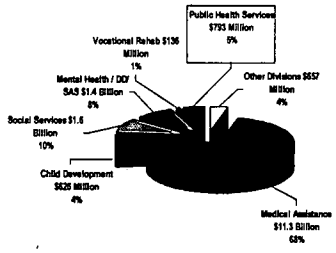
Why Focus on Prevention?

	North Carolina	Per Employee	Per Resident
Tobacco Use	$4.75 billion	$1,051	$536
Nutrition, Overweight and Obesity	$12.1 billion	$2,676	$1,366
Physical Inactivity	$8.970 billion	$1,984	$1,013
TOTAL	$25.82 billion ✓ Annually	$5,711	$2,915

(NC Prevention Partners, Prevention Report Card 2008)

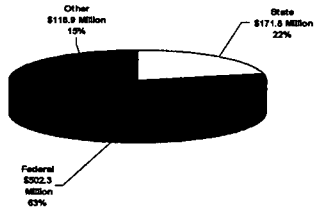
"Making North Carolina the Healthiest State"

State Spending on Health Services
DHHS Total Budget by Division 2006-2007 as of 06/29/07



"Making North Carolina the Healthiest State"

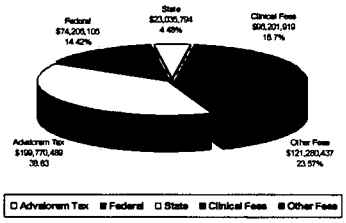
DPH Source of Funds 2006-2007



78% of the DPH budget comes from federal and other sources, 22% from the state

"Making North Carolina the Healthiest State"

Local Investment in Public Health



"Working for a healthier and safer North Carolina"

NC Public Health Mission

Our Mission -
"To promote and contribute to the highest possible level of health for the people of North Carolina."

"Making North Carolina the Healthiest State"

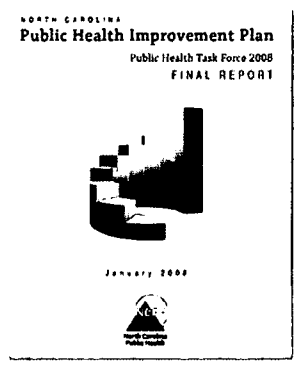
NC Public Health Goals

Improve health outcomes

Eliminate health disparities

"Making North Carolina the Healthiest State"

Partnerships



Lead Collaborative Efforts to Target Priorities that Measurably Improve the Health of North Carolinians

- Foster Focused Health Improvement Initiatives
- Create Unified Health Advocacy
- Strengthen North Carolina's Health Infrastructure
- Build Effective State and Local Collaboration

Critical Partnerships: Hospitals & Public Health Partnership

"Making North Carolina the Healthiest State"

Critical Health Partnerships

North Carolina Medical Society

North Carolina Institute for Public Health

NCIPH
THE NORTH CAROLINA INSTITUTE FOR PUBLIC HEALTH

"Making North Carolina the Healthiest State"

NC Public Health Priorities

Restoring Public Health Infrastructure:

Ten Essential Services

"Making North Carolina the Healthiest State"

NC Public Health Priorities

Reducing Obesity In children ~~by~~ to 10% by 2015

"Making North Carolina the Healthiest State"

Building School Health Services

school nurse is the leader.

School Nurse Ratio 1:750 by 2015

Approximately 1,200 school nurses statewide in 2007. Most funded by LHDs, LEAs, Hospitals, and local alliances.

Total of 311 funded by the General Assembly.

2007-2008 SN:Student Ratio is 1:1,280.

NC Public Health Priorities

Immunizations: Universal Vaccines for Children

"Making North Carolina the Healthiest State"

NC Public Health Priorities

Assuring Preparedness: Capturing our volunteer capacity!

"Making North Carolina the Healthiest State"

North Carolina Public Health

"We are all protected or we are all at risk."

Crosscutting issue – Eliminating Health Disparities

"Making North Carolina the Healthiest State"

NC Public Health Priorities

- ***Ten Public Health Essential Services***
- ***Obesity***
- ***School Health***
- ***Immunization***
- ***Public Health Preparedness***

"Making North Carolina the Healthiest State"

North Carolina Public Health Study Commission 2008

North Carolina the healthiest state!

By 2020

"Making North Carolina the Healthiest State"

Attachment ✓

Highlights of Public Health priorities

Chronic Disease Prevention
Dr. Marcus Plescia, DPH

"Working for a healthier and safer North Carolina"

Needs Identified
Chronic Disease Prevention

Proposed Focus Areas:

- Obesity and tobacco control
- Support chronic disease management
- Support public health surveillance
- Expand statewide dental health services

"Working for a healthier and safer North Carolina"

Needs Identified
Chronic Disease Prevention

Proposed Focus Areas:

Recommendations and Materials
- NC Burden of Obesity Report
- NC IOM Health Literacy task force recommendations
- NC IOM Chronic Kidney Disease task force recommendations
- JWTF Stroke Advisory Council recommendations


"Working for a healthier and safer North Carolina"

Needs Identified
Chronic Disease Prevention

Proposed Focus Areas:

Evidence and Best Practices
- Guide to Community Preventive Services
- Centers for Disease Control demonstration projects
- US Surgeon General Reports
- Institute of Medicine Reports



"Working for a healthier and safer North Carolina"

Chronic Disease - Recommendations

Reduce Obesity – Fund and Support Local Health Departments, local Healthy Carolinians Partnerships, and other community coalitions to implement "Eat Smart and Move More", NC's plan to prevent overweight, obesity, and related chronic diseases.
($10 million)

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Chronic Disease - Recommendations

Reduce Obesity –
- Community Demonstration Projects
- Statewide campaigns
- Support local coalitions
- Implement and enforce aggressive policy change

"Working for a healthier and safer North Carolina"

Chronic Disease - Recommendations

NC Tobacco Cessation Quit Line
($1.5 million)

- Needs-based
- Evidence-based
- Customer-oriented
- Cost Effective

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Chronic Disease - Recommendations

Improve Critical Health Surveillance and Accountability -
Expand and improve data collection, analysis and dissemination to better measure health threats, establish priorities, and secure additional federal funding to guide resource allocation at the state and local level.
($3.6 million)

"Working for a healthier and safer North Carolina"

Chronic Disease - Recommendations

Improve Critical Health Surveillance and Accountability –

- **Expand Surveillance Systems for Child Health and Cancer**
- **Improved race and ethnicity data collection by all health care providers**
- **Support community health assessment**
- **Public Health Informatics training**
- **Authority to govern critical eHealth initiatives**

"Working for a healthier and safer North Carolina"

Chronic Disease - Recommendations

Reduce the Leading Causes of Death –
Expand patient self-management of the risk factors associated with cancer, heart disease, stroke and asthma including high blood pressure, high cholesterol, diabetes and tobacco cessation across the State.
($5.2 million)

"Working for a healthier and safer North Carolina"

Chronic Disease - Recommendations

Reduce the Leading Causes of Death –
Resources:

- Diabetes, Hypertension/Chronic Kidney Disease
- Health literacy/Stroke Advisory Council
- Tobacco Quit Line

Substantive Legislation:

- Smoke-free worksites.
- Passenger safety in pick-up trucks.
- Unintentional drug overdoses.

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Highlights of Public Health Priorities

Communicable Disease and Preparedness
Dr. Jeff Engel, DPH

"Working for a healthier and safer North Carolina"

Needs Identified: *Communicable Disease and Preparedness*

The State Medical Examiner System
- Professionalization and regionalization
- Infrastructure support, training, electronic reporting

Local Epidemiology Teams
- Environmental health specialist
- Old and new demands (mandated activities and response to new threats)

The AIDS Drug Assistance Program

Substantive Legislation: Volunteer emergency responders

"Working for a healthier and safer North Carolina"

Communicable Disease and Preparedness - Recommendations

Reinvest in the NC Medical Examiner System –
Fully implement the strategic plan to modernize and professionalize the NC Medical Examiner System through regionalization of facilities and personnel.
($11.2 million for 2 new facilities - $1.6 million for operating)

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Communicable Disease and Preparedness - Recommendations

Shore up Local Epi Teams- $5.7 million

Increasing environmental health threats require local capacity to respond:

$5 million recurring for 100 new environmental health specialists in LHDs

$700,000 recurring to DENR for regional response and training

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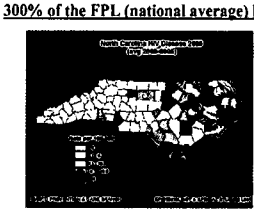
Communicable Disease and Preparedness – Recommendations

Raise eligibility for the AIDS Drug Assistance Program (ADAP) up to 300% of the FPL (national average) based on availability of funds.



- 2000 newly diagnosed/year
- 30,000 living with HIV

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Communicable Disease and Preparedness – Recommendations

Legislation to improve Public Health Preparedness and Response-

- The Uniform Emergency Volunteer Health Practitioners Act which renders immunity for out-of-state health practitioners volunteering during a declared state of emergency.
- An Act to Provide Liability Protection for Private Associations, Corporations and Non-Profit Entities and Organizations when Responding to In-State Incidents.

Make A Plan
Build A Kit
Be Involved
ReadyNC.org

North Carolina Public Health PREPAREDNESS & RESPONSE
PHP&R

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Highlights of Public Health priorities

Healthy Families
Dr. Kevin Ryan, DPH

"Working for a healthier and safer North Carolina"

Committee on Healthy Families

"Children are 20% of our population, but they are 100% of our future."

Action for Children

"Working for a healthier and safer North Carolina"

Committee on Healthy Families

Healthy Families Priorities

- Every Child Succeeds
  - School Nurse Focus
- Universal Vaccinations
- Improving Birth Outcomes
- Expand Statewide Dental Health Services

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Healthy Families – Needs Identified

- **Every Child Succeeds/School Age Children**
  - Good health a key to academic success
  - Improve the school nurse:student ratio to 1:750
  - Pursue coordinated school health approach

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Healthy Families – Needs Identified

- **Every Child Succeeds/School Age Children**
  - Unhealthy habits that lead to chronic diseases often established in childhood
  - Coordinated SH programs prepare students for lifetime of healthy choices
  - Rigorous studies show that SH programs can reduce risky behaviors in school kids (CDC)

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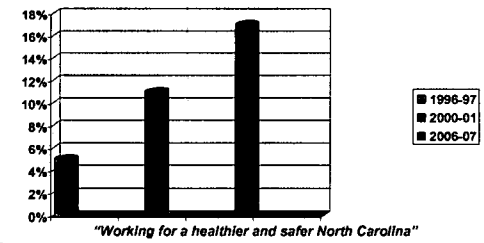
Healthy Families – Needs Identified

Percent of Students with Chronic Health Conditions Across The Decade



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Healthy Families – Needs Identified

1. **Every Child Succeeds**
   - Science of early childhood
   - Opportunity for lasting impact
   - A critical investment in our future

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Healthy Families – Needs Identified

- **Universal Vaccinations**

"Vaccinations are one of the top 10 greatest public health achievements of the 20th century." - CDC

- Immunizations are among the most cost-effective activities engaged in by government.
- Savings up to $15 for each $1 spent (CDC)
- Universal provision of vaccine is a cost-saving investment

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Healthy Families – Needs Identified

Big Effects: Pre-1990 Vaccines

Disease	20th Century Estimated Annual Morbidity †	2004 Reported Cases ††
Smallpox	29,005	0
Diphtheria	21,053	0
Measles	4,000,000	37
Mumps	162,344	258
Pertussis	200,752	25,827
Polio (paralytic)	16,316	0
Rubella	47,745	10
Congenital Rubella Syndrome	152	0
Tetanus	580	34

† Unpublished CDC data, reported December 2005

††CDC. *MMWR* August 12, 2005. 54(31); 770 and CDC. *MMWR* December 2, 2005. 54(47);1214

Healthy Families – Needs Identified

3. **Birth Outcomes**
   - Infant mortality rate 8.1 per 1,000 live births
   - Lowest in state history
   - Still 2.3x greater risk of death for minority babies
   - No silver bullet available

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Healthy Families – Needs Identified

4. Expand children's dental health services

- 40% kindergarteners have already had tooth decay
- Status of baby teeth best predictor of permanent teeth
- Improve PH Dental Hygienist:K-5 student ratio to 1:7000
  - Expand prevention & education services
  - Improve dental surveillance & referral
  - Increase preschool preventive dental services

NC Children Cavity-Free Forever

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Healthy Families - Recommendations

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Healthy Families - Recommendations

1. **Every Child Succeeds/School Age Children**

Core Recommendations

- Increase the SN:student ratio to 1:750 statewide within 5 years

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Healthy Families - Recommendations

1. Every Child Succeeds/School Age Children
Related Recommendations

- Require schools to provide medically accurate comprehensive sexuality education to all.
- Increase the capacity of school-based and school-linked health centers. (total $1,085,000)
- Expand the statewide dental prevention and education program for high risk children to reach a ratio of public health dental hygienist to elementary school (K-5) student of 1:7,000 (currently 1:14,000). ($549,500)
- Establish the definition of quality physical education in NC schools.

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Healthy Families - Recommendations

1. Every Child Succeeds
Additional Recommendations

- Implement a family support system to meet family needs. ($4 million)
- Reduce Unintended Teen Pregnancies using evidence-based strategies. ($1,828,000)
- Enact a felony child endangerment law.
- Ban corporal punishment in schools.
- Explore innovative strategies to support the social and emotional wellbeing of children.

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Healthy Families - Recommendations

2. Universal Vaccination

- Key driver of North Carolina's immunization rates
- Immunizations are among the most cost-effective activities engaged in by government.
- Savings up to $15 for each $1 spent (CDC)
- All children are treated equally, regardless of parents' level of insurance coverage or ability to pay

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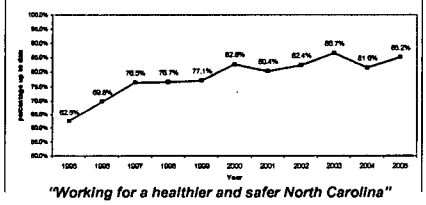
Healthy Families - Recommendations

North Carolina's Proud Record on Immunizations



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Healthy Families - Recommendations

Facing a New Challenge

Excellent new vaccines are available, but they are very costly.

"Working for a healthier and safer North Carolina"

Healthy Families - Recommendations

2. Universal Vaccination

- Pneumococcal Vaccine
- Flu Vaccine
- Rotavirus Vaccine
- HPV Vaccine
- Meningococcal Vaccine

approx. $27 million

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Healthy Families - Recommendations

What better legacy than to ensure the protection of all North Carolina's children from vaccine-preventable diseases?



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Healthy Families - Recommendations

3. Improve birth outcomes and early childhood health

- Expand the use of 17-P ($97,000)
- Cystic Fibrosis newborn screening ($160,000/$767,000)
- SIDS reduction ($250,000)

"Working for a healthier and safer North Carolina"

Healthy Families - Recommendations

3. Improve birth outcomes and early childhood health

- "Breastfeeding-friendly" policies
- Preschool tooth decay prevention ($767K)
- Expand Medicaid coverage for low income women
- Comprehensive plan

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Healthy Families

"Working for a healthier and safer North Carolina"

Highlights of Public Health priorities

Core Public Health & Finance
Dr. Rosie Summers, Orange County Department of Health
Dr. Steve Cline, DPH

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Core Public Health & Finance - Recommendations

Increase the capacity of Local Health Departments to provide the 10 essential public health services statewide. ($23 million)

- **Monitor the health of North Carolina citizens**
  - Expand the capacity for Community Health Assessment at the local level. $4,675,000
- **Identify and investigate health problems in the community**
  - Nurse epidemiologists for investigation, community follow-up and training $5,525,000

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Core Public Health & Finance - Recommendations

- **Develop policies and plans that support health programs**
  - Pilot funds to influence the built environment to support behavior changes. $10,000,000
- **Enforce laws & regulations that protect health and safety**
  - Administer and enforce food safety laws & regulations to prevent outbreaks and to assure response after an environmental release $5,600,000

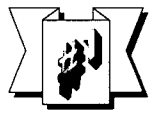
Core Public Health & Finance - Recommendations

- **Connect NC citizens to needed health services**
  - Fund local health departments and other safety net providers to support the provision of medical and dental care to low income children and families ineligible for Medicaid or Health Choice $15,300,000
- **Measure the effectiveness & quality of health services**
  - Increase the number of trained evaluators/quality improvement local staff to manage the quality improvement process $8,850,000
- **Inform and educate NC citizens about health issues**
  - Local media marketing for important health issues such as diabetes prevention, tobacco use, physical activity $6,375,000

Core Public Health & Finance - Recommendations

Local Health Department Accreditation –

Maintain the highly successful local public health accreditation program through ongoing re-accreditation cycles. ($200,000)



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Core Public Health & Finance - Recommendations

Assure the ability to recruit and retain an adequately trained public health workforce.
($1 million)

- Exempt state and local public health retirees from the requirement to wait six months before they are eligible to return to work full time without negatively impacting their retirement benefits.
- Establish public health loan repayment programs to attract qualified professionals into the field of Public Health. ($1 million)

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Core Public Health & Finance - Recommendations

Eliminate Health Disparities through cross-cutting program activities.
($5.7 million)
Increase local health department interpreter capacity to serve clients as required by Title VI.
($2.7 million)
Expand the Community Focused Eliminating Health Disparities Initiative (CFEHDI) Grants to local programs.
($3 million)
Improve the accuracy of reporting of race and ethnicity data by Medicaid providers, State Employees Health Plan, and all hospitals.
($10,000)

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Core Public Health & Finance - Recommendations

Reunite state level Public Health and Environmental Health in the Department of Environment and Natural Resources.

Sustain the current structure and governance for the local public health system as set out in the North Carolina General Statutes.

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Core Public Health & Finance - Recommendations

Opportunities for additional resources to improve essential public health programs and services.

- Increase the current tobacco excise tax to the national average of $1.09 per pack.
- Seek legislation to enable local authorities to set fees for food and lodging inspections.
- Legislatively create a permanent sustainable funding source for the Universal Vaccine Program.
- Correct the fee adjustment process for Local Health Departments and Child Development Service Agencies (CDSA).
- Adjust the newborn screening fee to support adding cystic fibrosis screening.

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Core Public Health & Finance - Recommendations

Opportunities to increase access to care through increased Medicaid reimbursement to providers.

- Establish the ***Medicaid*** reimbursement for vaccine administration for local health departments at the same level as for private providers.

- Increase ***Medicaid*** reimbursement rates for dental services to 80% of the national standard to increase access to dental care. ($40 million State share)

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NC Public Health Priorities

Ten Public Health Essential Services

Obesity

School Health

Immunization

Public Health Preparedness

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North Carolina Public Health

Highlights of Public Health priorities

Chronic Disease Prevention

Dr. Marcus Plescia, DPH

- *"Working for a healthier and safer North Carolina"*

North Carolina Public Health

Needs Identified
Chronic Disease Prevention

Proposed Focus Areas:

- Obesity and tobacco control
- Support chronic disease management
- Support public health surveillance
- Expand statewide dental health services

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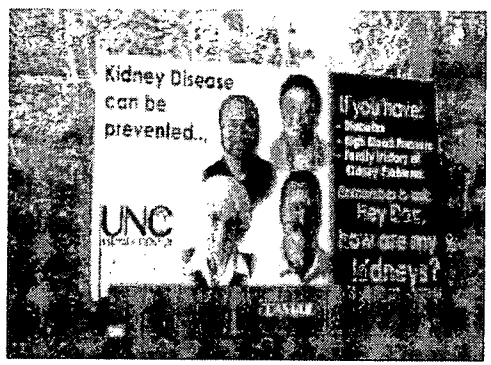
North Carolina Public Health

Needs Identified
Chronic Disease Prevention

Proposed Focus Areas:

Recommendations and Materials

- NC Burden of Obesity Report
- NC IOM Health Literacy task force recommendations
- NC IOM Chronic Kidney Disease task force recommendations
- JWTF Stroke Advisory Council recommendations



Start With Your Heart

NEW STROKE ADVISORY COUNCIL

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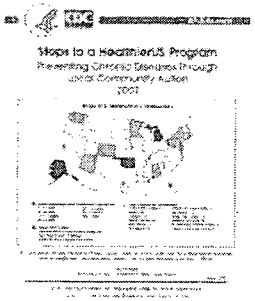
North Carolina Public Health

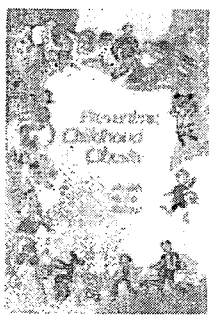
Needs Identified
Chronic Disease Prevention

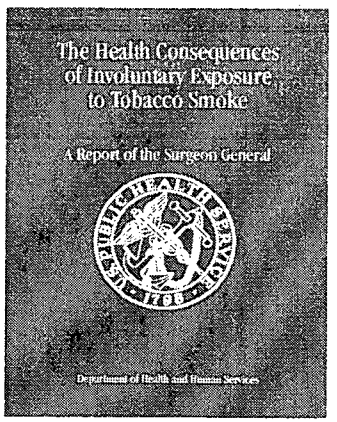
Proposed Focus Areas:

Evidence and Best Practices

- Guide to Community Preventive Services
- Centers for Disease Control demonstration projects
- US Surgeon General Reports
- Institute of Medicine Reports







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North Carolina Public Health

Chronic Disease - Recommendations

Reduce Obesity – Fund and Support Local Health Departments, local Healthy Carolinians Partnerships, and other community coalitions to implement "Eat Smart and Move More", NC's plan to prevent overweight, obesity, and related chronic diseases. ($10 million)

HEALTHY CAROLINIANS

Statewide Health Promotion
eat smart move more tobacco-free

Eat Smart Move More NORTH CAROLINA™

- *"Working for a healthier and safer North Carolina"*

North Carolina Public Health

Chronic Disease - Recommendations

Reduce Obesity –

- Community Demonstration Projects
- Statewide campaigns
- Support local coalitions
- Implement and enforce aggressive policy change

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"Working for a healthier and safer North Carolina"

North Carolina Public Health

Chronic Disease - Recommendations

NC Tobacco Cessation Quit Line
($1.5 million)

- Needs-based
- Evidence-based
- Customer-oriented
- Cost Effective

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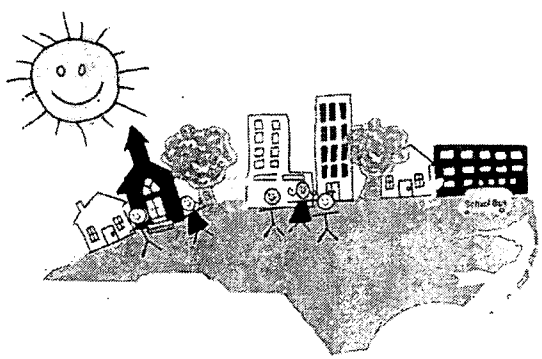
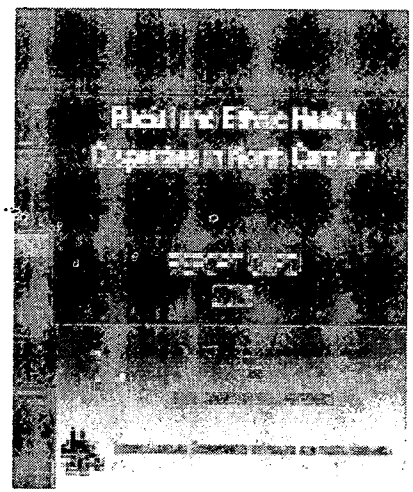
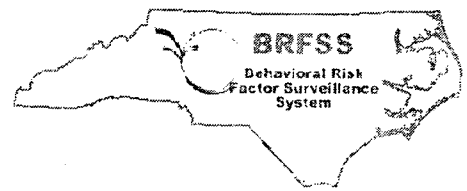
North Carolina Public Health

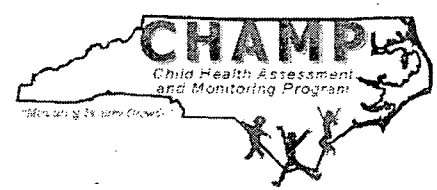
Chronic Disease - Recommendations

Improve Critical Health Surveillance and Accountability - Expand and improve data collection, analysis and dissemination to better measure health threats, establish priorities, and secure additional federal funding to guide resource allocation at the state and local level. ($3.6 million)









- *"Working for a healthier and safer North Carolina"*

North Carolina Public Health

Chronic Disease - Recommendations

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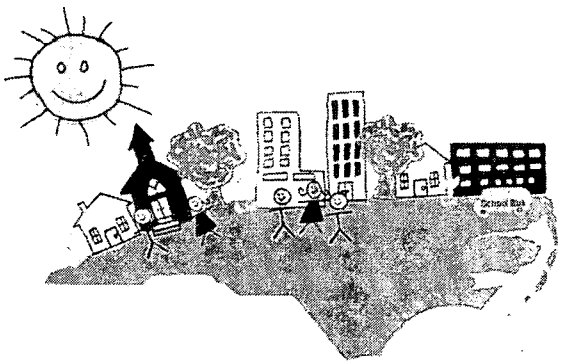

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North Carolina Public Health

Chronic Disease - Recommendations

Reduce the Leading Causes of Death –
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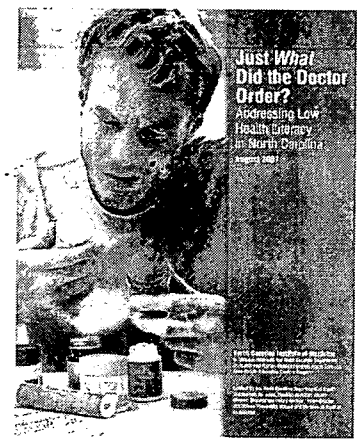
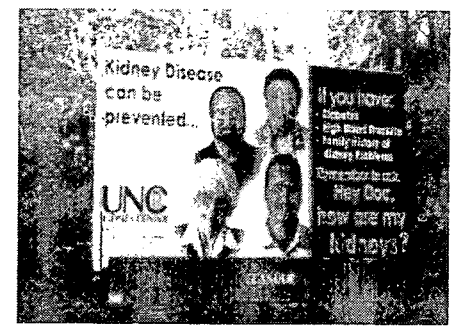
($5.2 million)

QuitlineNC.com
1-800-QUIT-NOW





- *"Working for a healthier and safer North Carolina"*

North Carolina Public Health

Chronic Disease - Recommendations

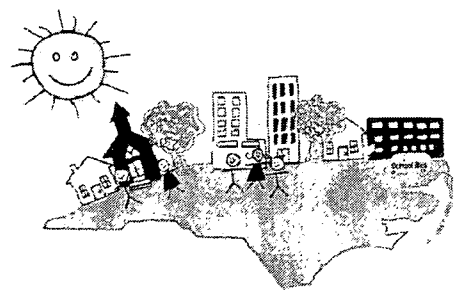
Reduce the Leading Causes of Death –

Resources:

- Diabetes, Hypertension/Chronic Kidney Disease
- Health literacy/Stroke Advisory Council
- Tobacco Quit Line

Substantive Legislation:

- Smoke-free worksites.
- Passenger safety in pick-up trucks.
- Unintentional drug overdoses.



"Working for a healthier and safer North Carolina"

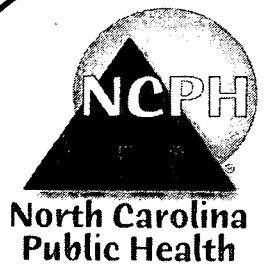
North Carolina Public Health

Highlights of Public Health Priorities

Communicable Disease and Preparedness

Dr. Jeff Engel, DPH

- *"Working for a healthier and safer North Carolina"*



Needs Identified:
Communicable Disease and Preparedness

The State Medical Examiner System

- Professionalization and regionalization
- Infrastructure support, training, electronic reporting

Local Epidemiology Teams

- Environmental health specialist
- Old and new demands (mandated activities and response to new threats)

The AIDS Drug Assistance Program

Substantive Legislation: Volunteer emergency responders

"Working for a healthier and safer North Carolina"

North Carolina Public Health

Communicable Disease and Preparedness - Recommendations

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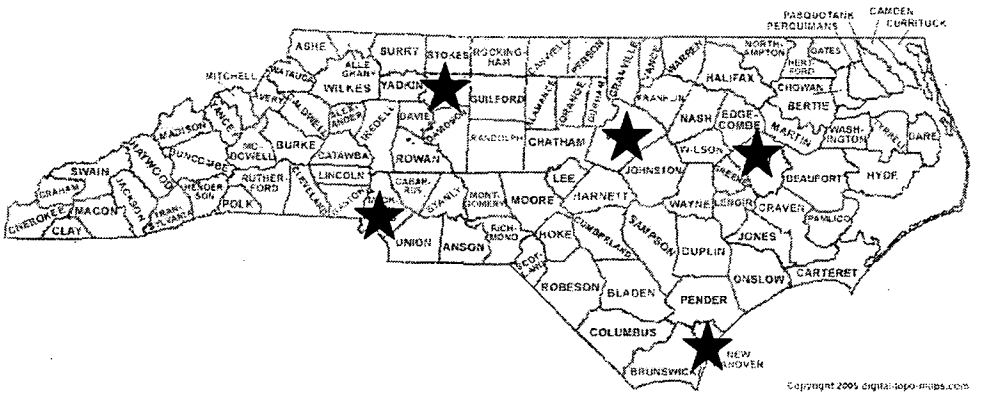
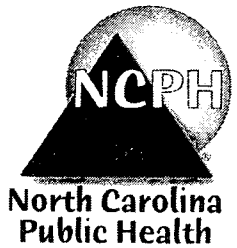


- *"Working for a healthier and safer North Carolina"*



Communicable Disease and Preparedness - Recommendations

Shore up Local Epi Teams- $5.7 million

Increasing environmental health threats require local capacity to respond:

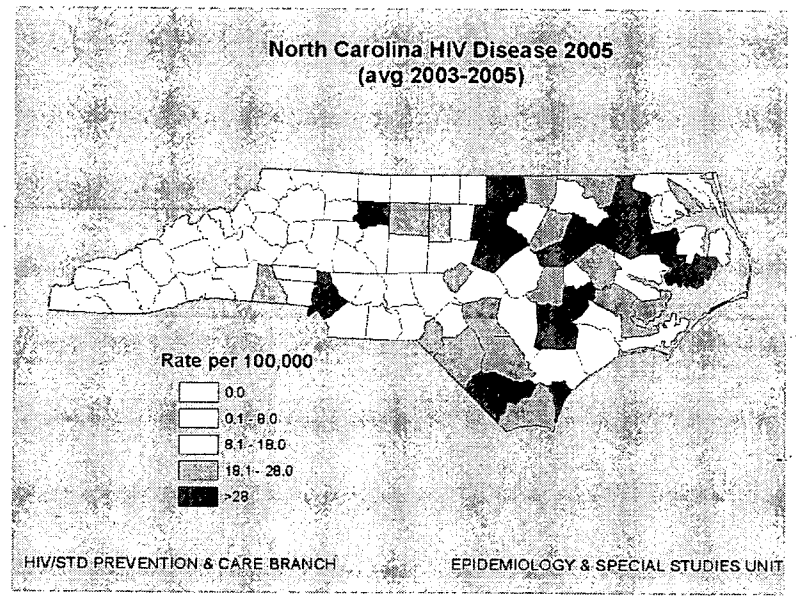
$5 million recurring for 100 new environmental health specialists in LHDs

$700,000 recurring to DENR for regional response and training

North Carolina Public Health

Communicable Disease and Preparedness – Recommendations

Raise eligibility for the AIDS Drug Assistance Program (ADAP) up to 300% of the FPL (national average) based on availability of funds.



- 2000 newly diagnosed/year
- 30,000 living with HIV

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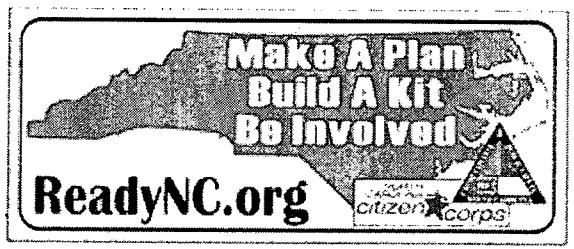
North Carolina Public Health

Communicable Disease and Preparedness – Recommendations

Legislation to improve Public Health Preparedness and Response-

- The Uniform Emergency Volunteer Health Practitioners Act which renders immunity for out-of-state health practitioners volunteering during a declared state of emergency.
- An Act to Provide Liability Protection for Private Associations, Corporations and Non-Profit Entities and Organizations when Responding to In-State Incidents.



North Carolina Public Health
PREPAREDNESS & RESPONSE
PHP&R

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North Carolina Public Health

Highlights of Public Health priorities

Healthy Families

Dr. Kevin Ryan, DPH

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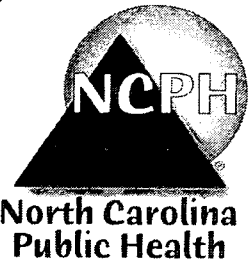
North Carolina Public Health

Committee on Healthy Families

"Children are 20% of our population, but they are 100% of our future."

Action for Children

"Working for a healthier and safer North Carolina"



Committee on Healthy Families

Healthy Families Priorities

1. Every Child Succeeds
   School Nurse Focus
2. Universal Vaccinations
3. Improving Birth Outcomes
4. Expand Statewide Dental Health Services

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North Carolina Public Health

Healthy Families – Needs Identified

1. Every Child Succeeds/School Age Children

- Good health a key to academic success
- Improve the school nurse:student ratio to 1:750
- Pursue coordinated school health approach

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North Carolina Public Health

Healthy Families – Needs Identified

1. Every Child Succeeds/School Age Children

- Unhealthy habits that lead to chronic diseases often established in childhood
- Coordinated SH programs prepare students for lifetime of healthy choices
- Rigorous studies show that SH programs can reduce risky behaviors in school kids (CDC)

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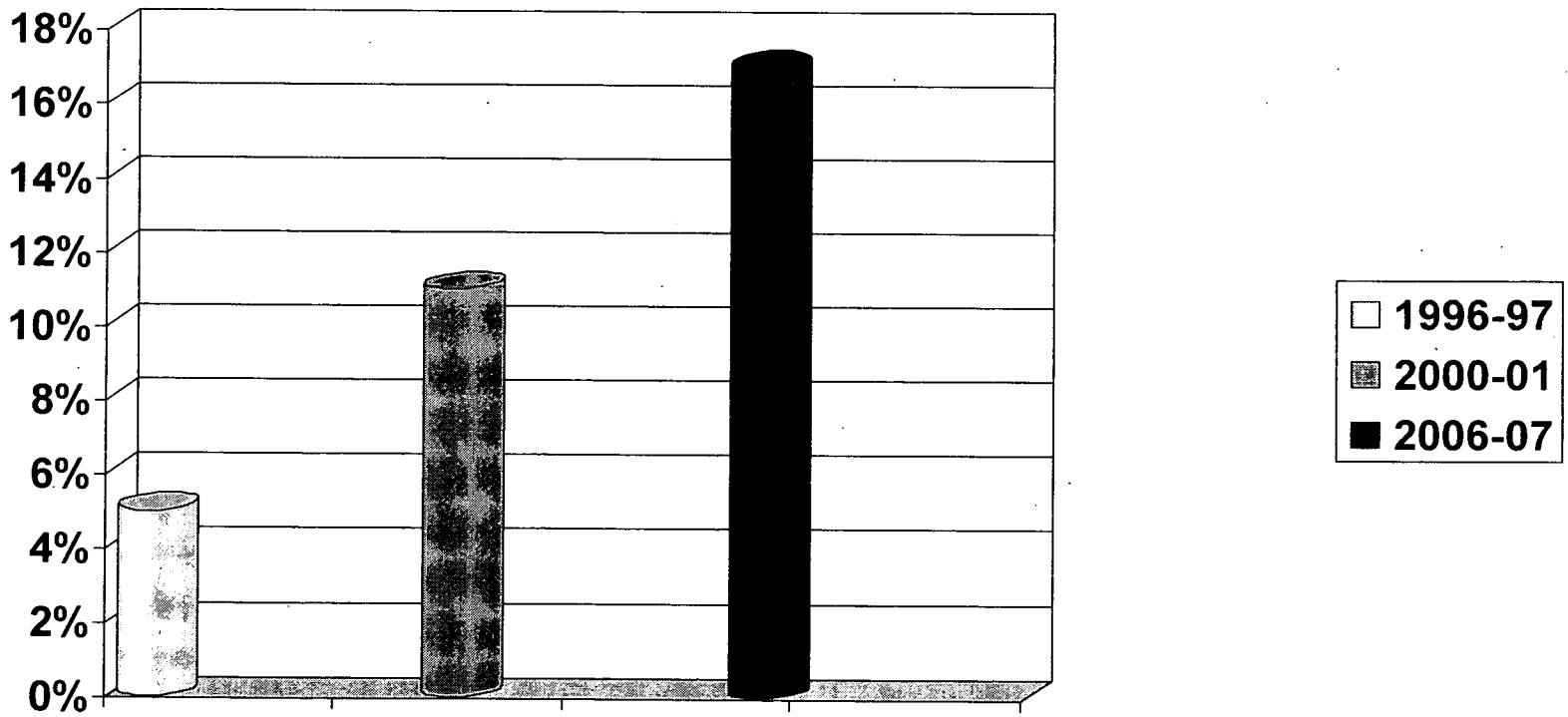
North Carolina Public Health

Healthy Families – Needs Identified

Percent of Students with Chronic Health Conditions Across The Decade



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North Carolina Public Health

Healthy Families – Needs Identified

1. **Every Child Succeeds**
   - Science of early childhood
   - Opportunity for lasting impact
   - A critical investment in our future

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North Carolina Public Health

Healthy Families – Needs Identified

2. Universal Vaccinations

"Vaccinations are one of the top 10 greatest public health achievements of the 20th century." - CDC

- Immunizations are among the most cost-effective activities engaged in by government.
- Savings up to $15 for each $1 spent (CDC)
- Universal provision of vaccine is a cost-saving investment

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North Carolina Public Health

Healthy Families – Needs Identified

Big Effects: Pre-1990 Vaccines

Disease	20th Century Estimated Annual Morbidity †	2004 Reported Cases ††
Smallpox	29,005	0
Diphtheria	21,053	0
Measles	4,000,000	37
Mumps	162,344	258
Pertussis	200,752	25,827
Polio (paralytic)	16,316	0
Rubella	47,745	10
Congenital Rubella Syndrome	152	0
Tetanus	580	34

† **Unpublished CDC data, reported December 2005**

††**CDC. *MMWR* August 12, 2005. 54(31); 770 and CDC. *MMWR* December 2, 2005. 54(47);1214**

North Carolina Public Health

Healthy Families – Needs Identified

3. **Birth Outcomes**
   - Infant mortality rate 8.1 per 1,000 live births
   - Lowest in state history
   - Still 2.3x greater risk of death for minority babies
   - No silver bullet available

North Carolina Public Health

Healthy Families – Needs Identified

4. Expand children's dental health services

- 40% kindergarteners have already had tooth decay
- Status of baby teeth best predictor of permanent teeth
- Improve PH Dental Hygienist:K-5 student ratio to 1:7000
  - Expand prevention & education services
  - Improve dental surveillance & referral
  - Increase preschool preventive dental services

NC Children Cavity-Free Forever

NC Oral Health Section

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North Carolina Public Health

Healthy Families - Recommendations

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North Carolina Public Health

Healthy Families - Recommendations

1. Every Child Succeeds/School Age Children

Core Recommendations

- Increase the SN:student ratio to 1:750 statewide within 5 years

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NCPH
North Carolina Public Health

Healthy Families - Recommendations

1. Every Child Succeeds/School Age Children Related Recommendations

- Require schools to provide medically accurate comprehensive sexuality education to all.
- Increase the capacity of school-based and school-linked health centers. (total $1,085,000)
- Expand the statewide dental prevention and education program for high risk children to reach a ratio of public health dental hygienist to elementary school (K-5) student of 1:7,000 (currently 1:14,000). ($549,500)
- Establish the definition of quality physical education in NC schools.

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North Carolina Public Health

Healthy Families - Recommendations

1. Every Child Succeeds
Additional Recommendations

- Implement a family support system to meet family needs. ($4 million)
- Reduce Unintended Teen Pregnancies using evidence-based strategies. ($1,828,000)
- Enact a felony child endangerment law.
- Ban corporal punishment in schools.
- Explore innovative strategies to support the social and emotional wellbeing of children.

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North Carolina Public Health

Healthy Families - Recommendations

2. Universal Vaccination

- Key driver of North Carolina's immunization rates
- Immunizations are among the most cost-effective activities engaged in by government.
- Savings up to $15 for each $1 spent (CDC)
- All children are treated equally, regardless of parents' level of insurance coverage or ability to pay

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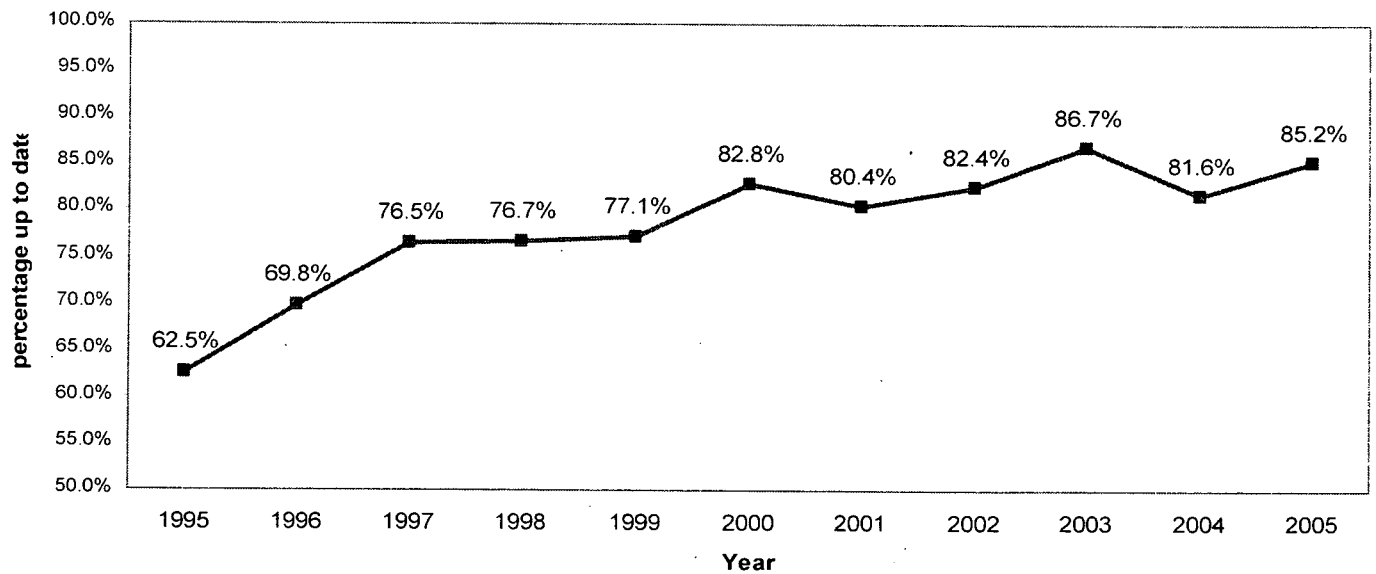
North Carolina Public Health

Healthy Families - Recommendations

North Carolina's Proud Record on Immunizations

North Carolina's Estimated Vaccination Coverage with the Selected Vaccination Series
4:3:1:3:3*
U.S., National Immunization Survey, 1995-2005



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North Carolina Public Health

Healthy Families - Recommendations

Facing a New Challenge

Excellent new vaccines are available, but they are very costly.

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North Carolina Public Health

Healthy Families - Recommendations

2. Universal Vaccination

- Pneumococcal Vaccine
- Flu Vaccine
- Rotavirus Vaccine
- HPV Vaccine
- Meningococcal Vaccine

approx. $27 million

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NCPH
North Carolina Public Health

Healthy Families - Recommendations

What better legacy than to ensure the protection of all North Carolina's children from vaccine-preventable diseases?

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North Carolina Public Health

Healthy Families - Recommendations

3. Improve birth outcomes and early childhood health

- Expand the use of 17-P ($97,000)
- Cystic Fibrosis newborn screening ($160,000/$767,000)
- SIDS reduction ($250,000)

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North Carolina Public Health

Healthy Families - Recommendations

3. Improve birth outcomes and early childhood health

- "Breastfeeding-friendly" policies
- Preschool tooth decay prevention ($767K)
- Expand Medicaid coverage for low income women
- Comprehensive plan

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North Carolina Public Health

Healthy Families

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North Carolina Public Health

Highlights of Public Health priorities

Core Public Health & Finance

Dr. Rosie Summers, Orange County Department of Health
Dr. Steve Cline, DPH

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North Carolina Public Health

Core Public Health & Finance - Recommendations

Increase the capacity of Local Health Departments to provide the 10 essential public health services statewide. ($23 million)

- **Monitor the health of North Carolina citizens**
  - Expand the capacity for Community Health Assessment at the local level. $4,675,000
- **Identify and investigate health problems in the community**
  - Nurse epidemiologists for investigation, community follow-up and training $5,525,000

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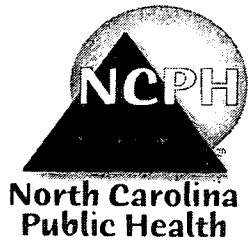
North Carolina Public Health

Core Public Health & Finance - Recommendations

- **Develop policies and plans that support health programs**
  - Pilot funds to influence the built environment to support behavior changes. $10,000,000
- **Enforce laws & regulations that protect health and safety**
  - Administer and enforce food safety laws & regulations to prevent outbreaks and to assure response after an environmental release $5,600,000



Core Public Health & Finance - Recommendations

- **Connect NC citizens to needed health services**
  - Fund local health departments and other safety net providers to support the provision of medical and dental care to low income children and families ineligible for Medicaid or Health Choice $15,300,000

- **Measure the effectiveness & quality of health services**
  - Increase the number of trained evaluators/quality improvement local staff to manage the quality improvement process $8,850,000

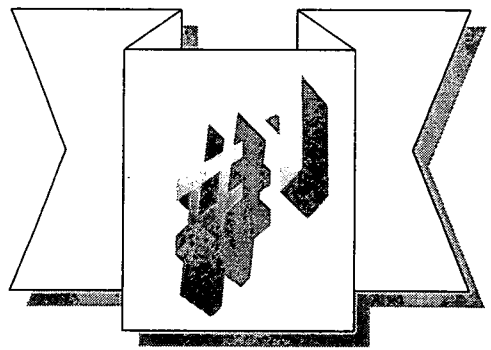
- **Inform and educate NC citizens about health issues**
  - Local media marketing for important health issues such as diabetes prevention, tobacco use, physical activity $6,375,000

North Carolina Public Health

Core Public Health & Finance - Recommendations

Local Health Department Accreditation –

Maintain the highly successful local public health accreditation program through ongoing re-accreditation cycles. ($200,000)



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North Carolina Public Health

Core Public Health & Finance - Recommendations

Assure the ability to recruit and retain an adequately trained public health workforce.
($1 million)

- Exempt state and local public health retirees from the requirement to wait six months before they are eligible to return to work full time without negatively impacting their retirement benefits.

- Establish public health loan repayment programs to attract qualified professionals into the field of Public Health.
  ($1 million)

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North Carolina Public Health

Core Public Health & Finance - Recommendations

Eliminate Health Disparities through cross-cutting program activities. ($5.7 million)

Increase local health department interpreter capacity to serve clients as required by Title VI.
($2.7 million)

Expand the Community Focused Eliminating Health Disparities Initiative (CFEHDI) Grants to local programs.
($3 million)

Improve the accuracy of reporting of race and ethnicity data by Medicaid providers, State Employees Health Plan, and all hospitals.
($10,000)

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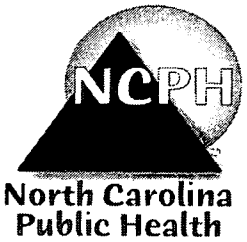
North Carolina Public Health

Core Public Health & Finance - Recommendations

Reunite state level Public Health and Environmental Health in the Department of Environment and Natural Resources.

Sustain the current structure and governance for the local public health system as set out in the North Carolina General Statutes.

- ***"Working for a healthier and safer North Carolina"***



Core Public Health & Finance - Recommendations

Opportunities for additional resources to improve essential public health programs and services.

- Increase the current tobacco excise tax to the national average of $1.09 per pack.
- Seek legislation to enable local authorities to set fees for food and lodging inspections.
- Legislatively create a permanent sustainable funding source for the Universal Vaccine Program.
- Correct the fee adjustment process for Local Health Departments and Child Development Service Agencies (CDSA).
- Adjust the newborn screening fee to support adding cystic fibrosis screening.

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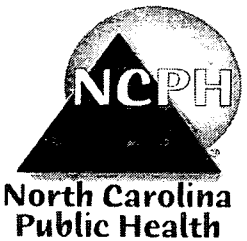
North Carolina Public Health

Core Public Health & Finance - Recommendations

Opportunities to increase access to care through increased Medicaid reimbursement to providers.

- Establish the ***Medicaid*** reimbursement for vaccine administration for local health departments at the same level as for private providers.

- Increase ***Medicaid*** reimbursement rates for dental services to 80% of the national standard to increase access to dental care. ($40 million State share)



NC Public Health Priorities

- *Ten Public Health Essential Services*
- *Obesity*
- *School Health*
- *Immunization*
- *Public Health Preparedness*

  - *"Working for a healthier and safer North Carolina"*

Att. VII

Environmental Health Specialists (EHS) Expansion Proposal
Public Health Study Commission, February 26, 2008

Jeffrey Engel, M.D., State Epidemiologist, NC DPH
Jeffrey.engel@ncmail.net

The Sanitarian (EHS): An Essential Member of the Epi Team

Mandated Activities of County EHS

1. Food Safety & Protection
2. Dairy Protection
3. Children's Environmental Health
4. Childhood Lead Poisoning Prevention
5. Wastewater Treatment
6. Private Wells Program
7. Institutional Sanitation
8. Public Swimming Pools

New Tasks of EHS

1. Changing population: new cultures, new foods, new venues
2. Emerging food pathogens (*E. coli*, *Listeria,* Norovirus)
3. Public Health Emergencies
   a. Food product recalls (Castleberry's botulism contamination, Peter Pan peanut butter *Salmonella* contamination)
   b. Hazardous waste and materials (methamphetamine lab clean-up, EQ fire in Apex, stump dump fire in Johnston County, statewide emergency response plan and training for environmental disasters)

Session Law 2007-107
AN ACT TO IMPROVE THE OVERSIGHT OF HAZARDOUS WASTE FACILITIES, AS RECOMMENDED BY THE GOVERNOR'S HAZARDOUS MATERIALS TASK FORCE.

NORTH CAROLINA GENERAL ASSEMBLY

Public Health Study Commission

MEMORANDUM

TO: Members, Public Health Study Commission

FROM: Senator William Purcell, Co-Chair
Representative Bob England, Co-Chair

SUBJECT: Meeting Notice

The Public Health Study Commission will meet on the following date:

DAY:	Tuesday
DATE:	March 25, 2008
TIME:	10:00 a.m.
LOCATION:	Room 544, LOB

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. The cost for visitor parking is $1.00 per hour or $8.00 per day and may be reimbursed with a parking receipt submitted with your travel reimbursement form.

If you have any questions concerning this meeting, please contact Lorraine Blake at 919-733-5953 or Lisa Brown at 919-733-5749.

2008

PUBLIC HEALTH STUDY COMMISSION

MINUTES

Agenda

Public Health Study Commission

Tuesday, March 25, 2008
10:00 a.m. – 1:00 p.m.
Room 544, LOB

I. Welcome and Introductions
Representative Bob England, Co-Chair
Senator Bill Purcell, Co-Chair

II. Obesity
Bill Pulley, North Carolina Hospital Association
Colleen Bridger, Director, Gaston County Health Department

III. Essential Public Health Services
Merle Green, Director, Guilford County Health Department
Dennis Harrington, Deputy Division Director & Chief of Administrative, Local & Community Support, Division of Public Health

IV. Preparedness

Emergency Volunteer Legislation
Gibbie Harris, Director, Wake County Health Department
Chris Hoke, Chief of Regulatory & Legal Affairs, Division of Public Health

Medical Examiner (Phase 1)
Dr. John Butts, Chief, Medical Examiner's Office, Division of Public Health
Dr. John Marrow, Director, Pitt County Health Department

V. School Nurses – Immunizations & Corporal Punishment
Tom Vitaglione, Action for Children North Carolina

VI. Quit Line
Dr. Jana Johnson, Medical Director, Tobacco Prevention & Control, Division of Public Health
Dr. Robert Monteiro, Chair, Craven County Board of Health

VII. Fluoridation, Cystic Fibrosis, AIDS Drug Assistance Program & SB 1226 – Retired Nurses Return to Work
Dr. Steve Cline, Deputy State Health Director, Division of Public Health

VIII. Discussion of Next Steps
Representative Bob England
Senator Bill Purcell

IX. Adjourn

PUBLIC HEALTH STUDY COMMISSION
MARCH 25, 2008
MINUTES

The Public Health Study Commission met on Tuesday, March 25, 2008 in Room 544 of the Legislative Office Building. Present were Cochairs Representative Bob England and Senator William Purcell. Committee members present were: Representatives Alma Adams, William Current, Verla Insko and Carolyn Justus; and Senators Bob Atwater and Katie Dorsett: public members Dr. Edward Baker, Director of the NC Institute for Public Health; Beth Lovette, Health Director Wilkes County; Ms. Anne Thomas, Health Director Dare County; Dr. Ronald Levine, former State Health Director and present member of the Commission for Public Health; and Dr. Leah Devlin, State Health Director, who is an ex-officio member of the Commission. Staff present was Ben Popkin, Shawn Parker, and Susan Barham; and Committee Assistants Lisa Brown and Becky Hedspeth.

Representative England called the meeting to order and introduced the Sergeant at Arms who would be assisting with the meeting. A welcome to the members was given by Representative England and he then stated that the Chairs had discussed the next step for the Committee which would be to work through the agenda and plan at the end to offer to adopt the full Task Force report for potential legislation.

Obesity

Representative England then recognized Mr. Bill Pulley, President of the North Carolina Hospital Association to speak before the Committee. He stated that he was asked to speak before the Committee because of an initiative that the Hospital Association and Public Health have started. The NC Hospital Association and its members are focused on health care reform and are trying to change health care in our state. One of the areas of changes in quality and patient safety is that North Carolina would have the safest hospitals in America. The other area they are focused on is community benefit which is where hospitals live by their non-profit missions. By September of this year you will be able to go into the Hospital Association web site and see every North Carolina hospitals community benefit report. Another area they have

been working on is in community health and this is where they have been collaborating with health departments and the School of Public Health in Chapel Hill.

Mr. Pulley stated that North Carolina has always ranked low among other states in terms of how healthy our state is. North Carolina is currently ranked at #34 which is the highest in his memory. With the help of a grant from the School of Public Health they have put together a strategic planning program last fall on how hospitals and public health departments could work together to improve community health. They want to build effective state and local collaborations at the community level to make sure they continue to work on their programs to improve health care.

Mr. Pulley then stated that they had identified four tracks of works that they want to work on. They created a leadership team that meets every month to find ways of working together on topics such as smoke free environments, ways to improve newborn screening, data gathering, and preparedness legislation. He stated that in North Carolina about 17% of children are obese and the national average is 15%. Their goal is to try and take that average down to 10%. The program that the State Health Department has put together includes state-wide coalition building and a public awareness campaign. There will be some funding for every county under this initiative but they are looking at six community demonstration projects and hopefully can take the successes from those and replicate them across the state.

Three years ago the North Carolina Hospital Association organized the North Carolina Center for Hospital and Patient Safety which is a clinically driven process to improve quality and patient safety in our hospitals. They put together a quality academy where they have actually been training hospital workers in how to do quality and performance improvement projects. The Hospital Association wants to work with Public Health to help break the high poverty and low education rates. The correlation between poverty, low education, and poor health is very dramatic in our state and so they are making a commitment to work with public education and also economic developers to help provide jobs to help eliminate poverty.

Representative England then recognized Senator Purcell who stated that there is a problem in schools in that the healthier foods are more expensive and so the school cafeterias cannot afford to provide them. He then asked what the Hospital Association is planning to do about childhood obesity. Mr. Pulley stated that they are discussing educating parents about the importance of good childhood nutrition. Senator Purcell stated that they all agree that prevention is much easier than treatment and he commends them for trying to prevent this problem.

Senator Dorsett was then recognized who asked which counties will be used for the community demonstration projects. Dr. Devlin was recognized who stated that the counties have not been identified at this time but that they want as much diversity as possible.

Representative England then recognized Ms. Colleen Bridger, Director of the Gaston County Health Department. She explained that two out of three people in North Carolina are overweight or obese and this issue affects us all. There are three components to the project discussed by Mr. Pulley and they are the community demonstration project, public awareness campaigns, and statewide coalition building.

Ms. Bridger stated that in dealing with community intervention you are looking at a multi-faceted approach which includes working within communities that know what their strengths are and know what their focuses need to be. When talking about the six demonstration projects they will be looking at counties that have the greatest need and capacity and from those six projects they will be able to have lessons learned that can be applied as best practices across the state. The demonstration projects are 7.5 million dollars per year with four million a year used to fund six counties for seven years.

From a local perspective, this will not be the first time that counties have been using funding to try and address the obesity epidemic. The challenge for them at the local level is that they get $20,000 which is one time funding and is for only one year which is very frustrating for them. The funding for the project is very good for them because it is significant funding over a significant period of time that allows them to not only get started with something but to be able to follow through on it and really incorporate it in the community. Specifically, the interventions that they are discussing include working with the pre-schools, elementary, middle, and high schools, as well as school menus and how they can do a better job of incorporating physical activity into the day when children are in school (Attachment 1). The concept of leading by example is very relevant when looking at work-site wellness in school systems and hospitals because they are some of the largest employers and they want to enable those large providers of jobs to be able to help with this problem. Having sidewalks, greenways, and bike trails have shown to decrease the rate of obesity in communities. Farmers market support through the project will provide better access for healthier foods for those in lower incomes. Primary health care providers support is another way of addressing the problem of obesity.

The Public Awareness Campaign will have 2.5 million dollars which comes to one dollar per child in North Carolina. The actual messages are about the seven key behaviors offered by the CDC which are:

- Move more every day
- Tame the tube
- Re-think your drink
- Prepare and eat more meals at home
- Right-size your portions
- Breastfeed your baby
- Enjoy more fruits and vegetables

Ms. Bridger stated that the target for this program is women ages 25 to 54 with a child at home and is going to be done through advertising, earned media, and social

marketing. This will not only be a statewide campaign but will also be concentrated in those six communities that have received one of the large demonstration grants. She then explained that statewide coalition building would include $50,000 for each county through the local health department and would allow them to promote policy and environmental changes for increased physical activity and healthy eating. Once they start getting the best practices from the large demonstration projects they will have coalitions ready to go and be able to disseminate them into their community. The thought is that it may be a little more finance intensive in those first six communities to determine what those best practices are but then they will be able to blanket the entire state through the coalitions.

Representative England then recognized Senator Purcell who asked Ms. Bridger how they plan to measure their outcome, will they use the body mass index or some other process. Dr. Mark Plescia of the Department of Public Health was recognized to answer. He stated that they will have a couple of different measurement systems in place; they have statewide surveys that they already do for adults and are expanding those surveys to do with children so they can collect information, not only about the parents report of the child's height and weight, but also how physically active the children are and what kinds of foods they are eating. They will also set up in the schools where the demonstration projects are a screening system for BMI.

Essential Public Health Services

Representative England then recognized Ms. Merle Green, Director of the Guilford County Health Department to speak before the Committee. Ms. Green presented a power point presentation, (Attachment 2), which highlights three major issues concerning public health. They are the unacceptable burden of dental diseases which affect oral health in children and adults, addressing access to health care for the uninsured, and school health, obesity, and chronic illness in children. An increasing percentage of children have had at least one tooth removed prior to age ten. They believe that an adequately funded health care system will prevent dental diseases in the primary teeth of children. In the Guilford County adult dental free clinic the number one procedure performed is anterior and posterior extractions.

Ms. Green stated that as part of public health assessment role they diagnose their community every two years. From the findings of this assessment Guilford County recently committed to improving access to care in their largest zip code area which boasted only one private medical practice, one adult dental clinic, and one pediatric clinic. This area has the county's highest rates of morbidity and mortality from such conditions as: heart disease, cancer, and kidney failure. They are hoping to create a private-public partnership to address the situation but their private benefactors will expect the public health institutions to contribute to the huge financial commitment this undertaking will require. Ms. Green then explained that it was essential to equip schools with professional nursing staff. With the increasing number of children with allergies, asthma, diabetes, ADHD, and obesity it is vital that public health dollars be appropriated for additional school nurses.

There being no questions for Ms. Green from Committee members, Representative England then recognized Mr. Dennis Harrington, Deputy Division Director & Chief of Administration, Local and Community Support, with the Division of Public Health, (Attachment 3). Mr. Harrington stated that Public Health needs to monitor the health of the community, identify and investigate health problems, inform and educate citizens about health issues, organize community partnerships to solve health problems, develop policy and plans to support needed health programs, enforce laws and regulations, protect the health and safety of our citizens, connect citizens to needed health services either by referral or by directly providing for them, ensure a competent health care work force, measure effectiveness and quality of health services, and identify new solutions to health problems.

Mr. Harrington explained that they have found in doing a study comparing North Carolina with 11 other states that the state direct appropriation to health departments in North Carolina was $2.61 per capita whereas the average in 11 southeastern states was $8.36. He stated that the two million additional dollars given to public health in the last session was used to add permanent staff, add contract hours in support of professional services, link people to needed health services, develop policies and plans to support established community health services, and enhance the system for communicable disease case reporting and working with the private medical community.

Mr. Harrington stated that in uncompensated care there was $9.8 million last year in only eight health departments. They need $23 million in state appropriations for local health departments in non-categorical stable funding to support the local public health system statewide so as to assure that they have 85 health departments with operational capacity. With this ongoing money each health department may use a piece of it in the next year to do a different service but the key is that it has to be stable funding with local flexibility.

Representative England asked if even though there is no defined program in the public health system for medical homes did he have any opinion as to the numbers of those who actually depend on the public health system in their locality as their medical home. Mr. Harrington explained that the last time they surveyed the health departments that were into primary care in a big way there were about 32 health departments that did this and they were also very active in the North Carolina Community Care networks.

Dr. Edward Baker was then recognized and stated that having been involved in developing the list of essential public health services he was very impressed with what North Carolina was doing now to accredit health departments with standards that are based on the ten services mentioned by Mr. Harrington. They now have 35 local health departments in this state that have been through an accreditation process which brings about an increasing awareness of the need to strengthen this local public health infrastructure.

Senator Atwater was recognized and asked when counties make proposals for homeland security monies do our local health departments ever share the funding received for preparation of those types of events. Mr. Harrington stated that there is funding for bioterrorism that goes to local health departments but unfortunately at this time they are getting ready to suffer a six million dollar cut statewide in bioterrorism money so they are scrambling to find ways to support the infrastructure that has been put in place.

Senator Atwater then asked if our Congressmen have been questioned about this matter. Dr. Devlin was recognized who explained that they do communicate regularly with leadership in Washington and had discussed this issue with them at a recent meeting.

Preparedness

Emergency Volunteer Legislation

Representative England recognized Ms. Gibbie Harris, Director of the Wake County Health Department. Ms. Harris explained that over the past few years the role of public health in preparedness has changed dramatically. Due to legislation passed in recent years they more able to deal with issues than in the past but they still have several issues that need to be dealt with. She cited the tremendous growth in Wake County and based on CDC information if they were to have to vaccinate or medicate every person in Wake County in 48 hours they estimate that there would have to be 43 sites across the county in order to have this done. If you look at the number of people needed to complete this task, the county government does not have enough staff. They have resources that smaller counties don't have but they will still not be enough to meet those needs.

Ms. Harris asked the Committee members to think about how they might be able to pull volunteers from the medical community, non-profits, and faith based organizations to help with overwhelming situations such as the case of Hurricane Katrina. The problem they are facing is liability issues for those groups which come up in these situations. There are two bills, (Attachment 4 and 5), that have been drafted for this purpose. The first has to do with extending the immunity that the North Carolina Emergency Management law provides to individuals expanding that to involve non-profits and businesses. This would allow them to engage those non-profit and business entities in helping them with overwhelming situations. They would also have the opportunity to manage that system through the language in the law.

The second bill deals with the enactment of the Uniform Emergency Volunteer Health Practitioners Act which was developed and approved by the National Conference of Commissioners. The Act allows sharing volunteers, especially health care volunteers, across states during an emergency. There are systems in place that would allow health care practitioners, nurses and physicians in particular, but also others like dentists and pharmacists to register ahead of time so if there is a need to deploy they will

automatically be allowed to go where they are needed. This law would make those volunteers available and protect the public health and safety by making sure they are licensed and that they can do the work they say they are coming to do. It also provides the country wide registration, makes sure they are properly regulated, and protect the volunteers themselves through workers comp. and making sure they are not subject to liability as long as they are working within the scope of work they are registered to provide.

Mr. Chris Hoke, Chief of Regulatory & Legal Affairs with the Division of Public Health was then recognized to speak about the two bills Ms. Harris discussed. Mr. Hoke stated that the two bills are all about being prepared for overwhelming events in our state and we need to have the right plans in place for ease of recovery. They need some changes in the law to have an all hands on deck approach to protecting and preserving our communities. Public health officials have been working very closely with officials at Emergency Management, the Division of Emergency Management, Emergency Medical Services, and the Attorney Generals Office who represents those agencies. The bill for entity volunteers extends the same kind of liability protection given to individual volunteers to businesses and non-profits.

The National Conference of Commissioners on Uniform State Laws is a group that has been around for years and keeps up with the need for uniformity in state laws. They put together the Uniform Emergency Volunteer Health Practitioners Act which is in response to the tragedy of Hurricane Katrina where assistance broke down. North Carolina has excellent Emergency Management and Preparedness laws but under the strain of certain kinds of catastrophes we haven't experienced before our system may not work. This is what the National Conference heard from advocates, disaster relief organizations, health care professionals and people on the ground dealing with the aftermath of Katrina and Rita. Over a period of a couple of years the Conference put together the Uniform Law with the idea to have every state in the country adopt the law so that health care practitioners and volunteers who want to help know that the same kind of law in their state is also in all the others and they will be able to help in emergency situations without fear of repercussions.

The law works just like the Entity Law which talks about health care practitioner volunteers who will be working under the direction and control of Emergency Management officials and the Emergency Management System. Those two groups will greatly control the activities of these volunteers and they will be able to respond quickly in emergency situations knowing what their protections are. The bill will also give workers compensation protection for individuals that don't otherwise have workers comp coverage. Six states have already adopted this Uniform Law and many others are currently considering the bill.

Dr. Levine was recognized who stated that he strongly supported the bills and asked Mr. Hoke if any of the other states that have already passed the bill made changes in it and does it have to be passed word for word. Mr. Hoke explained that it doesn't have to be passed word for word and in fact what the attorneys in our Attorney Generals

office have done is took the model law, look at what the changes other states had made which were very insignificant, and filled in the model accordingly. Dr. Levine then stated that the implication is pretty strong when they talk about the so-called health practitioner that they are licensed or some other type of accreditation registration and yet in the definition section of what a volunteer health practitioner means it could be almost anything. He would also like to suggest that staff talk to someone from the Medical Board because they have already taken significant action to help move this along until a bill of this nature is passed. They developed what they have called "Temporary Emergency License" which covers physicians, nurse practitioners, and physician assistants working under physicians in other states.

Representative Justus asked if this has any impact on just a regular volunteer who stops to help someone who is injured. Mr. Hoke explained that no; it does not. These acts only begin when there is a Governor declared emergency but there is a Good Samaritan Law in North Carolina which would impact on that situation.

Senator Atwater thanked the Division of Public Health for trying to be prepared in this area which would definitely enable a more adequate response to the kinds of emergencies being addressed in the meeting. He then cited 2b of the Liability Protection draft which states, "and the right of any such person to receive any benefits of compensation under any act of Congress shall not be affected by the performance of Emergency Management functions", and asked if they are in a position as a matter of state law to assure a federal benefit. Ben Popkin of staff was recognized who stated that this is existing law and would appear to read such that the state law is not going to infringe on any rights under federal law. The Uniform Act does touch on a wide range of substantive areas of law and so staff has discussed possible ways to approach that; possibly to make a recommendation that the General Statutes Commission meet and work through the Uniform Act in great detail to give consideration to all the substantive areas of law that may or may not need to be amended or enhanced to incorporate the provisions of the Act would be in order.

Medical Examiner (Phase 1)

Representative England then recognized Dr. John Morrow, Director of the Pitt County Health Department to speak before the Committee. Dr. Morrow stated that he was there to discuss the modernization and professionalization of the North Carolina Medical Examiners system. DNA testing and other technology like revolutionized forensic pathology in their ability to recognize both victims and suspects and to pick up on new diseases they are learning about. The forensic pathologists are very highly trained individuals that are in short supply and are very hard to recruit. The first two of the ten essential services of Public Health are to monitor health status and to diagnose and investigate health problems. Local Health Departments handle vital records in our counties every day. All birth and death certificates come through there and are processed by local health department staff and much of the information and data they get from those death certificates is used to gauge how they are doing as a public health department and

how our communities are doing with the health care of our citizens. The mortality data ultimately determines where they make their investments into the health care system which makes it critical that the proper diagnosis is made by pathologists.

Now we are facing with bio-terrorism and also with emerging infectious diseases such as SARS and Avian Flu which makes it even more critical that the proper cause of death is identified and done quickly. The Medical Examiners system is a key component of North Carolina's preparedness and defense against these new threats to all of our citizens. Looking back through history you will see that what has killed people in large numbers is not war but plagues of infectious diseases. When large numbers of people begin dying we must have a medical examiners system that is well prepared and we now need five well staffed, well equipped offices across the state to be assured of the public's health.

Dr. John Butts, Chief, Medical Examiner's Office of the Division of Public Health was then recognized to speak before the Committee. Dr. Butts stated that the goals of their effort is to fully implement a strategic plan that was put together in 2001 which was intended to modernize and professionalize the Medical Examiner's system. The system worked very well when we were more rural than we are now and does not work as well now that we are more modernized. We have three significant urban areas across the state that can no longer work with the old system which was designed to piggyback death investigation functions on our existing health care system to use basically volunteer part-time people to do the work. They want to consolidate all of the forensic autopsy services into five regional facilities, one each in the Triangle, Triad, Charlotte-Mecklenburg area, north east, and south east of the state which they feel is the best way to meet the goal of providing services to those areas. The centers in those areas currently perform most of the examinations so they will be moving a small percentage from local providers to the larger centers.

Their goal is that every one of the facilities put into place would be able to handle a full range of all types of medical-legal autopsy services. Currently, only three of the major locations are capable of handling all types of investigations of deceased individuals. They want to have every autopsy done to be performed by an individual specifically trained in medical-legal death investigation. At this time four of our major facilities do have board certified forensic pathologists performing all examinations but one does not, nor do the smaller local centers. They want to have all of the facilities linked electronically by the medical examiners information system and at this time only the Chapel Hill and Mecklenburg offices are linked. This will provide real time recording to the central office of all cases that come in which will allow them to know at the moment an individual is received at one of the facilities who the individual is and what type of case they are dealing with. The linking will allow them to monitor and deal with issues of emerging infections, possible anthrax concerns, or other issues that may arise. These facilities should have adequate storage and be of sufficient size to handle local mass fatality incidents and have full time trained personnel.

They also want to ensure that all facilities have sufficient personnel; not only pathologists to provide autopsy services but also the ancillary personnel to provide feedback to the local county medical examiners and local law enforcement to do case follow-up gaining additional information which they believe would strengthen the role and function of the local volunteer county medical examiners. This would also speed up the resolution of cases and finalization of death certificates in cases where there are pending studies. This is a continuous problem across the state for families and other survivors who when there is an investigation and there are issues and doubts they have a considerable wait until those issues can be resolved.

Dr. Butts explained that what they are asking for is providing specific functions to augment services at the pre-existing facilities as well as to provide some additional services to their office in Chapel Hill in order to respond to the increasing number of deaths they are seeing as a result of drug overdoses. They are asking for $1.4 million for the recurring expenses for operations, supporting the local systems that are in place, and eventually funding new facilities when they are built and $11.2 million to build new facilities.

Representative Insko asked how the information goes to others after their office receives it. Dr. Butts stated that once they set up electronic links with the other offices information can be shared by all immediately but as they are now it is done by phone calls and e-mails.

Dr. Levine stated that this system makes tremendous contributions to the protection of public health. When they are investigating a farm pond drowning, tractor roll-overs, etc., they are coming up with information that can help develop measures to prevent such occurrences from repeating themselves in the future.

Dr. Devlin stated that there was one other issue that they have been in discussions with the Department and Governors office on in terms of amending the statutes so that the deaths occurring in the mental institutions would be reported to the medical examiners office for death revue and autopsy as appropriate. There are about 80 to 100 deaths that would be sent over in a year and they expect to autopsy about 60 of those. There would be a fiscal note of about $158,000 to do that work for the mental health system.

Representative England asked if this would be reported to the local medical examiner or to the Chief Medical Examiners office. Dr. Butts stated that currently they are going to report all deaths to the local medical examiners office or their office depending on whichever happens to be covering that area. If they go to legislation they may have to rethink exactly how they do this.

Quit Line

Representative England then recognized Ms, Jana Johnson, Medical Director of the Tobacco Prevention & Control, Division of Public Health to speak before the Committee, (Attachment 6). Ms. Johnson stated that tobacco use exerts an enormous health and economic toll on our North Carolina communities with one out of every five deaths caused by tobacco use. For every death there are twenty others who are sick from tobacco use and that translates into 11,900 deaths per year from tobacco use. In terms of economic cost we are looking at $2.46 billion per year just to take care of those with tobacco related illnesses. These costs do not take into account productivity costs or time away from work. In 2004 the North Carolina Medicaid program spent $769 million on tobacco related illnesses but the good news is that these costs are preventable. In North Carolina we have the North Carolina Tobacco Use Quit Line which is a comprehensive, evidence based cessation program that uses all of the evidence derived from their literature to provide free services to help people quit. The service is free and confidential and is available from 8:00 am to midnight, seven days a week, and staffed by live professionally trained quit coaches who undergo 90 hours of training before taking live calls. A tobacco user has a couple of different options. The first is enrolling in the One Call Program which involves talking to a quit coach for up to an hour, setting a quit plan, coming up with strategies to deal with cravings, and helping get support when you are at home. The other option is to enroll in the Four Call Program which includes everything you get with the One Call Program but also three calls back with the quit coach at agreed upon times. In the world of quit lines this is considered a proactive service meaning that those coaches will make outbound calls to the tobacco user who has enrolled in the program to check on quitting progress. This is the kind of service that has been proven in the medical literature to significantly increase quit rates.

Generally the first call is the longest and the next three calls happen after the quit date is set to check and see how things are going after the important first week. The other option which is linked to the Quit Line calls is a new interactive web based program. If someone enrolls in the Four Call Program they have a password protected access to a web based resource of information about cessation and can do this anytime they like. The One Call Program is $100 per participant, the Four Call Program is $180 per participant, and the other costs involve $10 for quit kit materials the Quit Line sends out depending where the person is in the quitting process. The CDC has estimated that the average cost for these kinds of programs for a proactive service in the Country is between $175 and $230 dollars.

Dr. Robert Monteiro, Chairman of the Craven County Board of Health was then recognized to speak before the Committee. Dr. Monteiro explained that he works on the front line of dealing with the devastating effects of tobacco related illnesses. He stated that every other month or so he has diagnosed a patient with lung cancer and this is a disease that only 5 out of 100 people that are diagnosed will survive five years. Quitting tobacco is extremely difficult but they are very fortunate to have a number of tools to help their patients. Advising his patients by simply saying that he thinks they should quit

will greatly increase the rate of people's success in quitting. They also have a number of medications that can be used in the process and they have been proven to more effective than a placebo. Counseling is so effective that it doubles the effectiveness of the other ways used in cessation treatment.

The time factor is crucial because a person in their forties who quits tobacco use has a far greater chance of not having lung cancer than a person in their fifties and sixties. Using the Quit Line is very easy and is a powerful tool. He has been fortunate enough to see people who have benefited from the program and has been very happy with the way the program works.

Representative Insko asked if a person quits smoking does the damage stay the same or does the body do some healing. Dr. Monteiro stated that there are physical changes that occur and some are reversible and some are irreversible. The scarring and physical expansion of the lungs is irreversible but damage to the cells that line the respiratory airways can recover within a couple of weeks. When patients actually quit their cough worsens in the first couple of weeks because the lungs are healing. Representative Adams stated that what they can do in the legislative process to keep the Quit Line going will have a tremendous impact on our citizens and budget.

School Nurses – Immunizations & Corporal Punishment

Improve Immunization Rates For All Recommended Vaccines

Mr. Tom Vitaglione of Action for Children North Carolina was then introduced to speak before the Committee, (Attachment 7). Mr. Vitaglione explained that the General Assembly made the decision over a decade ago to make universal vaccines available for those vaccines required by State law to all children regardless of family income. North Carolina now ranks second in the nation with regard to the immunization of the youngest children in our state. These immunizations not only protect the individual children from mortality and morbidity from these communicable diseases but they also protect others who would come in contact with those children. Each dollar spent on vaccines saves $15 in cost to treat diseases and this is one of the few places where you can actually measure in dollar values the effect of public health.

There are five very important childhood vaccines recommended by the CDC but which are not yet available to our children because of insufficient funding. These five are Influenza, PCV7 (pneumococcal), Rotavirus, MCV4 (meningococcal), and HPV (human papillomavirus). While federal funding is available to provide these vaccines to children in Medicaid and other groups, the requested funding will ensure that every child has access to all recommended vaccines.

The newer vaccines are more expensive than the others that are used for diseases that have been wiped out. It will cost an estimated $31.3 million in recurring appropriations to provide all five vaccines to all children.

Representative Insko asked if they actually capture all of the Medicaid dollars that they are eligible for and is the funding for this program such that any child, even if they are Medicaid eligible, is getting it without charging Medicaid. Dr. Devlin responded by saying that typically the federal funds are provided for the universal vaccine for children for the Medicaid eligible population.

Improve the School Nurse: Student Ratio to 1:750 in 5 Years

Mr. Vitaglione stated that the positive correlation between health and school performance is not only intuitive, but has been shown in numerous studies. Healthy students have better attendance, are more attentive, and have generally better educational outcomes, (Attachment 8).

A comprehensive school health program has eight components, ranging from health education to school-based/ school-linked health centers. The critical linchpin in a comprehensive program is the school health nurse. They provide preventive health services for all students, both administer and monitor medications for students who need them during the school day, and they respond to the growing number of students with special health needs. The national standard is that there be one school nurse for every 750 students and at this time the current ratio remains at approximately 1:1280. An increased appropriation of $10.8 million is needed in each of the next five years to improve the ratio. Mr. Vitaglione then stated that he had learned just that morning that approximately 40% of children with special needs in our schools don't graduate.

Representative Insko asked what the qualification requirements are for our current school nurses and do they have to be RNs. Dr. Kevin Ryan, Head of Maternal and Child Health, stated that yes, the do have to be RNs and to satisfy the Department of Public Instruction requirements they need either be or become qualified as school nurses. Representative Insko then asked if they are paid through the Health Department or on one of the education salary schedules. Dr. Ryan stated that this is a local decision and a great majority of school nurses are employed either by LEAs, local health departments, or a variety of other places so they are paid according to the scales set by the agency they are hired by.

Corporal Punishment, Suspension, or Expulsion of Pupils

Mr. Vitaglione stated that in the 1940's corporal punishment was allowed across the country but now North Carolina is just one of 22 states that still allow this in the public schools. In 2007 a bill was considered that would ban corporal punishment but was defeated. They have realized during debates that there is no definition of corporal punishment in the law or in state board policy, nor is there any requirement for reporting.

Since the definition is neither in law or policy they feel that it is time to try to do something about it. There are tremendous variances in the way corporal punishment is administered across the state. Some spank, others use paddles, some allow the principal to select the size of the paddle, and some allow holes to be drilled into the paddle for

velocity. There is no training, no proscriptions in regard to large men hitting little girls, and no proscriptions about removing clothing before it takes place. They want the law changed so that they can better define corporal punishment in North Carolina and to require that there be reports so they will know exactly who is being punished and where it is being carried out.

Mr. Vitaglione presented a draft of legislation that includes a reporting requirement, restriction to hand spanking to get rid of the paddles being used, the administrator of the punishment has to be the same gender as the recipient student, there has to be training, and that the customary mode of dress would be maintained, (Attachment 9).

Senator Purcell asked how you can train someone to spank. Mr. Vitaglione explained that they would like for there to be some orientation on where to hit and to make them do this carefully so as not to do serious or lasting injury to the child.

Ms. Thomas asked why would there not be a ban altogether and has it shown to be an effective mode of discipline. Mr. Vitaglione explained that no; it hasn't been shown to be effective. Because the bill considered in the last session was defeated it cannot be brought back in the short session so they wanted to at least make it as safe as possible and done without disproportionality.

Cystic Fibrosis, AIDS Drug Assistance Program & SB 1226 – Retired Nurses Return to Work

Dr. Steve Cline, Deputy State Health Director of the Division of Public Health was then recognized to speak before the Committee. Dr. Cline stated that while their four major initiatives are obesity, preparedness, the Quit Line, and child health issues there are also a few others that need to be discussed. They feel that it is time for Cystic Fibrosis to be added to the screening panel that already exists for newborn screening. In North Carolina every child is screened for more than 30 metabolic disorders through a heel stick of the child. The Cystic Fibrosis screening technology is available and will raise the screening fee from about $14 to about $17 and allow the revenues generated from that to increase the capacity for testing in the State Laboratory of Public Health. This will not require an appropriation but they will need the authority to raise the fee. They will need an appropriation to increase the capacity of their public health workers to do the appropriate follow-up, tracking, and counseling for the patients and families who are discovered to either have Cystic Fibrosis combination or be a carrier of that gene. They estimate that out of nearly 135,000 births per year in North Carolina there will be about 36 newborns with Cystic Fibrosis and about 3,600 genetic carriers.

Another issue is their ADAP (AIDS Drug Assistance Program) eligibility. This is a joint federal and state program that provides necessary life saving drugs to low income individuals who have no other source of getting those drugs paid for. Through increases in state and federal funding they have been able to raise their eligibility and are asking

now for the General Assembly to give them the authority based on the availability of funds to raise the eligibility to 300% of the federal poverty level.

Dr. Cline then explained that an aging workforce and the narrowing of the supply line of people who choose public health as a profession are causing a great shortfall in the public health workforce. This is a large problem and the Public Health Taskforce has recommended that public health workers be allowed an exemption for returning back to work as retirees. This would at least buy time for people who are trained, experienced, and valuable to the public health workforce now to remain in the workforce without it negatively impacting their retirement benefits.

Representative England asked if there was any clarification on the difference in the IRS problems relative to public health workers versus school teachers and the problems that still exist for them returning to work after retirement. Dr. Cline stated that he knew there were some tax implications but in Senate Bill 1226 there was some language about how the tax implications could be managed and what would be deferred based on if they were an eligible retiree.

Representative Insko asked if the bill included a specific number of months that a person needs to be out of work to be defined as retired. Dr. Cline stated that it defines the eligibility for being a retiree, how long they have been in that job capacity, and the length of time they need to be out before they can return is six months.

Representative Justus asked if a family has insurance or Medicaid do those pay for newborn screening or does the state. Dr. Devlin stated that she would assume that the hospital would charge the patient and their insurance would cover the newborn screening. Immunizations are provided in North Carolina through a universal program for all but the five vaccines discussed earlier.

Representative England stated that he would at this time entertain a motion to accept the Task Force report in its entirety. Dr. Levine was then recognized who made a motion to accept the Task Force recommendations. The motion passed.

Respectfully submitted,

Lisa Brown, Committee Assistant

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Representative Bob England, M.D., Co-Chair

House Pages

Name Of Committee: PUBLIC HEALTH STUDY COMMISSION Date: 28-MAR-08

1. Name: _____

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Sgt-At-Arms

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3. Name: DUSTY RHODES
4. Name: JERALD PERRY
5. Name: BOB ROBBY

VISITOR REGISTRATION SHEET

Public Health Study Commission — March 25, 2008

Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
GENE MATTHEWS	UNC - NC INST. FOR PUBLIC HEALTH C.B. 8165 CHAPEL HILL NC 27599
ANNA WOOD	"
	DPH
TOM VITAGLIONE	ACTION FOR CHILDREN
	Born Assoc.
	JR, NC, PA
	ACCAHA
Dana Simps	Smith Anders
Christine Craig	WakeMed
Hannah Elmore	WakeMed
Drexdal Pratt	NC OEMS

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Public Health Study Commission — March 25, 2008

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NAME	FIRM OR AGENCY AND ADDRESS
Doug Hoell	NC Div. of Emergency Mgmt.
Colleen Kochanek	Smith Moore - NCCEP
Elizabeth Dalton	NCRMA
Patrick Buffkin	Nelson Mullins
Ken Melton	Ken Melton & Associates
Gudrun Haselhorst	EHSE

VISITOR REGISTRATION SHEET

Public Health Study Commission — March 25, 2008

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NAME	FIRM OR AGENCY AND ADDRESS
Eugene Barufkin	Healthcare for All NC NC Black Leadership Caucus
Charlotte Ranz	NC Alliance for Health
Ashley Bell	American Cancer Society
Julia Leggett	The Arc of NC
Kevin Ryan	NC DPH
William H Potter Jr.	NC Dent Soc / NC Phys Thera Ass'n

VISITOR REGISTRATION SHEET

Public Health Study Commission — March 25, 2008

Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
AL DEITCH	DOA/YAIO
John Morrow, MD	Pitt Public H.
SALLY HERNDON MALEK	DPH, Tobacco Prevention + Control
Colleen Bridger	Boston County Health Dept.
JANA JOHNSON	DPH, Tobacco Prevention + Control
Jane Smith	DHHS
Robert Montero, MD	Craven County Board of Health
Jeff Engel	NC DHHS / DPH
John Burris	NCHHS / DPH OCME
Lynette Z	NCHLHJ
Marcus Plescia	DHHS / DPH

Attach I

Reducing Childhood Obesity in North Carolina

NC Division of Public Health and NC Hospital Association Collaboration

$12.5 Million Recurring Proposal

Impacting childhood obesity rates by 2015

Part 1 $7.5 Million

$5.0 M **A.** **Community Demonstration Projects**

Six counties receive $4.0 Million for seven years for interventions and technical assistance

The community demonstration projects will implement interventions in preschools, schools, local communities, faith organizations, and healthcare settings that promote and support physical activity and healthy eating. The Division of Public Health will provide technical support and disseminate best practices. Funds must be used to:

- Implement the Nutrition and Physical Activity Self-Assessment (NAP-SACC) for Child Care
- Implement the NC Nutrition Standards in elementary, middle, and high schools
- Establish worksite wellness coordinators for each Local Education Agency (LEA)
- Support YMCA's in building community collaborations and developing projects supporting physical activity and healthy eating
- Implement a pedestrian and bicycle master plan for local communities
- Create farmers' markets or farm stands
- Implement multi-level interventions in select faith communities
- Provide Eat Smart, Move More Clinician and case management tools for Community Care of NC (CCNC) practices and implement use of an electronic kindergarten assessment form
- Establish worksite wellness coordinators to work with hospital worksite wellness committees at each hospital setting

ESMM Community Competitive Grants ($1,000,000)

The ESMM Community Grants Program provides competitive funding to local communities to implement strategies that advance the goals and objectives of Eat Smart, Move More, North Carolina's Obesity Prevention Plan. Funding is awarded yearly, based on availability of funds. The purpose of the Community Grants is to fund projects that change policy and environments that support eating smart and/or moving more. Projects supported through this grant program must use science-based strategies that change eating and/or physical activity behavior, thereby promoting healthy weight and reducing chronic disease.

$2.5 M **B.** **Public Awareness** ($2,500,000 for 2,500,000 kids in NC at $1.00 per child)

The goal of the public awareness campaign is to raise awareness of our target audiences of the need for policy and environmental supports for the **seven** key behaviors offered by CDC and cornerstones of Eat Smart, Move More North Carolina **(move more every day, everywhere; tame the tube; re-think your drink; prepare and eat more meals at home; right-size your portions; breastfeed your baby; enjoy more fruits and veggies).** The primary target audiences are key decision makers and women ages 25 to 54 with at least one child in the home. The campaign features a combination of advertising, media relations garnering earned media, and public relations directing consumers to Eat Smart, Move More North Carolina partner services and programs. The statewide campaign will target the 6 demonstration project communities.

Part 2 $5 Million

$5.0 M **Community Based Programs** ($50,000 per county)

Each county will implement community-based programs promoting policy and environmental changes supportive of increased physical activity and healthy eating in childcare centers, schools, community settings, worksites, faith communities, and/or healthcare settings. Counties must demonstrate strong working relationships between the health department, local hospital(s) and community partners.

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- Create farmers' markets or farm stands
- Implement multi-level interventions in select faith communities
- Provide Eat Smart, Move More Clinician and case management tools for Community Care of NC (CCNC) practices and implement use of an electronic kindergarten assessment form
- Establish worksite wellness coordinators to work with hospital worksite wellness committees at each hospital setting

ESMM Community Competitive Grants ($1,000,000)

The ESMM Community Grants Program provides competitive funding to local communities to implement strategies that advance the goals and objectives of Eat Smart, Move More, North Carolina's Obesity Prevention Plan. Funding is awarded yearly, based on availability of funds. The purpose of the Community Grants is to fund projects that change policy and environments that support eating smart and/or moving more. Projects supported through this grant program must use science-based strategies that change eating and/or physical activity behavior, thereby promoting healthy weight and reducing chronic disease.

$2.5 M **B.** **Public Awareness** ($2,500,000 for 2,500,000 kids in NC at $1.00 per child)

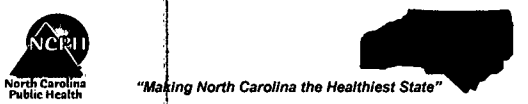
The goal of the public awareness campaign is to raise awareness of our target audiences of the need for policy and environmental supports for the **seven** key behaviors offered by CDC and cornerstones of Eat Smart, Move More North Carolina **(move more every day, everywhere; tame the tube; re-think your drink; prepare and eat more meals at home; right-size your portions; breastfeed your baby; enjoy more fruits and veggies).** The primary target audiences are key decision makers and women ages 25 to 54 with at least one child in the home. The campaign features a combination of advertising, media relations garnering earned media, and public relations directing consumers to Eat Smart, Move More North Carolina partner services and programs. The statewide campaign will target the 6 demonstration project communities.

Part 2 $5 Million

$5.0 M **Community Based Programs** ($50,000 per county)

Each county will implement community-based programs promoting policy and environmental changes supportive of increased physical activity and healthy eating in childcare centers, schools, community settings, worksites, faith communities, and/or healthcare settings. Counties must demonstrate strong working relationships between the health department, local hospital(s) and community partners.

Attach II



NC Public Health Study Commission – March 25th 2008

Merle Green, MPH
Health Director, Guilford County

NC Public Health Issues

- ***Unacceptable burden of dental diseases, affecting oral health of children and adults***
- ***Addressing access to health care for all***
- ***School Health, obesity & chronic illness in children***

"Making North Carolina the Healthiest State"

NC Public Health Issues

Unacceptable burden of dental diseases, affecting oral health of children and adults –

- ***Most dental disease is entirely preventable***
- ***Prevention works! – We must continue prevention education, oral health promotion, fluoride varnish, school-based programs***
- ***With adequate funding, dental treatment and prevention for children can be effectively achieved***

"Making North Carolina the Healthiest State"

NC Public Health Issues

Unacceptable burden of dental diseases, affecting oral health of children and adults –

- ***Guilford County Adult Free Dental Clinic reports that:***

  -The number one procedure performed is the extraction of front and back teeth!

  - For most patients, the level of oral disease is so severe, most teeth are beyond saving.
- ***As with children, prevention works if access is available!***

"Making North Carolina the Healthiest State"

NC Public Health Issues

Addressing access to health care for all-

- ***A recent community health diagnosis in Guilford County showed that the largest zip code area of the county:***

  - had only one private medical provider, only one public medical provider, and only one public pediatric provider

  - this area also had the highest rates of morbidity and mortality for heart disease, cancer and kidney failure
- ***We must have public –private partnerships to solve access to care, and the private sector must play a larger role***

"Making North Carolina the Healthiest State"

NC Public Health Issues

School Health, obesity & chronic illness in children-

- ***Health issues in schools are exacerbated by a shortage of School Nurses***
- ***National recommended ratio of a School Nurse to students is 1:750. Guilford County ratio is 1:2000***

"Making North Carolina the Healthiest State"

North Carolina Public Health Study Commission 2008

QUESTIONS?

"Making North Carolina the Healthiest State"

Attach III

North Carolina Public Health

"Making North Carolina the Healthiest State"

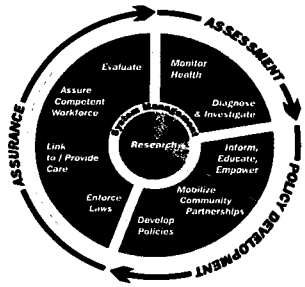
NC Public Health Study Commission – March 25th 2008

Dennis E. Harrington, Deputy Director

NC Division of Public Health

North Carolina Public Health

NC Public Health Priorities



Ten Essential Services

"Making North Carolina the Healthiest State"

North Carolina Public Health

NC Public Health Priorities

Restoring Public Health Infrastructure:

Historical funding –

- ***1973 - $4.9 million***

...34 years later...

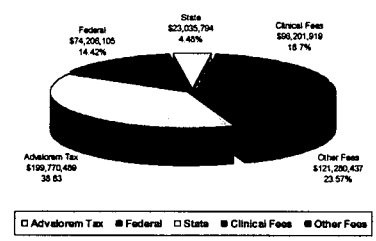
- ***2007 - $4.9 million + 2.0 million = $6.9 million***

"Making North Carolina the Healthiest State"

North Carolina Public Health

Local Investment in Public Health

Who currently pays the bills?



"Working for a healthier and safer North Carolina"

Local Investment in Public Health
Who currently pays the bills? NC vs. other Southeastern (SE) States

Comparison of NC State Appropriations for LHDs vs. "State direct appropriations" of 11 South Eastern States for SFY 05-06. *

"State direct appropriations" for SFY 05-06 to Local health departments was $2.61 per capita. The average of the 11 southeastern states compared in the calculation was $8.36 per capital of "state direct appropriation" for their LHDs.

11 SE State average per capita "state direct appropriation" $8.36
NC FY 05-06 "state direct appropriation" $2.61
NC Shortfall $5.75 per capita
to bring NC up to regional average

*Source: NACCHO Financial Report - "National Profile of Local Health Departments 2005"

"Working for a healthier and safer North Carolina"

Local Investment in Public Health
Who currently pays the bills? NC vs. other Southeastern (SE) States

5 year expansion plan: $5.57/ 5 = $1.15 per capita per year

Using NC Population figures 2005 of 8.5 million this would conservatively support an increase of $9.75 million per year. We are behind given the appropriation for the current year.

Again, per the PH Task Force Report 2007, we are supporting $23 million ask for bringing the system up nearer to a Regional average based on similar services and population needs.

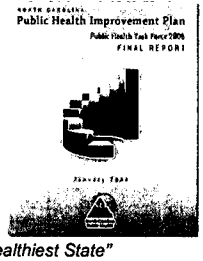
"Working for a healthier and safer North Carolina"

What funding is needed?

Universe of additional resource needs in support of the 10 Essential Services in LHDs is estimated:

$62.8 million

(NC Public Health Improvement Plan 2007 – appendix)



"Making North Carolina the Healthiest State"

How LHDs *used* the additional $2 million 2007 - general Aid-To-Counties (ATC) Funds

SERVICES:

•Add permanent staff or increase contract hours in support of professional service activities

• Inform and/or educate and empower citizens regarding health issues

• Link people to needed health services – provide services when not otherwise available

• Develop policies and plans to support and establish community health services

"Making North Carolina the Healthiest State"

How LHDs *used* the additional $2 million 2007 - general Aid-To-Counties (ATC) Funds

OTHER ACTIVITIES:

- *Support reporting systems for communicable disease cases within the private medical community*
- *Increase HIV counseling and testing hours and/or locations within communities*
- *Improve the system of Environmental Health complaint investigations*

"Making North Carolina the Healthiest State"

How LHDs *would* use additional general Aid-To-Counties (ATC) Funds (*If they won the PH Lottery!*)

SERVICES:

- *Increase clinical care (including basic primary care where needed)*
- *Increase programming to prevent development of chronic diseases through health promotion and health education to affect behavioral changes*
- *Increase capacity to investigate and respond to Communicable disease outbreaks*

"Making North Carolina the Healthiest State"

How LHDs *would* use additional general Aid-To-Counties (ATC) Funds (*If they won the PH Lottery!*)

SERVICES:

- *Provide Dental Care for clients – especially adults without resources or third party coverage*
- *Increase and develop language support and general cultural competency within PH workforce – recruit bilingual staff when at all possible (recruitment goal).*
- *Purchase needed equipment in support of PH programming: examples - dental chairs, computers, exam tables*

"Making North Carolina the Healthiest State"

Growing challenges for LHDs – "Uncompensated Care" ~ $9.8 million

- Uncompensated Primary Care (PC) that is Public Health Specific. This primary care occurs predominately within the context of traditional public health clinics. However, it also represents a growing need for traditional primary care clinics in certain communities - 8 LHDs (11 counties) $9.8 million

"Making North Carolina the Healthiest State"

Growing challenges for LHDs – "Uncompensated Care" ~ $9.8 million

- Does not represent a situation of competition among the providers of local medical community in the vast majority of situations (PC is provided when others are not available, able or willing to provide care)

"Making North Carolina the Healthiest State"

What is needed?

$23 million in state appropriations for local health departments in Non-Categorical, stable funding to support the local public health system statewide to assure the operational capacity of local health departments.

"Making North Carolina the Healthiest State"

What is needed?

Key consideration for use of this funding:

LOCAL FLEXIBILITY

"Making North Carolina the Healthiest State"

North Carolina Public Health Study Commission 2008

QUESTIONS?

"Making North Carolina the Healthiest State"

Medical Examiner System Expansion Proposal

- Phase 1 (2008): Operations
  - $533,000 Winston/Salem (WFU)
  - $533,000 Greenville (ECU)
  - $350,000 Raleigh (toxicology and laboratory)

  TOTAL = $1,416,000 recurring
- Phase 2 (2009): Capital and Operations
  - $7.5M new SE facility
  - $3.7M replacement WFU facility (shared cost)
  - $1.2M operations for new SE facility

  TOTAL = $11,200,000 non-recurring; $1.2M recurring
- Governor's comprehensive MH package (2008)
  - $159,000 recurring for investigations of all deaths at state institutions

"Making North Carolina the Healthiest State"

Medical Examiner System Expansion Proposal - Goals

- Consolidate all forensic autopsy services into 5 regional facilities : Triangle, Triad, Southwest, Northeast and Southeast - currently exams are done in 14 locations
- All facilities equipped to handle full range of cases with adequate body storage - currently only 3 locations are so equipped :OCME, CMMEO and ECU – new facilities needed for Triad and Southeast
- All autopsies to be performed by board certified forensic pathologists – currently OCME, CMMEO, ECU, WFU
- All facilities linked electronically by MEIS – currently OCME and CMMEO
- Facilities to have sufficient personnel to provide case follow-up and coordination with County MEs and local law enforcement and assist in case completion

"Making North Carolina the Healthiest State"

Attach IV

DRAFT
GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2008

AN ACT TO ENACT THE UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT RECOMMENDED AND APPROVED BY THE NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS

The General Assembly of North Carolina enacts:

Section 1. G.S. Chapter166A is amended by adding the following new Article to read:

"ARTICLE 5

UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT

G.S. 166A-54. SHORT TITLE. This Act may be cited as the Uniform Emergency Volunteer Health Practitioners Act.

G.S. 166A-55. DEFINITIONS. In this Act:

(1) "Disaster" means as it is defined in G.S. 166A-4(1).

(2) "Disaster declaration" means as it is defined in G.S. 166A-6.

(3) "Disaster relief organization" means an entity that provides emergency or disaster relief services that include health or veterinary services provided by volunteer health practitioners and that:

(A) is designated or recognized as a provider of those services pursuant to a disaster response and recovery plan adopted by an agency of the federal government or the Governor or his or her designee.

(B) regularly plans and conducts its activities in coordination with an agency of the federal government or the Division of Emergency Management.

(4) "Emergency" means an event or condition that is an emergency under 14-288.12.

(5) "Emergency declaration" means a declaration of emergency issued by a person authorized to do so pursuant to G.S. 14-288.12, G.S. 14-288.13, or 14-288.14.

(6) "Emergency Management Assistance Compact" means the interstate compact established under G.S. 166A-40 et seq.

(7) "Entity" means a person other than an individual.

(8) "Health facility" means an entity licensed under the laws of this or another state to provide health or veterinary services.

(9) "Health practitioner" means an individual licensed under the laws of this or another state to provide health or veterinary services.

(10) "Health services" means the provision of treatment, care, advice or guidance, or other services, or supplies, related to the health or death of individuals or human populations, to the extent necessary to respond to an emergency, including:

(A) the following, concerning the physical or mental condition or functional status of an individual or affecting the structure or function of the body:

(i) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; and

(ii) counseling, assessment, procedures, or other services;

(B) sale or dispensing of a drug, a device, equipment, or another item to an individual in accordance with a prescription; and

(C) funeral, cremation, cemetery, or other mortuary services.

(11) "Host entity" means an entity operating in this state which uses volunteer health practitioners to respond to an emergency.

(12) "License" means authorization by a state to engage in health or veterinary services. The term includes authorization under the laws of this state to an individual to provide health or veterinary services based upon a national certification issued by a public or private entity.

(13) "Person" means an individual, corporation, business trust, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(14) "Scope of practice" means the extent of the authorization to provide health or veterinary services granted to a health practitioner by a license issued to the practitioner in the state in which the principal part of the practitioners services are rendered, including any conditions imposed by the licensing authority.

(15) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(16) "Veterinary services" means the provision of treatment, care, advice or guidance, or other services, or supplies, related to the health or death of an animal or to animal populations, to the extent necessary to respond to an emergency, including:

(A) diagnosis, treatment, or prevention of an animal disease, injury, or other physical or mental condition by the prescription, administration, or dispensing of vaccine, medicine, surgery, or therapy;

(B) use of a procedure for reproductive management; and

(C) monitoring and treatment of animal populations for diseases that have spread or demonstrate the potential to spread to humans.

(17) "Volunteer health practitioner" means a health practitioner who provides health or veterinary services, whether or not the practitioner receives compensation for those services. The term does not include a practitioner who receives compensation pursuant to a preexisting employment relationship with a host entity or affiliate which requires the practitioner to provide health services in this state, unless the practitioner is not a resident of this state and is employed by a disaster relief organization providing services in this state while a disaster declaration or emergency declaration is in effect.

G.S. 166A-56. APPLICABILITY TO VOLUNTEER HEALTH PRACTITIONERS. This Act applies to volunteer health practitioners who register with a registration system that complies with Section 5 and who, while so registered, provide health or veterinary services in this state for a host entity while a disaster declaration or emergency declaration is in effect.

G.S. 166A-57. REGULATION OF SERVICES DURING EMERGENCY.

(a) While a disaster declaration or emergency declaration is in effect, the Governor or his designee may limit, restrict, or otherwise regulate:

(1) the duration of practice by volunteer health practitioners;

(2) the geographical areas in which volunteer health practitioners may practice;

(3) the types of volunteer health practitioners who may practice; and

(4) any other matters necessary to coordinate effectively the provision of health or veterinary services during the emergency.

(b) An order issued pursuant to subsection (a) may take effect immediately, without prior notice or comment, and is not a rule within the meaning of G.S. 150B.

(c) A host entity that uses volunteer health practitioners to provide health or veterinary services in this state shall consult and coordinate its activities with the Secretary of the Department of Crime Control and Public Safety to provide for the efficient and effective use of volunteer health practitioners.

G.S. 166A-58. VOLUNTEER HEALTH PRACTITIONER REGISTRATION SYSTEMS.

(a) To qualify as a volunteer health practitioner registration system, a system must:

(1) accept applications for the registration of volunteer health practitioners before or during an emergency or disaster;

(2) include information about the licensure and good standing of health practitioners which is accessible by authorized persons;

(3) be capable of confirming the accuracy of information concerning whether a health practitioner is licensed and in good standing before health services or veterinary services are provided under this [act]; and

(4) meet one of the following conditions:

(A) be an emergency system for advance registration of volunteer health-care practitioners established by a state and funded through the Department of Health and Human Services under Section 319I of the Public Health Services Act, 42 USC Section 247d-7b [as amended];

(B) be a local unit consisting of trained and equipped emergency response, public health, and medical personnel formed pursuant to Section 2801 of the Public Health Services Act, 42 U.S.C. Section 300hh [as amended];

(C) be operated by a:

(i) disaster relief organization;

(ii) licensing board;

(iii) national or regional association of licensing boards or health practitioners;

(iv) health facility that provides comprehensive inpatient and outpatient health-care services, including a tertiary care and teaching hospital; or

(v) governmental entity; or

(D) be designated by the Department of Health and Human Services as a registration system for purposes of this Act.

(b) While a disaster declaration or emergency declaration is in effect, the Department of Health and Human Services or a host entity may confirm whether volunteer health practitioners utilized in this state are registered with a registration system that complies with subsection (a). Confirmation is limited to obtaining identities of the practitioners from the system and determining whether the system indicates that the practitioners are licensed and in good standing.

(c) Upon request of a person in this state authorized under subsection (b), or a similarly authorized person in another state, a registration system located in this state shall notify the person of the identities of volunteer health practitioners and whether the practitioners are licensed and in good standing.

(d) A host entity is not required to use the services of a volunteer health practitioner even if the practitioner is registered with a registration system that indicates that the practitioner is licensed and in good standing.

G.S. 166A-59. RECOGNITION OF VOLUNTEER HEALTH PRACTITIONERS LICENSED IN OTHER STATES.

(a) While a disaster declaration or emergency declaration is in effect, a volunteer health practitioner, registered with a registration system that complies with Section 5 and licensed and in good standing in the state upon which the practitioner's registration is based, may practice in this state to the extent authorized by this Act as if the practitioner were licensed in this state.

(b) A volunteer health practitioner qualified under subsection (a) is not entitled to the protections of this Act if the practitioner is licensed in more than one state and any license of the practitioner is suspended, revoked, or subject to an agency order limiting or restricting practice privileges, or has been voluntarily terminated under threat of sanction.

G.S. 166A-60. NO EFFECT ON CREDENTIALING AND PRIVILEGING.

(a) In this section:

(1) "Credentialing" means obtaining, verifying, and assessing the qualifications of a health practitioner to provide treatment, care, or services in or for a health facility.

(2) "Privileging" means the authorizing by an appropriate authority, such as a governing body, of a health practitioner to provide specific treatment, care, or services at a health facility subject to limits based on factors that include license, education, training, experience, competence, health status, and specialized skill.

(b) This Act does not affect credentialing or privileging standards of a health facility and does not preclude a health facility from waiving or modifying those standards while a disaster declaration or emergency declaration is in effect.

G.S. 166A-61. PROVISION OF VOLUNTEER HEALTH OR VETERINARY SERVICES; ADMINISTRATIVE SANCTIONS.

(a) Subject to subsections (b) and (c), a volunteer health practitioner shall adhere to the scope of practice for a similarly licensed practitioner established by the licensing provisions, practice acts, or other laws of this state.

(b) Except as otherwise provided in subsection (c), this Act does not authorize a volunteer health practitioner to provide services that are outside the practitioner's scope of practice, even if a similarly licensed practitioner in this state would be permitted to provide the services.

(c) The Governor and his or her designee may modify or restrict the health or veterinary services that volunteer health practitioners may provide pursuant to this Act. An order under this subsection may take effect immediately, without prior notice or comment, and is not a rule within the meaning of G.S. 150B.

(d) A host entity may restrict the health or veterinary services that a volunteer health practitioner may provide pursuant to this Act.

(e) A volunteer health practitioner does not engage in unauthorized practice unless the practitioner has reason to know of any limitation, modification, or restriction under this section or that a similarly licensed practitioner in this state would not be permitted to provide the services. A volunteer health practitioner has reason to know of a limitation, modification, or restriction or that a similarly licensed practitioner in this state would not be permitted to provide a service if:

(1) the practitioner knows the limitation, modification, or restriction exists or that a similarly licensed practitioner in this state would not be permitted to provide the service; or

(2) from all the facts and circumstances known to the practitioner at the relevant time, a reasonable person would conclude that the limitation, modification, or restriction exists or that a similarly licensed practitioner in this state would not be permitted to provide the service.

(f) In addition to the authority granted by law of this state other than this Act to regulate the conduct of health practitioners, a licensing board or other disciplinary authority in this state:

(1) may impose administrative sanctions upon a health practitioner licensed in this state for conduct outside of this state in response to an out-of-state emergency;

(2) may impose administrative sanctions upon a practitioner not licensed in this state for conduct in this state in response to an in-state emergency; and

(3) shall report any administrative sanctions imposed upon a practitioner licensed in another state to the appropriate licensing board or other disciplinary authority in any other state in which the practitioner is known to be licensed.

(g) In determining whether to impose administrative sanctions under subsection (f), a licensing board or other disciplinary authority shall consider the circumstances in which the conduct took place, including any exigent circumstances, and the practitioner's scope of practice, education, training, experience, and specialized skill.

G.S. 166A-62. RELATION TO OTHER LAWS.

(a) This Act does not limit rights, privileges, or immunities provided to volunteer health practitioners by laws other than this Act. Except as otherwise provided in subsection (b), this Act does not affect requirements for the use of health practitioners pursuant to the Emergency Management Assistance Compact.

(b) The Governor and his or her designee, pursuant to the Emergency Management Assistance Compact, may incorporate into the emergency forces of this state volunteer health practitioners who are not officers or employees of this state, a political subdivision of this state, or a municipality or other local government within this state.

G.S. 166A-63. REGULATORY AUTHORITY. The Governor or his or her designee may adopt rules to implement this Act. In doing so the Governor or his or her designee shall consult with and consider rules adopted by similarly empowered agencies in other states to promote uniformity of application of this Act and make the emergency response systems in the various states reasonably compatible.

G.S. 166A-64. LIMITATIONS ON CIVIL LIABILITY FOR VOLUNTEER HEALTH PRACTITIONERS.

(a) Subject to subsection (c), a volunteer health practitioner who provides health or veterinary services pursuant to this Act is not liable for damages for an act or omission of the practitioner in providing those services.

(b) No person is vicariously liable for damages for an act or omission of a volunteer health practitioner if the practitioner is not liable for the damages under subsection (a).

(c) This section does not limit the liability of a volunteer health practitioner for:

(1) willful misconduct or wanton, grossly negligent, reckless, criminal conduct or bad faith;

(2) an intentional tort;

(3) breach of contract;

(4) a claim asserted by a host entity; or

(5) an act or omission relating to the operation of a motor vehicle, vessel, aircraft, or other vehicle.

(d) A person that, pursuant to this Act, operates, uses, or relies upon information provided by a volunteer health practitioner registration system is not liable for damages for an act or omission relating to that operation, use, or reliance unless the act or omission is an intentional tort or is willful misconduct or wanton, grossly negligent, reckless criminal conduct or bad faith.

G.S. 166A-65. WORKERS COMPENSATION COVERAGE.

(a) In this section, "injury" means an injury or disease for which an employee of this state who is injured or contracts the disease in the course of the employee's employment would be entitled to benefits under the workers' compensation law of this state.

(b) A volunteer health practitioner who dies or is injured as the result of providing health or veterinary services pursuant to this Act is deemed to be an employee of this state for the purpose of receiving benefits for the death or injury under the workers-compensation law of this state if the practitioner is not otherwise eligible for such benefits for the injury or death under the law of this or another state.

(c) The Governor or his or her designee shall adopt rules, enter into agreements with other states, or take other measures to facilitate the receipt of benefits for injury or death under the workers- compensation law of this state by volunteer health practitioners who reside in other states, and may waive or modify requirements for filing, processing, and paying claims that unreasonably burden the practitioners. To promote uniformity of application of this Act with other states that enact similar legislation, the Governor or his or her designee shall consult with

and consider the practices for filing, processing, and paying claims by agencies with similar authority in other states.

G.S. 166A-66. UNIFORMITY OF APPLICATION AND CONSTRUCTION. In applying and construing this uniform act, consideration must be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it."

SEC. 2. This Act is effective when it becomes law.

Attach 3

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION _____

_____ BILL ____

Short Title: Liability Protection for private associations, private corporations and private non-profit entities and organizations (Public)

Sponsors:

Referred to:

Month Date, Year

A BILL TO BE ENTITLED

AN ACT TO PROVIDE LIABILITY PROTECTION FOR PRIVATE ASSOCIATIONS, PRIVATE CORPORATIONS AND PRIVATE NON-PROFIT ENTITIES AND ORGANIZATIONS WHEN RESPONDING TO IN-STATE INCIDENTS .

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 166A-14 reads as rewritten:

"§ 166A-14. Immunity and exemption.

"Section 166A-14. Immunity and exemption.

(a) All functions hereunder and all other activities relating to emergency management are hereby declared to be governmental functions. Neither the State nor any political subdivision thereof, nor, except in cases of willful misconduct, gross negligence or bad faith, any emergency management worker, individual, firm, partnership, association or corporation complying with or reasonably attempting to comply with this Article or any order, rule or regulation promulgated pursuant to the provisions of this Article or pursuant to any ordinance relating to any emergency management measures enacted by any political subdivision of the State, shall be liable for the death of or injury to persons, or for damage to property as a result of any such activity. The immunity provided in this subsection applies only to:

(1) individuals, firms, partnerships, associations or corporations performing emergency management services at any place in this State, subject to the order or control of or pursuant to a request of the State government or any political subdivision thereof; and

(2) firms, partnerships, associations or corporations performing emergency management services without compensation or with compensation limited to no more than actual expenses.

The immunity provided in this subsection shall not apply to any private individual, firm, partnership, association or corporation, or to any employee or agent of such individual, firm, partnership, association or corporation whose act or omission caused in whole or in part the actual or imminent disaster, emergency or **whose act or omission necessitated** emergency management measures. N.C.G.S. 1-539.10(b) does not apply to the immunity provided in this subsection.

(b) The rights of any person to receive benefits to which the person would otherwise be entitled under this Article or under the Workers' Compensation Law or under any pension law, and the right of any such person to receive any benefits or compensation under any act of Congress shall not be affected by performance of emergency management functions.

(c) Any requirement for a license to practice any professional, mechanical or other skill shall not apply to any authorized emergency management worker who shall, in the course of performing the worker's duties as such, practice such professional, mechanical or other skill during a state of disaster.

(d) As used in this section, the term "emergency management worker" shall include any full or part-time paid, volunteer or auxiliary employee of this State or other states, territories, possessions or the District of Columbia, of the federal government or any neighboring country or of any political subdivision thereof or of any agency or organization performing emergency management services at any place in this State, subject to the order or control of or pursuant to a request of the State government or any political subdivision thereof. The term "emergency management worker" under this section shall also include any health care worker performing health care services as a member of a hospital-based or county-based State Medical Assistance Team designated by the North Carolina Office of Emergency Medical Services and any person performing emergency health care services under G.S. 90-12.2.

(e) Any emergency management worker, as defined in this section, performing emergency management services at any place in this State pursuant to agreements, compacts or arrangements for mutual aid and assistance to which the State or a political subdivision thereof is a party, shall possess the same powers, duties, immunities and privileges the person would ordinarily possess if performing duties in the State, or political subdivision thereof in which normally employed or rendering services."

SECTION 2. This act is effective when it becomes law.

NC DHHS requests $1.5 million to expand NC Quitline services to adult tobacco users who want to quit in 2008.

The purpose of this request is to provide coverage of evidence based tobacco cessation services to adults in order to promote good health, prolong life, prevent cancer, heart and lung disease as well as the vast number of other diseases caused by tobacco use.

This request is for recurring funding to the Division of Public Health to pay for a cost effective and evidence based tobacco cessation service, 1-800-QUIT-NOW for **adult tobacco users ages 25+ who want to quit the use of tobacco** and whose quitline services are not covered by Health and Wellness Trust Fund.

Quitline services are the most cost effective means to provide expert cessation service. This service is provided by professionally trained quit coaches who work with each tobacco user who calls to develop and implement a quit plan that is right for them. Services are available 8am – midnight daily, in multiple languages. Professionally trained quit coaches offer a proactive service, meaning that they can, upon request, call back Quitline users to check on quitting progress, continue the tailored quit plan and answer questions.

$1.5 million allows NC Tobacco Use Quitline to Reach an additional 10,720 tobacco users who want to quit

NC QUIT LINE	1-CALL PLAN	4-CALL PLAN	TOTAL
# CALLERS	5,370	5,350	
COST/CALLER	$100	$180	10,720 CALLERS
TOTAL	$537,000	$963,000	$1,500,00

1-Call Plan: Tobacco user speaks with an expert quit coach to develop tailored quit plan, can last up to an hour

4-Call Plan: 1-Call Plan plus 3 call-backs from quit coach to check on quitting progress and continue tailored quit plan

Why provide funding for the NC Tobacco Use Quitline?

- Tobacco use is responsible for one out of five North Carolina deaths. At present **22.1% of adult North Carolinians are addicted to cigarettes**. That is **1,480,947 adult smokers** in our state.
- Most tobacco users **began as children** (age 12-14) and **most want to quit**
- **57.3% of NC adults who smoke made a serious but failed attempt to quit in 2006. (NC BRFSS). That equals 848,583 tobacco users in NC who are trying to quit.**
- 2007-08 annual funding allows the NC Tobacco use Quitline to reach far less than one percent of smokers in North Carolina.
- Tobacco use is responsible for **one out of five deaths** in NC. For every death, there are **20 more that are sick or disabled** due to tobacco use.
- The **costs of tobacco use** are enormous and preventable:
  - **Smoking costs NC $2.46 billion annually in medical costs alone** (2004). Each pack of cigarettes sold in NC costs an estimated $3.06 in direct medical expenses attributable to smoking.

- **Smoking costs the NC Medicaid program $769 million per year** (2004). In 2004, for each pack of cigarettes sold in 2004, North Carolina spent an estimated $.96 in Medicaid costs to treat preventable smoking-related diseases.
- The **State Health Plan has estimated that the annual direct medical costs for smokers in 2007 were $217,368,390.** CDC estimates the ***additional medical costs* of smokers to be $1,623 per smoker per year**. This represents recurrent annual savings after successful cessation.

What are the consequences of not expanding the help to tobacco users who want to quit?

More than 40% of tobacco users in the United States will try to quit each year, but without assistance most will relapse.

Unless the prevalence of tobacco use is reduced dramatically, one out of two current smokers in NC will die prematurely of a disease caused by their dependence on tobacco, shortening lives by an average of 13-14 years.

While NC is making great progress in reducing the prevalence of tobacco use among youth, making real progress in tobacco deaths requires an investment in helping adult tobacco users quit. Research shows that unless current smokers quit, smoking deaths will rise dramatically over the next 50 years. [1]

Quitline Callers Satisfaction

Preliminary data show that **94 percent of callers to the quitline are satisfied or very satisfied** with their NC Quitline experience.

> *If you call, they will help you. If it hadn't been for the Quitline, I would not have quit. They really helped me a lot. Its been 5 weeks now.*
> *-Mr. JW, A Veteran, 336 area code*

NC Quitline: Administration and Funding

This core public health service is administered by the NC Division of Public Health, Tobacco Prevention and Control Branch. It is co-funded by the NC Health and Wellness Trust Fund (for their populations which include youth, young adults, and those adults whose tobacco use behavior influences youth including any employee of K-12 school system or child care center or a primary caregiver of a child under 18 years of age living at home), Blue Cross Blue Shield of NC and the Centers for Disease Control and Prevention through the NC Division of Public Health.

Current NC Budget for 2008-09:

Quitline services for adult tobacco users who want to quit:	$127,199
Quitline services for HWTF populations:	$800,000*
Total	$927,199

* This does not include funding that the HWTF has budgeted for Quitline promotions.

Contacts:
Please direct any questions to the Tobacco Prevention and Control Branch, NC Division of Public Health attn. Sally Herndon Malek, MPH at 919-707-5401, sally.malek@ncmail.net.

[1] Peto and Lopez, 2000

Quitlines are evidence based, accessible and cost effective

According to the Centers for Disease Control and Prevention's ***Best Practices for Comprehensive Tobacco Control Programs:***

- **Interventions that increase quitting can decrease premature mortality and tobacco-related health care costs in the short term.**
- Tobacco use screening and brief interventions are **top ranked clinical preventive services** that produce a beneficial public health impact and are **effective, cost effective and cost-saving**.
- Tobacco use treatment is more cost-effective than other commonly provided clinical preventive services, including mammography, colon cancer screening, pap tests, treatment of mild to moderate hypertension, and treatment of high cholesterol.

All 50 states and the District of Columbia offer Quitline services as an evidence-based and core public health practice. 1-800-QUIT-NOW is the portal for all state quitlines.

The Centers for Disease Control and Prevention recommends that state quitlines increase funding to reach six percent of North Carolina smokers. Nationally, state quitlines reach an average of four percent of smokers while NC Tobacco Use Quitline funding has not been available to reach 1% of NC smokers. This budget request is an incremental step toward that goal.

Proactive quitline telephone services increase abstinence rates by 41% over tobacco users who do not use quitline services.

Combining tobacco use cessation coaching with evidence based cessation medications is most effective. Many state quitlines provide evidence based nicotine replacement therapy (NRT) as a part of the service.

Quitlines are accessible at times when tobacco users may need the assistance, unlike cessation classes or busy clinic staff.

Quitlines are an excellent referral resource for busy physicians.

> *I was anxious, nervous, scared; but the Quitline supported me all the way through.*
>
> *-Ms. SM, 22 years old, Kitty Hawk, NC*

North Carolina Public Health

How Does the North Carolina Tobacco Use Quitline Work?

Expert Services are Free and Accessible to Individual Quitline Users

- NC provides this free and confidential health service from interactive expert quit coaches 8AM to Midnight 7 days per week to all North Carolinians, both youth and adults, who want to quit using tobacco.
- For those who need services linked to their quit coach from midnight to 8am, or those who prefer an online program, an interactive web-based quit program is available 24 hours a day, in which the tobacco user can go through cessation support materials, continue to develop a quit plan and work on other quitting strategies. These activities can later be reviewed by the quit coach and tobacco user together at the next call. During hours of operation tobacco users may also click a web link prompting a quit coach to call them within a few minutes time.
- The caller may enroll in the 4-call program in which the quit coach helps the tobacco user make a plan to quit and arranges to call the participant back at agreed upon times to check on quitting progress, offer support and answer questions. Callers can also enroll in a one-call program, talking with an expert quit coach for up to an hour.
- There is no cost to the quitline participant for educational materials.

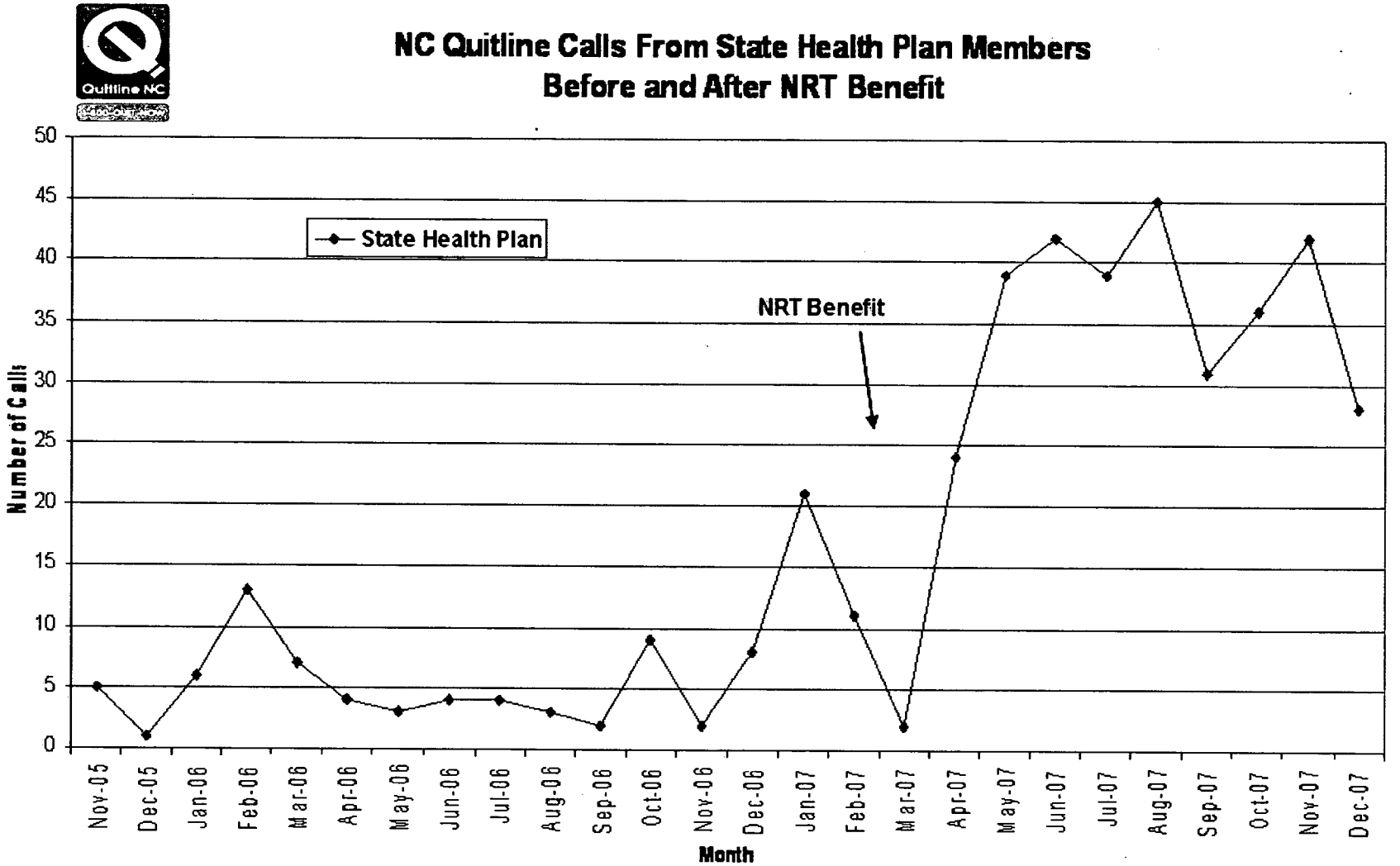
How do tobacco users know to call the Quitline?

- **The most common way tobacco users hear about the NC Tobacco Use Quitline to-date is through their healthcare provider.** The NC Tobacco Use Quitline has been marketed to health care providers across the state and health care providers are beginning to utilize this valuable referral resource.
- Tobacco users also hear about the NC Tobacco Use Quitline through family members and friends; their workplace or community organizations; through paid Radio or TV ads; or through the news media.
- NC employers and health plans are also beginning to market the quitline as an effective tool to help prevent illness and avoidable health care expenditures.
- Paid media promotions produces predictable spikes in call volume if they are focus group tested with the target audience and placed by a competent vendor.
- The Quitline call volume is directly tied to promotions. When funding is available to provide services, call volume can be increased through promotions. When services funding is limited, promotions must be limited or cut back. Promotions can be targeted to increase call volume in specific groups.

Costs of Quitline Service to NC

- The 4-call program actual cost is $180. The tobacco user has an initial coaching session with an expert quit coach plus three call-backs from the expert quit coach after the quit date, at times arranged with the caller, to continue tailored cessation assistance.
- One-call program actual cost is $100. The tobacco user speaks with a quit coach at a time that is convenient for the caller. These tailored sessions with an expert quit coach may last up to one hour.
- Quit Kit educational materials cost is $10. Each caller receives a quit kit consisting of tailored educational materials designed to assist the caller through the cessation process.
- CDC documents the average costs for quitline services provided by states in 2004 dollars were between $175-230 per program participant served by a proactive Quitline. Thus, North Carolina's Quitline costs of $180 per program participant in the 4-call program are in line with other states' quitline costs per comparable service.
- These costs do not include costs to promote the NC Tobacco Use Quitline. HWTF and NC DPH have modest, separate budgets and plans to promote 1-800-QuitNow.

North Carolina Public Health


NC Quitline Calls From State Health Plan Members
Before and After NRT Benefit
Quitline NC
State Health Plan
NRT Benefit
Number of Calls
Month
0
5
10
15
20
25
30
35
40
45
50
Nov-05
Dec-05
Jan-06
Feb-06
Mar-06
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Sep-06
Oct-06
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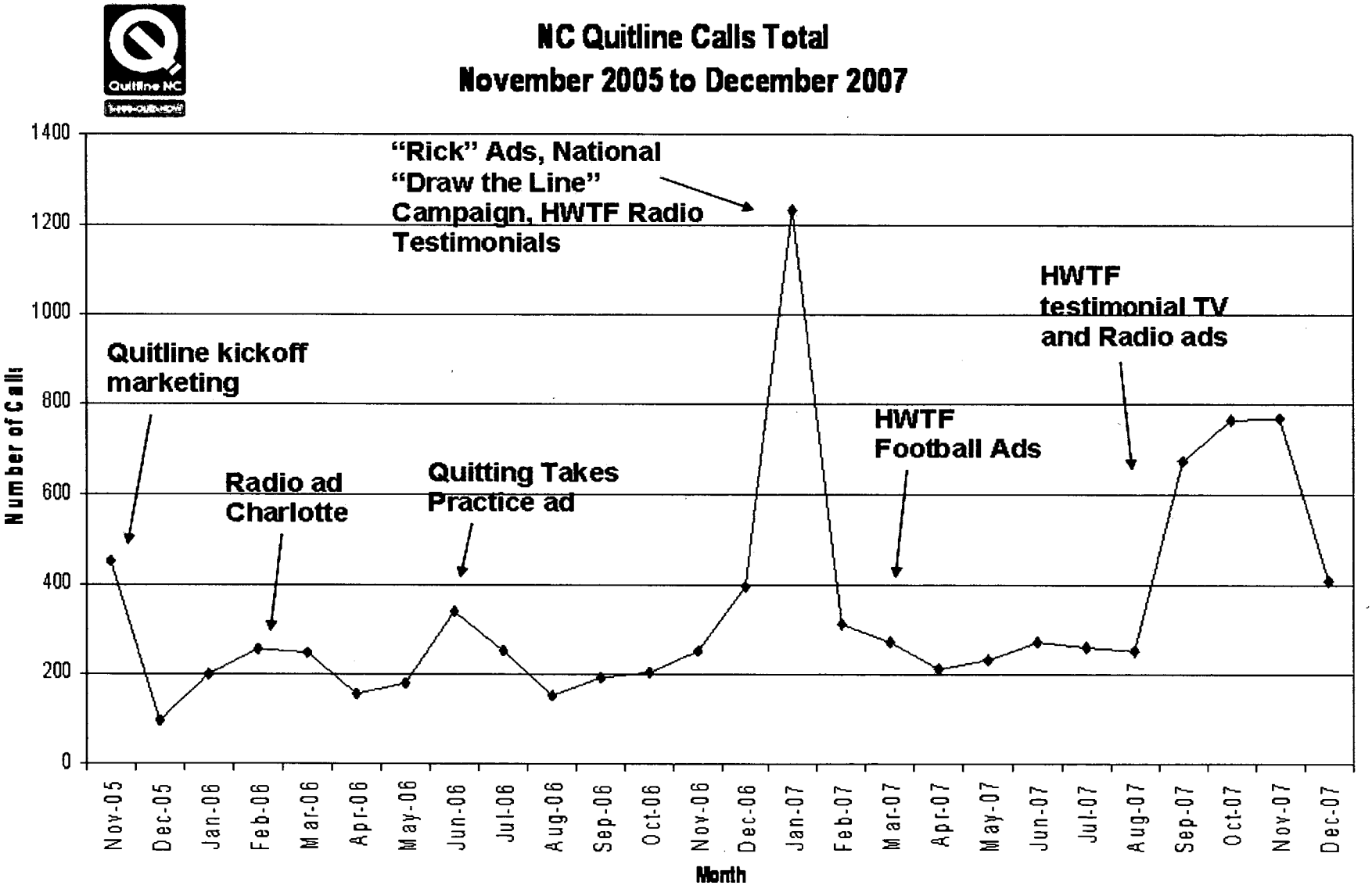
NC Quitline Calls Total
November 2005 to December 2007
Quitline NC
"Rick" Ads, National "Draw the Line" Campaign, HWTF Radio Testimonials
HWTF testimonial TV and Radio ads
Quitline kickoff marketing
HWTF Football Ads
Radio ad Charlotte
Quitting Takes Practice ad
Number of Calls
1400
1200
1000
800
600
400
200
0
Nov-05
Dec-05
Jan-06
Feb-06
Mar-06
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Sep-06
Oct-06
Nov-06
Dec-06
Jan-07
Feb-07
Mar-07
Apr-07
May-07
Jun-07
Jul-07
Aug-07
Sep-07
Oct-07
Nov-07
Dec-07
Month

What is the brief history of the NC Tobacco Use Quitline?

The NC Tobacco Use Quitline was launched by the NC Division of Public Health in November 2005 with modest start up funds from CDC and Health and Wellness Trust Fund. As of January 2008, over 9,800 tobacco users have reached the NC Quitline for cessation assistance, with average over the time it has been operational of approximately 360 calls per month. As health care providers learn what an excellent service this is, and workplaces and health plans begin referring to the NC Tobacco Use Quitline, there is a growing demand.

NC Quitline: Call Volume and Satisfaction

- **Call volume is directly tied to promotions**. Call volume can be easily increased by marketing the NC Tobacco Use Quitline services. Paid and earned media events show a marked spike in call volume.
- **The most common way tobacco users hear about the NC Tobacco Use Quitline to-date is through their healthcare provider.** The NC Tobacco Use Quitline has been marketed to health care providers across the state and health care providers are beginning to utilize this valuable referral resource.
- Preliminary data show that **94 percent of callers to the quitline are satisfied or very satisfied** with their NC Quitline experience.
- The **State Health Plan** is promoting the NC Quitline in conjunction with free evidence based cessation medications to help state employees who want to quit. This is very timely as per S.L.2007-193, state controlled buildings are smokefree as of January 1, 2008.
- Current annual funding allows the NC Quitline to reach far less than one percent of smokers in North Carolina.
- State quitlines across the US currently reach an average of four percent of smokers.
- The Centers for Disease Control and Prevention recommend that state quitlines reach six percent of smokers. Quitlines must be promoted in order to reach tobacco users who are ready to quit. This can be done through mass media, earned media, referrals from health care professionals and promotions within worksite, school and community settings.

> *For anybody who is quitting, its great to have someone who is neutral, with advice and information when you are going through withdrawal, who is not nagging like my family does. It's great to have the Quitline to call.*
>
> *-Ms. DA, Greensboro, disabled, smoked for 35 years and quit to be able to volunteer to read to young children*

North Carolina Public Health

Tobacco Use Prevention and Cessation -- What Works?

Quitlines are a part of a comprehensive evidence based tobacco prevention and control program that:

1. Prevents the initiation of tobacco use;
2. Promotes and provides assistance in quitting tobacco use; and
3. Eliminates exposure to secondhand smoke; and 3) Identifies and eliminates tobacco-related health disparities.

While Quitlines alone are not the answer, they are an integral part of what we know to be effective.

The Task Force on Community Preventive Services **strongly recommends**:

- Increasing the unit price of tobacco products
- Conducting mass media campaigns combined with community interventions
- Providing telephone based cessation support
- Reducing out of pocket costs for patients
- Implementing health care provider reminder systems (alone or combined with provider education)
- Smoking bans in workplaces and public places

What was your experience with the NC Tobacco Use Quitline like?

Up front thought it was corny and cheesy, but after talking to Quitline, talked through it - it was a motivating process.

-Mr. J.I., 32 years old, Charlotte

North Carolina Public Health

References

1. Morbidity and Mortality Weekly Report. Annual smoking-attributable mortality, years of potential life lost, and productivity losses – United States, 1995-1999. April 12, 2002 http://www.cdc.gov/MMWR/preview/mmwrhtml/mm5114a2.htm.
2. Fiore et al. Progress, Setbacks and Future Needs: Prevention 3 Million Premature Deaths and Helping 5 Million Smokers Quit: A National Action Plan for Tobacco Cessation. American Journal of Public Health. February 2004.
3. Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs October 2007 pp 40,
4. Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs August 1999. www.cdc.gov/tobac/bestprac.htm
5. Centers for Disease Control and Prevention. Telephone Quitlines: A Resource for Development, Implementation and Evaluation. Atlanta GA: US DHHS, Sept 2004.

Attach 7

Objective: **Improve Immunization Rates For *All* Recommended Vaccines**

Cost: $31.3 million in Recurring Appropriations to Add 5 Vaccines Not Yet Included in the NC Universal Immunization Program

Justification:

- The General Assembly has determined that providing all vaccines required by the state free of charge to all children, regardless of family income, is sound public policy. It has increased immunization rates (NC now ranks second nationally); it protects not only children from the mortality and morbidity associated with communicable diseases, but also others who come in contact with children; it helps keep children within their medical home; and each dollar spent on vaccines saves $15 in costs to treat diseases.

- There are now 5 childhood vaccines recommended by the CDC which cannot be provided universally in North Carolina because of insufficient funding. The 5 vaccines are:

    - Influenza
    - PCV7 (pneumococcal)
    - Rotavirus
    - MCV4 (meningococcal)
    - HPV (human papillomavirus)

- While federal funding is available to provide these vaccines to children enrolled in Medicaid and selected other groups, the requested funding will ensure that every child has access to all recommended vaccines.

- These newer vaccines tend to be much more costly than those already included in the NC Universal Immunization Program. An estimated $31.3 million in recurring appropriations is required to assure that these vaccines would be universally available to our children.

Attach 8

Objective: **Improve the School Nurse: Student Ratio to 1:750 in 5 Years**

Request: Additional $10.8 million Recurring Each Year for 5 Years

Justification:

- The positive correlation between health and school performance is not only intuitive, but has been shown in numerous studies. Healthy students have better attendance, are more attentive, and have generally better educational outcomes.

- A comprehensive school health program has eight components, ranging from health education to school-based/ school-linked health centers.

- The critical linchpin in such a comprehensive program is the school health nurse. These specially trained professionals provide preventive health services for all students, and both administer and monitor medications for students who need them during the school day. More critically, they respond to the growing number of students with special health needs by participating in the development of health care plans, as well as directly providing nebulizer treatments, tube feedings, blood glucose monitoring, management of insulin pumps, and other services without which these students would not be able to attend and succeed at school.

- The national standard is that there be one school nurse for each 750 students. As a result of increased appropriations provided by the General Assembly in recent years, the school nurse-student ratio has been reduced. However, the current ratio remains approximately 1: 1280, leaving many students with inadequate services.

- Taking into account projected increases in student enrollment, increased appropriations of $10.8 million are needed in each of the next 5 years to improve the school nurse: student ratio to 1:750.

Attach 9

Objective: **To Clarify the Definition and Occurrence of Corporal Punishment In the Public Schools**

Justification:

- North Carolina is one of 22 states that still allows corporal punishment in its public schools. Local school boards may ban the practice if they wish.

- In 2007, the NC House considered and defeated a bill to ban corporal punishment. In the course of the debate, it became evident that the current law does not include a definition of corporal punishment, nor does it require that reports of its occurrence be submitted by local districts to the State Board of Education. Thus, no one knows the current extent of this practice in our state.

- Since a definition is neither in state law nor State Board of Education policies, corporal punishment may be administered quite differently across the state. A review of local policies (which are not filed with the State Board) shows variations on the use of implements, the involvement of parental consent, whether men can hit girls, etc. There appear to be no requirements for training, and the use of "discretion' within each individual school is often cited. To standardize the practice of corporal punishment and to avoid "due process" complaints, statutory guidance is needed.

- In addition, when allegations were made that minority students are disproportionately subjected to corporal punishment, there are no data to support or refute those allegations. In fact, many local districts do not even require school principals to report such occurrences to the local superintendent. Thus, the administration of corporal punishment is largely unmonitored. Once again, statutory guidance appears necessary to help assure that corporal punishment is being administered in accordance with constitutional requirements.

- The following draft is designed to standardize the administration of corporal punishment across the state, as well as to monitor its administration on an ongoing basis.

Sec. 115C-391. Corporal Punishment, suspension, or expulsion of pupils.

(a) Local boards of education shall adopt policies not inconsistent with the provisions of the Constitutions of the United States and North Carolina, governing the conduct of students and establishing procedures to be followed by school officials in suspending or expelling any student, or in disciplining any student if the offensive behavior could result in suspension, expulsion, or the administration of corporal punishment. Local boards of education shall include a reasonable dress code for students in these policies.

The policies that shall be adopted for the administration of corporal punishment shall include at a minimum the following conditions:

(1) Corporal punishment shall be administered only by hand spanking on the buttocks through the student's customary mode of dress;

(2) The student body shall be informed beforehand what general types of misconduct could result in corporal punishment;

(3) Only a teacher, principal, or assistant principal of the same gender of the student and who has been trained in the administration of corporal punishment may administer corporal punishment and may do so only in the presence of a principal, assistant principal, teacher, substitute teacher, teacher assistant, or student teacher, who shall be informed beforehand and in the student's presence of the reason for the punishment; and

(4) An appropriate school official shall provide the child's parent or guardian with notification that corporal punishment has been administered, and upon request, the official who administered the corporal punishment shall provide the child's parent or guardian a written explanation of the reasons and the name of the second school official who was present.

Each local board shall report to the State Board of Education annually the number of times that corporal punishment has been administered by student's age, gender, race, and whether the student is receiving special education services, in a manner prescribed by the State Board, except that the first report shall be submitted by January 31, 2009, and shall cover the period August-December 2008.

Each local board shall publish all the policies mandated by this subsection and make them available to each student and his parent or guardian at the beginning of each school year. Notwithstanding any policy adopted pursuant to this section, school personnel may use reasonable force, including corporal punishment, to control behavior or remove a person from the scene in those situations when necessary:

(1) To quell a disturbance threatening injury to others;

(2) To obtain possession of weapons or other dangerous objects on the person, or within the control, of a student;

(3) For self-defense;

(4) For the protection of persons or property; or

(5) To maintain order on school property, in the classroom, or at a school-related activity on or off school property.

Note: The remainder of this Section relates to suspension and expulsion. No changes are proposed.

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Note: The remainder of this Section relates to suspension and expulsion. No changes are proposed.

NORTH CAROLINA GENERAL ASSEMBLY

PUBLIC HEALTH STUDY COMMISSION
MINUTES
April 22, 2008

The Public Health Study Commission met on Tuesday, April 22, 2008 in Room 544 of the Legislative Office Building. Members present were Cochairs Senator William Purcell and Representative Bob England. Committee members present were Senators Atwater and Dorsett; Representatives Adams, Current, Insko, and Justus. Public Members who attended were Dr. Baker, Ms. Lovette, Ms. Thomas, and Dr. Leah Devlin, Ex-Officio member. Staff present was Shawn Parker, Ben Popkin, Lisa Brown and Lorraine Blake.

The meeting was called to order by Senator William Purcell. The purpose of this meeting was to present to the full committee the Public Health Study Commission Report to the 2008 Regular Session of the 2007 General Assembly. A copy of that report is included with these minutes as Attachment II.

The report includes the minutes of the two previous meetings of this Commission, the first on February 26, 2008 and the second on March 25, 2008. The report contains five recommendations from the Commission as a result of their study. (1) Provide liability protection for private entities when responding to In-State Incidents; (2) Direct the N.C. General Statues Commission to study the Uniform Emergency Volunteer Health Practitioners Act and Make Recommendations to the General Assembly. (3) Clarify Corporal Punishment Policies in Public Schools. (4) Appropriate Funds to Implement High Priority Initiatives Within the North Carolina Public Health Improvement Plan and (5) Endorse Findings and Recommendations Presented in The Public Health Task Force 2008 Final Report- "North Carolina Public Health Improvement Plan". The last section of the Final Report contains the Draft Legislation to accomplish those recommendations.

Final action needed by the Commission was the approval of this Final Report to the 2008 Regular Session of the 2007 General Assembly. The Commission unanimously approved this report.

Respectfully submitted,

Lorraine Blake \ Becky Hedspeth

Lorraine Blake, Committee ~~Clerk~~

William R. Purcell

Senator William R. Purcell, M.D., Co-Chair

Representative Bob England, Co-Chair

NORTH CAROLINA GENERAL ASSEMBLY

Public Health Study Commission

MEMORANDUM

TO: Members, Public Health Study Commission

FROM: Senator William Purcell, Co-Chair
Representative Bob England, Co-Chair

SUBJECT: Meeting Notice

The Public Health Study Commission will meet on the following date:

DAY: Tuesday
DATE: April 22, 2008
TIME: 10:00 a.m.
LOCATION: Room 544, LOB

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. The cost for visitor parking is $1.00 per hour or $8.00 per day and may be reimbursed with a parking receipt submitted with your travel reimbursement form.

If you have any questions concerning this meeting, please contact Becky Hedspeth at 919-733-5953 or Lisa Brown at 919-733-5749.

Agenda

Public Health Study Commission

Tuesday, April 22, 2008
10:00 a.m. – 12:00 p.m.
Room 544, LOB

I. Welcome and Introductions
Senator Bill Purcell, Co-Chair
Representative Bob England, Co-Chair

II. Overview of Public Health Study Commission Report to the General Assembly.
Ben Popkin, Commission Staff

III. Draft Legislation
Shawn Parker, Commission Staff
Ben Popkin, Commission Staff

IV. Discussion and Adoption of Interim Report
Public Health Study Commission Members

V. Adjourn

PUBLIC HEALTH STUDY COMMISSION

REPORT TO THE 2008 REGULAR SESSION OF THE 2007 GENERAL ASSEMBLY

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STATE OF NORTH CAROLINA

PUBLIC HEALTH STUDY COMMISSION

May 12, 2008

TO THE MEMBERS OF THE 2007 GENERAL ASSEMBLY (2008 Regular Session)

The Public Health Study Commission submits for your consideration its report pursuant to G.S. 120-202.

Respectfully submitted,

Senator William Purcell, MD

Representative Bob England, MD

PUBLIC HEALTH STUDY COMMISSION
MEMBERSHIP LIST
2007-2008

Pro Tem's Appointments

Sen. William Robert Purcell MD - Co-Chair
North Carolina Senate
300 N. Salisbury Street, Room 625
Raleigh, NC 27603-5925
(919) 733-5953

Sen. Robert C. Atwater
North Carolina Senate
300 N. Salisbury Street, Room 312A
Raleigh, NC 27603-5925
(919) 715-3036

Sen. Katie G. Dorsett
North Carolina Senate
16 W. Jones Street, Room 2106
Raleigh, NC 27601-2808
(919) 715-3042

Sen. James Summers Forrester
North Carolina Senate
16 W. Jones Street, Room 1129
Raleigh, NC 27601-2808
(919) 715-3050

Sen. Vernon Malone
North Carolina Senate
300 N. Salisbury Street, Room 314
Raleigh, NC 27603-5925
(919) 733-5880

Ms. Beth Lovette (Public Member)
306 College Street
Wilkesboro, NC 28697

Ms. Anne Thomas (Public Member)
109 Exeter Street
Manteo, NC 27954

Governor's Appointments

Dr. Ronald H. Levine (Public Member)
2404 White Oak Road
Raleigh, NC 27609

Speaker's Appointments

Rep. Bob F. England MD – Co-Chair
North Carolina House of Representatives
16 W. Jones Street, Room 2219
Raleigh, NC 27601-1096
(919) 733-5749

Rep. Alma S. Adams
North Carolina House of Representatives
300 N. Salisbury Street, Room 304
Raleigh, NC 27603-5925
(919) 733-5802

Rep. William A. Current Sr.
North Carolina House of Representatives
300 N. Salisbury Street, Room 418A
Raleigh, NC 27603-5925
(919) 733-5809

Rep. Verla C. Insko
North Carolina House of Representatives
300 N. Salisbury Street, Room 307B1
Raleigh, NC 27603-5925
(919) 733-7208

Rep. Carolyn K. Justus
North Carolina House of Representatives
16 W. Jones Street, Room 1023
Raleigh, NC 27601-1096
(919) 733-5956

Dr. Edward L. Baker Jr. (Public Member)
Institute for Public Health
UNC-Chapel Hill, Campus Box 8165
Chapel Hill, NC 27599-8165 NC

Dr. Evelyn Schmidt (Public Member)
2330 Bedford Street
Durham, NC 27707

Other's Appointments

Dr. Leah Devlin (Ex Officio)
5605 Six Forks Rd, 1st Floor (27609)
1931 Mail Service Center
Raleigh, NC 27699-1931

Rev. Reginald Wells (Public Member)
466 Cornwallis Road
Teachey, NC 28464

Staff List

Lorraine Blake (Sen. Purcell) -Commission Clerk
(919) 733-5953

Lisa Brown (Rep. England) – Commission Clerk
(919) 733-5749

Ben Popkin, Research Division
(919) 733-2578
Email: benp@ncleg.net

Shawn Parker, Research Division
(919) 733-2578
Email: shawnp@ncleg.net

Susan Barham, Research Division
(919) 733-2578
Email: susanb@ncleg.net

COMMISSION PROCEEDINGS

The Public Health Study Commission met 3 times during the 2007-2008 interim. Following is a summary of the Commission's proceedings.

February 26, 2008

The Public Health Study Commission met on Tuesday, February 26, 2008 in Room 544 of the Legislative Office Building. Senator Purcell, Co-Chair, called the meeting to order and commission members introduced themselves.

Shawn Parker, Research Division, reviewed G.S. 120-195 that created the Public Health Study Commission and G.S. 120-196 that set out the duties and powers of the Commission.

Dempsey Benton, Secretary of the Department of Health and Human Services and chair of the Public Health Task Force 2008, gave opening remarks commending the Final Report of the North Carolina Public Health Task Force 2008 and its recommendations. Four sub-committees worked on the 2008 Report and include: Strengthen Core Public Health, Chronic Disease and Injury, Healthy Children and Families, and Communicable Disease and Preparedness.

Dr. Leah Devlin, State Health Director, Division of Public Health (DPH), addressed the Commission on three areas of focus for the meeting: the state of health in North Carolina; the investments in the public health governmental system; and the recommended priorities for the future. Dr. Devlin stated the solution for the major health risks of tobacco, obesity, and physical inactivity was prevention. Tobacco use, obesity, and physical inactivity cost our State $25.82 billion annually in health care costs.

Dr. Marcus Plescia, Chronic Disease and Injury Section Chief, DPH, reported on obesity and tobacco control, support for chronic disease management, support for public health surveillance, and expansion of statewide dental health services.

Dr. Jeff Engle, Epidemiology Section Chief, DPH presented public health priorities: needs within the State Medical Examiner System, shoring up local epidemiology teams, raising eligibility for the AIDS Drug Assistance Program, and legislation to improve public health preparedness and response.

Dr. Kevin Ryan, Women's and Children's Health Section Chief, DPH, reported on healthy families. Priorities in this area included Every Child Succeeds, school nurses, universal vaccinations, improving birth outcomes, and expansion of statewide dental health services.

Dr. Rosie Summers, Orange County Health Director, discussed recommendations on core public health issues and finance.

Dr. Steve Cline, Deputy State Health Director, DPH, addressed funding recommendations for public health: increasing the tobacco tax to the national average of $1.09 per pack; enabling local authorities to set fees for food and lodging inspections; creating a permanent and sustainable funding source for the Universal Vaccine Program; correcting the fee adjustment process for local health departments and child development service agencies; and adjusting the newborn screening fee to support adding cystic fibrosis screening.

March 25, 2008

The Public Health Study Commission met on Tuesday, March 25, 2008 in Room 544 of the Legislative Office Building. Representative Bob England, Co-Chair, called the meeting to order.

Bill Pully, North Carolina Hospital Association, discussed the NC Hospital and Public Health Strategic Planning Initiative.

Colleen Bridger, Director, Gaston County Health Department, presented a proposal to reduce childhood obesity through community demonstration projects, public awareness, and statewide coalition building.

Merle Green, Director, Guilford County Health Department, discussed the effects of dental disease on the oral health of children and adults, access to health care, school health, and obesity and chronic illnesses in children.

Dennis Harrington, Deputy Director and Chief of Administrative, Local, and Community Support, DPH, explained that funding for local health departments needed to be non-categorical and stable to support the local system.

Gibbie Harris, Director, Wake County Health Department, explained the need for emergency volunteer legislation in the event of a disaster or pandemic.

Chris Hoke, Chief of Regulatory and Legal Affairs, DPH, presented options for emergency volunteer legislation including liability protection for private entities when responding to State emergencies or disasters and a uniform act for emergency volunteer health practitioners.

Dr. John Morrow, Director, Pitt County Health Department, and Dr. John Butts, Chief, Medical Examiner's Office, DPH, discussed the funding options and goals for the medical examiner expansion proposal.

Dr. Jana Johnson, Medical Director, Tobacco Prevention and Control, DPH, reviewed information on Quit Line NC, a prevention and cessation program that promotes and provides assistance in quitting tobacco use.

Dr. Robert Monteiro, Chair, Craven County Board of Health, discussed the benefits of smoking prevention and cessation.

Tom Vitaglione, Action for Children North Carolina, provided information on improving immunization rates for recommended vaccines, defining corporal punishment in schools, and improving school nurse ratios.

Dr. Steve Cline, Deputy State Health Director, DPH, discussed cystic fibrosis, the AIDS Drug Assistance Program, and retired nurses return to work.

April 22, 2008

The Public Health Study Commission met on Tuesday, April 22, 2008 in Room 544 of the Legislative Office Building. Senator Purcell, Co-Chair, called the meeting to order.

Ben Popkin, Research Division, and Shawn Parker, Research Division, presented the final report and draft legislation to the Commission.

Senator Purcell made the motion that the report be approved and authorized staff to make technical corrections as necessary. The motion was approved by the Commission.

RECOMMENDATIONS

Chairs:

Senator William Purcell, MD
Representative Bob England, MD

RECOMMENDATION 1: PROVIDE LIABILITY PROTECTION FOR PRIVATE ENTITIES WHEN RESPONDING TO IN-STATE INCIDENTS.

The Public Health Study Commission recommends that the General Assembly enact legislation to provide liability protection for private associations, private corporations and private non-profit entities and organizations that volunteer to aid in the response to Governor declared emergencies.

RECOMMENDATION 2: DIRECT THE NORTH CAROLINA GENERAL STATUTES COMMISSION TO STUDY THE UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT AND MAKE RECOMMENDATIONS TO THE GENERAL ASSEMBLY.

The Public Health Study Commission recommends that the General Assembly enact legislation to direct the North Carolina General Statutes Commission to study the Uniform Emergency Volunteer Health Practitioners Act in consultation with interested parties and report to the 2009 General Assembly on the Commission's recommendations and legislative proposals.

RECOMMENDATION 3: CLARIFY CORPORAL PUNISHMENT POLICIES IN PUBLIC SCHOOLS.

The Public Health Study Commission recommends that the General Assembly enact legislation to clarify corporal punishment policies in public schools, to include defining what specific action constitutes corporal punishment, call for training in the administration of corporal punishment, and require annual reporting of corporal punishment administered to students.

RECOMMENDATION 4: APPROPRIATE FUNDS TO IMPLEMENT HIGH PRIORITY INITIATIVES WITHIN THE NORTH CAROLINA PUBLIC HEALTH IMPROVEMENT PLAN.

The Public Health Study Commission recommends that the General Assembly enact legislation to appropriate funds from the General Fund to the Department of Health and Human Services, Division of Public Health, to implement high priority initiatives within the North Carolina Public Health Improvement Plan, Public Health Task Force 2008 Final Report. Funds appropriated should be used to supplement and not supplant existing State, federal, county, or other funds allocated for the following identified purposes: build local health department capacity to provide the 10 essential public health services, implement "Eat Smart and Move More" the State's obesity prevention plan, support the State's smoking cessation help line, hire additional school nurses, provide universal childhood vaccines to all children in the State, and to fund improvements and the

operations of the Office of the Chief Medical Examiner's regional medical examiner facilities.

RECOMMENDATION 5: ENDORSE FINDINGS AND RECOMMENDATIONS PRESENTED IN THE PUBLIC HEALTH TASK FORCE 2008 FINAL REPORT – "NORTH CAROLINA PUBLIC HEALTH IMPROVEMENT PLAN".

The Public Health Study Commission endorses the findings and recommendations presented in the "North Carolina Public Health Improvement Plan," the Final Report of the Public Health Task Force 2008. Recommendations contained in the report identify issues, programs, and policies to which attention must be paid to enable the State to continue to improve the health of all residents of the State.

DRAFT LEGISLATION

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-RDz-25 [v.3] (04/18)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/21/2008 4:53:01 PM

Short Title: Liability protection/private orgs/emergencies. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE LIABILITY PROTECTION FOR PRIVATE ASSOCIATIONS, PRIVATE CORPORATIONS AND PRIVATE NON-PROFIT ENTITIES AND ORGANIZATIONS WHEN RESPONDING TO GOVERNOR DECLARED EMERGENCIES, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 166A-14 reads as rewritten:

"**§ 166A-14. Immunity and exemption.**

(a) All functions hereunder and all other activities relating to emergency management are hereby declared to be governmental functions. Neither the State nor any political subdivision thereof, nor, except in cases of willful misconduct, gross negligence or bad faith, any emergency management ~~worker~~ worker, individual, firm, partnership, association, or corporation complying with or reasonably attempting to comply with this Article or any order, rule or regulation promulgated pursuant to the provisions of this Article or pursuant to any ordinance relating to any emergency management measures enacted by any political subdivision of the State, shall be liable for the death of or injury to persons, or for damage to property as a result of any such activity. The immunity provided in this subsection applies only to:

(1) individuals, firms, partnerships, associations or corporations performing emergency management services at any place in this State, subject to the order or control of or pursuant to a request of the State government or any political subdivision thereof; and

(2) firms, partnerships, associations or corporations performing emergency management services without compensation or with compensation limited to no more than actual expenses

The immunity provided in this subsection shall not apply to any private individual, firm, partnership, association or corporation, or to any employee or agent of such individual, firm, partnership, association or corporation whose act or omission caused in whole or in part the actual or imminent disaster, emergency or whose act or omission necessitated emergency management measures. G.S. 1-539.10(b) does not apply to the immunity provided in this subsection.

(b) The rights of any person to receive benefits to which the person would otherwise be entitled under this Article or under the Workers' Compensation Law or under any pension law, and the right of any such person to receive any benefits or compensation under any act of Congress shall not be affected by performance of emergency management functions.

(c) Any requirement for a license to practice any professional, mechanical or other skill shall not apply to any authorized emergency management worker who shall, in the course of performing the worker's duties as such, practice such professional, mechanical or other skill during a state of disaster.

(d) As used in this section, the term "emergency management worker" shall include any full or part-time paid, volunteer or auxiliary employee of this State or other states, territories, possessions or the District of Columbia, of the federal government or any neighboring country or of any political subdivision thereof or of any agency or organization performing emergency management services at any place in this State, subject to the order or control of or pursuant to a request of the State government or any political subdivision thereof. The term "emergency management worker" under this section shall also include any health care worker performing health care services as a member of a hospital-based or county-based State Medical Assistance Team designated by the North Carolina Office of Emergency Medical Services and any person performing emergency health care services under G.S. 90-12.2.

(e) Any emergency management worker, as defined in this section, performing emergency management services at any place in this State pursuant to agreements, compacts or arrangements for mutual aid and assistance to which the State or a political subdivision thereof is a party, shall possess the same powers, duties, immunities and privileges the person would ordinarily possess if performing duties in the State, or political subdivision thereof in which normally employed or rendering services."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-RDz-21 [v.4] (04/15)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/21/2008 5:24:59 PM

Short Title: GS Commiss Study Uniform Vol Hlth Pract Act. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE NORTH CAROLINA GENERAL STATUTES COMMISSION TO STUDY THE UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT AND MAKE RECOMMENDATIONS TO THE GENERAL ASSEMBLY, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina General Statutes Commission shall study the Uniform Emergency Volunteer Health Practitioners Act in consultation with interested parties and report to the 2009 General Assembly on the Commission's recommendations and legislative proposals.

SECTION 2. This act becomes effective October 1, 2008.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-RDz-24 [v.3] (04/18)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/21/2008 3:22:51 PM

Short Title: Clarify Corporal Punishment Policy. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO CLARIFY CORPORAL PUNISHMENT POLICIES IN PUBLIC SCHOOLS, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-391(a) reads as rewritten:

"**§ 115C-391. Corporal punishment, suspension, or expulsion of pupils.**

(a) Local boards of education shall adopt policies not inconsistent with the provisions of the Constitutions of the United States and North Carolina, governing the conduct of students and establishing procedures to be followed by school officials in suspending or expelling any student, or in disciplining any student if the offensive behavior could result in suspension, expulsion, or the administration of corporal punishment. Local boards of education shall include a reasonable dress code for students in these policies.

The policies that shall be adopted for the administration of corporal punishment shall include at a minimum the following conditions:

(1) Corporal punishment shall be administered only by hand spanking on the buttocks through the student's customary mode of dress; ~~Corporal punishment shall not be administered in a classroom with other children present~~;

(2) The student body shall be informed beforehand what general types of misconduct could result in corporal punishment;

(3) Only a teacher, substitute teacher, principal, or assistant principal of the same gender of the student and who has been trained in the administration of corporal punishment may administer corporal punishment and may do so only in the presence of a principal, assistant principal, teacher, substitute teacher, teacher assistant, or student

teacher, who shall be informed beforehand and in the student's presence of the reason for the punishment; and

(4) An appropriate school official shall provide the child's parent or guardian with notification that corporal punishment has been administered, and upon request, the official who administered the corporal punishment shall provide the child's parent or guardian a written explanation of the reasons and the name of the second school official who was present.

Each local board shall report to the State Board of Education annually the number of times that corporal punishment has been administered by student's age, gender, race, and whether the student is receiving special education services, in a manner prescribed by the State Board of Education, except that the first report shall be submitted by January 31, 2009, and shall cover the period of August to December 2008.

Each local board shall publish all the policies mandated by this subsection and make them available to each student and his parent or guardian at the beginning of each school year. Notwithstanding any policy adopted pursuant to this section, school personnel may use reasonable force, including corporal punishment, to control behavior or to remove a person from the scene in those situations when necessary:

(1) To quell a disturbance threatening injury to others;

(2) To obtain possession of weapons or other dangerous objects on the person, or within the control, of a student;

(3) For self-defense;

(4) For the protection of persons or property; or

(5) To maintain order on school property, in the classroom, or at a school-related activity on or off school property."

SECTION 2. This act is effective when it becomes law and applies beginning with the 2008-2009 school year.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-RDz-23 [v.4] (04/18)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/21/2008 3:20:46 PM

Short Title: Fund Public Health Improvement Initiatives. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO IMPLEMENT HIGH PRIORITY INITIATIVES WITHIN THE NORTH CAROLINA PUBLIC HEALTH IMPROVEMENT PLAN, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of eighty million one hundred thirty-four thousand four hundred thirty-six dollars ($80,134,436) for the 2008-2009 fiscal year. Funds appropriated by this act shall be used to supplement and not supplant existing State, federal, county, or other funds allocated for the identified purpose. These funds shall be used to implement high priority initiatives presented in the North Carolina Public Health Improvement Plan, and shall be allocated by the Department of Health and Human Services, Division of Public Health, in the following amounts for the purposes indicated:

(1) $23,000,000 as noncategorical General Aid to County funds to build capacity for the 10 essential public health services in local health departments statewide.

(2) $12,500,000 to support community demonstration projects, community grants, a public awareness campaign, and county implementation of community-based programs that advance the goals and objectives of "East Smart and Move More", North Carolina's obesity prevention plan.

(3) $1,500,000 to support operation of the Tobacco Quit Line.

(4) $10,400,000 to hire additional school nurses to work toward the goal of achieving a statewide school nurse to student ratio of 1:750.

(5) $31,317,772 to provide all CDC-recommended childhood vaccines to all children in the State.

(6) $1,416,664 to support improvements and ongoing operations of the three existing regional medical examiner facilities.

SECTION 2. This act becomes effective July 1, 2008.

Agenda

Public Health Study Commission

Tuesday, December 2, 2008
10:00 a.m. – 1:00 p.m.
Room 1027/1128, Legislative Building

I. Welcome and Introductions
Representative Bob England, Co-Chair
Senator Bill Purcell, Co-Chair

II. Report - NC Public Health Incubator Collaboratives
Dr. Ed Baker, Director, North Carolina Institute for Public Health

III. Opening Remarks
Dr. Leah Devlin, State Health Director, Division of Public Health

IV. Strengthening Public Health Infrastructure – Essential Public Health Services
Rosemary Summers, Orange County Health Director
President, NC Association of Local Health Directors

V. Chronic Disease:
- **Obesity Prevention**
- **Diabetes Education**

Dr. Marcus Plescia, Chief, Chronic Disease and Injury Section, Division of Public Health

VI. Communicable Disease Control:
- **HIV Bridges from the Correction System**
- **Chlamydia Testing in Males**

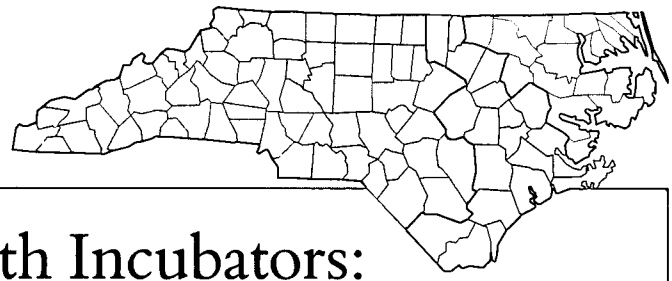
Dr. Jeff Engel, Chief, Epidemiology Section, Division of Public Health

VII. Women and Children's Health:
- **School Health**
- **Early Intervention**
- **Infant Mortality**

Dr. Kevin Ryan, Chief, Women's and Children's Health Section, Division of Public Health

VIII. Discussion and Next Steps
Representative Bob England
Senator Bill Purcell

IX. Adjourn



North Carolina Public Health Incubators: A Record of Success

Based on a unique model of public health collaboration in Northeastern North Carolina, the North Carolina General Assembly began funding Public Health Incubator Collaboratives in 2004. With approximately $1 million in recurring funding, the Public Health Incubator Program brings local health departments together in partnership to find new solutions to pressing public health problems. Four years later, the return on the legislature's investment is clear:

- The state's funding has helped leverage more than $14 million in grant funds for public health improvement in North Carolina.
- Eighty-one counties now participate in one of six regional incubator partnerships to share ideas and pool resources, solve common problems, improve public health – and spread this success across the state.
- In FY08, incubator partnerships took on nine intervention projects to improve public health in North Carolina. These projects include diabetes programs, tobacco use prevention, HIV/AIDS, heart disease and stroke, health disparities among minorities, access to health care, senior health and immunization to prevent cervical cancer.
- The incubator partnerships also worked on 20 projects in FY08 to increase their work capacity. These projects promote workforce development, build stronger ties between researchers and practitioners to accelerate the impact of new research, improve clinic efficiency and improve and automate business practices.
- A survey of public health leaders, who provide the leadership for the Incubator program, indicates it plays a critical role in countless North Carolina communities.

The partnerships and their counties include:

- **The Central North Carolina Partnership** for Public Health includes: Alamance, Caswell, Chatham, Durham, Guilford, Orange, Person, Rockingham, and Wake Counties
- **The Northeastern North Carolina Partnership** for Public Health includes: Bertie, Beaufort, Camden, Chowan, Currituck, Dare, Edgecombe, Gates, Halifax, Hertford, Hyde, Martin, Northampton, Pasquotank, Perquimans, Tyrrell, Warren and Washington Counties
- **The Northwest North Carolina Partnership** for Public Health includes: Alleghany, Ashe, Davidson, Davie, Forsyth, Stokes, Surry, Watauga, Wilkes, and Yadkin Counties
- **The South Central North Carolina Partnership** for Public Health includes: Anson, Bladen, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, Robeson, Sampson, and Scotland Counties
- **The Southern Piedmont North Carolina Partnership** for Public Health includes: Alexander, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union Counties
- **The Western NC Partnership** for Public Health includes: Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania and Yancey Counties.

A list of contacts for each of the partnerships is included in the appendix of this report.

Project Examples

The Incubator program has three main goals. The first goal is to provide services to North Carolinians who would not otherwise receive them. The second goal is to serve as an engine for innovation. The third goal is to spark the creation of programs that are of benefit to other counties – or to the state as a whole.

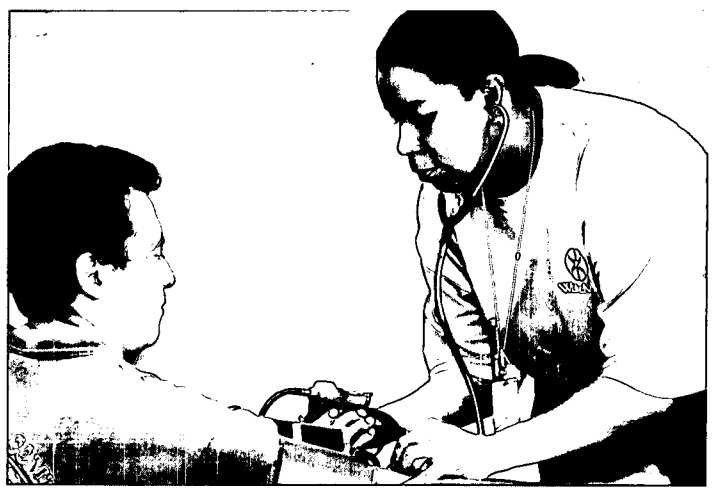
These goals are reflected in the work the various partnerships have taken on:

> "In my 25 years of public health, I have found my involvement in the incubator process to be one of my most productive and innovative experiences."

All quotes in this report come from incubator partnership members surveyed confidentially for incubator evaluation.

- In **Northeastern North Carolina**, the Incubator program's support for a mobile clinic increases access to health screening, HIV/AIDS care and HIV prevention services in the partnership's 19 county region. The partnership has also received grant funding to build on this work with case management, new testing strategies and jail health outreach.
- The **Southern Piedmont Incubator Partnership** won funding from the Robert Wood Johnson Foundation and the Federal Communications Commission to use cutting-edge technology and allow patients to send their doctors the latest information about their condition. This program will allow doctors to improve care in rural areas and create a statewide broadband network for medical providers and patients in even the most remote communities in the state.
- The **South Central Incubator Partnership** provided seed funding for CATCH, an online "data warehouse" to allow officials to easily identify public health priorities, measure the impact of services and programs, target specific populations for health improvements and obtain data for grant proposals and other priorities. CATCH was created with the help of UNC-Charlotte and the State Center for Health Statistics.
- **The Diabetes Sentinel Program** in the northeast includes 31 churches in 19 counties to help hundreds of people at risk of diabetes by training youth leaders to detect early signs of diabetes among their relatives and family friends and refer them to services and other resources about the disease.
- This summer, environmental health data collection systems in **15 Western partnership counties** were completely automated - immensely improving officials' ability to coordinate and improve their efforts to protect public health and the environment. In the process, the Western Partnership in conjunction with the Northeastern and South Central Partnerships saved $275,000 by purchasing software and hardware together.
- Finding and keeping capable employees is a serious challenge for local health departments. The **Central, Northwest and Western partnerships** work together on recruitment and internships and collaborate with county human resource departments to build a competent, responsive and diverse public health workforce.

These are just a few examples of the impact the Incubator Partnerships are having in North Carolina. An overview of each partnership and its work is included in the appendix of this report.
In addition to encouraging regional cooperation, the incubators also help local public health departments and state public health agencies to build stronger, more efficient partnerships. The North Carolina Division of Public Health, the North Carolina Institute of Public Health and North Carolina Association of Local Health Directors all play critical roles in the incubators' success.



Incubators Leverage Private Funds

Together, the Incubator Parnternships have developed some of the most innovative public health programs in North Carolina – and attracted $14 million in grant funding for North Carolina's public health system. This funding includes:

- $6 million from the Federal Communications Commission to provide high speed internet access to local health departments and free clinics in NC.
- $800,000 from the NC Health and Wellness Trust Fund for the Sentinel program to diagnose and manage diabetes among African-Americans in Northeast North Carolina.
- $600,000 from the Robert Wood Johnson Foundation to help train practitioners in workflow analysis and design a regional health information exchange program.
- $660,000 from the NC Health and Wellness Trust Fund for the Sparrow cardiovascular disease and stroke intervention program.

A summary of grant funding provided to the NC Incubator Program is provided in the appendix.

The incubator program recruited and placed more than 1,100 lay health advisors and student mentors in FY 2008 to improve health outcomes regarding diabetes, tobacco use, stroke and heart disease.

In addition to these efforts, incubator partnerships in North Carolina are involved in a wide variety of services and programs:

- Workforce assessments and trainings
- Internships and student learning opportunities
- Practitioner and scholar forums
- Grant writing
- Clinical quality improvement projects
- Disseminating Incubator materials and tools for sharing
- Collective purchasing of equipment and services to benefit from economies of scale
- Supporting public health interventions to address tobacco use, diabetes, heart disease, HIV infection, HPV infections, and cancer screening
- Evaluating incubator project process and efficacy

As the incubator programs mature and have more success, they are sparking innovation across North Carolina, including:

- Workforce development efforts developed in the Western Partnership have been copied in the Northwest and Central Partnerships.
- Business practices to save money and increase efficiency in the Southern Piedmont Partnership are being duplicated in the Northeast Partnership.
- The CATCH "online data warehouse" started with seed funding from the South Central Partnership and will be available statewide when its rollout is completed this year.
- Together, the Incubator Partnerships provided seed funding to create a diabetes education and disease management program within the NC Department of Health and Human Services' Division of Public Health to help local health departments obtain reimbursement for their diabetes efforts – and increase funding for diabetes programs in North Carolina.
- Numerous public health tools developed by incubators and local health departments - for training, public health improvement, and business practices, among many other topics –are now available online for all public health departments.

"It is doubtful that any one county could have received funding for this program. We certainly couldn't have reached the numbers we have without the Incubator funding."

Incubator Partners

A Steering Committee provides guidance and leadership for the Incubator and the individual partnerships. This group includes:

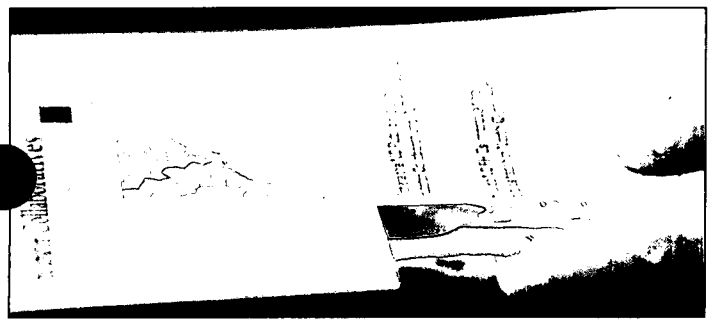
- North Carolina Division of Public Health (NC-DPH) Representative
- North Carolina Association of Local Health Directors (NCALHD) President
- North Carolina Public Health Association (NCPHA) Director
- North Carolina Institute for Public Health (NCIPH) Representatives
- Two representatives from each of the six partnerships

In FY 2008, Incubator partnerships helped evaluate and improve the effectiveness of 18 clinical and environmental health programs.

NC Institute for Public Health

The NCIPH provides administrative oversight and support of the Incubator program and the individual partnerships by:

- Providing logistical support for selected conferences and legislative meetings
- Supporting collaboration with evaluations, training, strategic planning and team-building activities
- Coordinating agendas, facilitating planning sessions and overseeing financial reporting
- Providing project management/implementation support for selected incubator projects
- Staffing Incubator Steering Committee, Project Selection and Public Relations Subcommittees
- Overseeing the Incubator evaluation process
- Providing communications assistance to health directors and public health association leadership.



NC DHHS Division of Public Health

Division of Public Health (DPH) is a key partner in the Incubators' success. DPH reviews incubator plans and progress, and consults with each regional group on project activities. DPH staff members help develop project ideas and assure their alignment with statewide public health priorities and programs. DPH also provides leadership to the Incubators as a member of both the Incubator Steering Committee and Project Selection Committee.

"All [the] projects our department has been involved in have been a huge asset . . . The regional collaboration, networking and alliances generated as a result of the Incubator Collaborative will have long term positive results."

Evaluation of the NC Incubator Program

The first survey and evaluation was conducted in 2006. The survey inquired about various aspects of the incubator program including administration, funding, networking, project implementation, and support received by the NCIPH. Survey results were included in the FY07 and FY08 evaluations. Summaries of both evaluations are included in the appendix.

The FY07 evaluation showed positive ratings for all indicators, including:

- Achieving project goals and objectives.
- Meeting health department needs with the Incubator administrative structure.
- Appropriately distributing resources among member health agencies.
- Improving communication and increasing networking opportunities for public health staff.
- Assisting public health departments in developing best management practices and innovative solutions.

Evaluation of the NC Incubator Program (cont.)

While these results were largely positive, the evaluation did reveal areas for improvement, including the need to identify additional public and private funding sources as well as a desire among Partnership members to do more networking with peers in other regions. In response, the partnerships made several changes to the program including:

- Identifying Partnership priorities and scanning for and disseminating funding opportunities.
- Improving communication strategies to beef up coordination about projects.
- Creating a new website to allow Partnerships to improve communication and coordinate scheduling.
- Holding quarterly Incubator coordinator meetings to increase idea sharing and decrease duplication.
- Organizing the partnerships' annual "All-hands" meeting to increase communication using round table discussions and health director presentations.
- Publishing a quarterly newsletter to increase communication and coordination.

More than 600 people received training in FY 2008 to improve their work in environmental health, dental health, business practices and other core public health competencies.

A second, more extensive evaluation of the Incubators for FY08 was recently completed. The evaluation was again largely positive and indicated strong progress on the areas in need of improvement identified in the FY07 evaluation. The evaluation again identified a need for the partnerships to obtain additional non-state funds to make progress on pressing public health challenges. This result is not surprising in light of North Carolina's growing population, the increasing complexity of the state's public health challenges and the demand on public resources to address them.

Incubator partnerships plan to discuss the evaluation in the coming months and integrate its findings into their work for the rest of FY 2009 as well as for the 2010-2012 biennium.

"The Incubator provides an opportunity to work with other Health Directors on a project instead of just attending meetings together. This helps us develop better working relationships that could be helpful in emergencies . . . "

Key Partnership Contacts

Central
Kelly Goonan
336.641.7777
goonan@email.unc.edu

Northeastern
Joanne Eddy
252.358.7833
joanne.eddy@ncmail.net

Northwest
Candice DuVernois
828.264.4995
candiced@apphealth.com

South Central
Rick Steeves
910.277.7319
normas@carolina.net

Southern Piedmont
Cappie Stanley
704.920.1341
clstanley@cabarrushealth.org

Western
George Bond
828.693.1119
georgebond@bellsouth.net

NC Institute for Public Health
John Graham
919.966-8460
jwgraham@email.unc.edu

Appendix

- Individual NC Incubator Partnership Profiles
- External Funding for Incubator-sponsored Projects
- 2008 NC Public Health Incubator Collaboratives Stakeholder Evaluation Report
- 2007 NC Public Health Incubator Collaboratives Stakeholder Evaluation Report

External Funding for Incubator-Sponsored Projects [1]

How Incubator Projects are leveraged for additional funds.

rant/contract	Funding Source	Amount	Comments
Teen Tobacco	Health Wellness Trust Fund	1,945,367	Teen tobacco prevention and cessation, serving 11 counties
Sentinel Project	Health Wellness Trust Fund	800,000	Diagnose & manage diabetes among African Americans for Northeastern partnership
College Tobacco	Health Wellness Trust Fund	170,730	Area college tobacco prevention and cessation
Sparrow Project	Health Wellness Trust Fund	660,000	South Central cardiovascular disease (CVD) and stroke intervention
MLC III	Robert Wood Johnson Foundation	25,000	Quality initiative for the Central Partnership
Common Grounds S. Piedmont	Robert Wood Johnson Foundation	600,000	Train practitioners in workflow analysis & design, design regional health information exchange
Common Grounds S. Central	Robert Wood Johnson Foundation	30,000	Train practitioners in workflow analysis & design, design HIS related business process
TeleHealth project	Federal Communications Commission	6,000,000	Providing high-speed, redundant Internet Access to local health department and Free Clinics
NE Partnership Administration	U.S. Health Resources and Services Administration	600,000	Provide core admin support for NE Partnership
alth in Motion obile Enhance.	Kate B. Reynolds Charitable Trust	207,069	Make enhancements to the mobile HIV van to expand screening capabilities
Practice-Based Research Network	Robert Wood Johnson Foundation	90,000	Promote research that more readily meets the needs of the practice community
Subtotal [2]		**11,128,166**	
PHTIN Node	Year-end CDC/Preparedness Funding	515,000	Place a PHTIN node in ARHS for Partnership training and communications
Disparity Gap Program	NC Office of Minority Health	240,000	Link local health department health educators to coordinate disparities projects
Health in Motion Mobile Van	HIV/Aids Branch	190,000	Purchase mobile van for screening and treatment
HIV Jail Health	HIV/Aids Branch	60,874	Serving jails in Hertford, Martin, and Bertie counties
Nontraditional Testing HIV	HIV/Aids Branch	230,000	Coordinates mobile outreach regional HIV activities for local health departments and nonprofits
HIV Clinic Continuation Expansion	HIV/Aids Branch	495,000	Delivers HIV medical care, screening, for Northeastern partnership counties
HOPWA	CDC	9,269	Coordinates HIV mobile van activities
ECHAP	HIV/Aids Branch	191,217	Regional staffing for case management
ncer	NC Office of Minority Health	4,500	
Heart Disease/Stroke Prevention/CDC	NC Heart Disease and Stroke Branch	300,000	Improving emergency response for stroke

Grant/contract	Funding Source	Amount	Comments
Disparity Gap Advisory Council	NC Office of Minority Health	20,000	
[redacted]ltural Sensitivity [redacted]pplement	NC Office of Minority Health	6,000	
Subtotal [3]		**2,261,860**	
CATCH	Kate B. Reynolds Charitable Trust	200,000	Community assessment data warehouse construction
Diabetes Umbrella Project	Kate B. Reynolds Charitable Trust	300,000	Secure ADA certification to enable local health department diabetes management
Subtotal[4]		**500,000**	
CDP discounts		275,000	Software license discount for collective purchase of licenses
Subtotal [5]		**275,000**	
Total		**14,165,026**	

1 These funds supplement the legislative funds provided by the NC Legislature. They support individual incubator projects or compliment incubator seed money for joint projects.

2 Grant funds dedicated to incubator projects.

3 Contract funds principally from DPH directly or as pass-through funds from the CDC.

4 Grant funds dedicated to joint projects for which Incubators provided seed money to initiate the projects.

[redacted]avings realized through collective purchasing enabled by incubator collaboration.

North Carolina Public Health Incubator Collaboratives

Fiscal Year 2008

Excerpts from:

Stakeholder Evaluation Report

November 2008

UNC
SCHOOL OF PUBLIC HEALTH

NCIPH

BACKGROUND

The NC Public Health Incubator Collaboratives (NCPHICs) are teams of local health departments voluntarily working together to address pressing local public health issues using innovative approaches. Six NC PHICs (Western, Northwest, Central, South Central, Southern Piedmont, Northeastern) have been formed representing 81 counties. This report includes information collected from an on-line survey of Incubator members administered in June 2008 and from Incubator project reports (for projects funded from July 2007 to June 2008) submitted by Incubator coordinators and staff. For more information about the NC PHICs, visit: www.sph.unc.edu/nciph/incubator. NCIPH, the NCPHIC Administrator, facilitates Incubator activities and manages the program.

EVALUATION METHODOLOGY

Design

The purpose of the evaluation was to examine the experiences of the six Incubator Collaboratives according to the following two questions: 1) Are Incubators providing value to member health departments through specific projects at a regional level?; and 2) Is the NCIPH meeting Incubator partnership needs for support and facilitation?. Evaluation results will be used to inform the Incubator Collaboratives process in the future (e.g., program changes, strategic planning sessions, technical assistance).

Data Collection Methods and Participants

The evaluation involved two components: an on-line survey administered to Incubator members and a review of mid-year and final progress reports submitted by Incubators in an on-line reporting system. The on-line survey asked about participants' experiences with several aspects of the NC PHICs, including: administration; funding; networking; project implementation; and support received by the NCIPH. For all rating questions, respondents were asked to rate their level of agreement on a scale from 1 – Not at all agree to 6 – Strongly agree.

Data Analysis

Data from the on-line survey were organized by evaluation question and survey questions to summarize key findings. Data are presented as means which were calculated for continuous

variables; and/or top two ratings (i.e., percent of respondents that rated a given indicator a 5 or 6); and lists of responses were prepared for all qualitative survey items. Progress reports were reviewed in detail and analyzed according to the three main components of the NCPHIC logic model: Incubator Functioning; Intervention Projects; and Capacity Projects.

RESULTS

Response Rates

The overall response rate for the on-line survey was 85%, with 88% of health director partners responding (Table 1).

Table 1. Survey Response Rates.

Participant Group	Response Rate
Overall Incubator Membership	85% (n=79)[a]
- Health Directors	88% (n=67)
- Incubator Managers	100% (n=6)
- DPH	33% (n=6)

[a] Incubator Partnership response rates ranged from 77% to 100%

Incubator Functioning

Table 2 provides a summary of staffing and specific project areas for Fiscal Year 2008. Variation in staffing levels exists across the Partnerships. Most staff is funded through grants.

Table 2. NCPHIC Staffing and Project Information Summary.

Staffing Categories	Description	Total
# of Full Time Staff	3 partnerships: NW, NE, and C. NE has 22, nearly all of whom are funded through grants.	25
# of Part Time Staff	4 partnerships: NE, SC, C, W	7
# of Interns	NE, SC, C, NW, SP	8
# of Consultants	2 partnerships: NW, W	3

Other evaluation results related to Incubator Functioning come from the survey. Overall, the majority (76%) of respondents mostly or strongly agreed that regional projects benefit local health agencies. When asked what the greatest benefit of the Incubator Collaboratives was to their health department, health directors noted the following: collaboration on projects; working on standardized policies and procedures and gaining access to best practices; access to resources; regionalization; and innovation. One health director described the benefit of gaining access to resources,

> *Identifying innovative ways to address old public health issues confronting our region while sharing limited funds/resources to accomplish the task.*

Administrative – Survey respondents were asked to rate their level of agreement with five statements related to the administrative functions of their Incubator (Table 3). Seventy-one percent or higher of all Incubator members mostly or strongly agreed with these statements.

Table 3. Administrative Statements Regarding Incubators.

Administrative Statements	Mean	% Rating 5 or 6
1) Current structure effectively meets need (63)	4.9	73%
2) Appropriately distributes resources among members (61)	5.1	75%
3) Clear about roles and responsibilities (63)	5.2	84%
4) Partners can manage conflict (61)	5.0	71%
5) I have a say in decisions (63)	5.3	81%

Funding – Survey respondents were asked to rate the extent to which their Incubator provides funding that meets the need of their agency, community, and region's population (Table 4). Between 63% and 67% of respondents mostly or strongly agreed that their Incubator met such needs. Fifty-six percent of respondents mostly or strongly agreed that their Incubator is effectively identifying additional funding sources to meet regional needs.

Table 4. Funding Statements Regarding Incubators.

Provides funding that meets the need of my:	Mean	Top Two
1) Agency (63)	4.7	67%
2) Community (62)	4.6	63%
3) Region's Population (63)	4.8	67%
4) My Incubator is effectively identifying additional funding sources to meet regional needs (62)	4.5	56%

Networking – Survey respondents were asked to rate the extent to which their Incubator helped improve networking ability with their peers and staff (Table 5). Eighty six percent of respondents mostly or strongly agreed that it helped improve their ability to network with peers within their region; whereas just 37% provided such ratings for improving networking with peers in other regions. Sixty percent indicated such agreement for enhancing networking opportunities for health agency staff.

Table 5. Networking Statements Regarding Incubators.

Networking	Mean	Top Two
1) Helped improve my ability to network with peers within my region (63)	5.3	86%
2) Helped improve my ability to network with peers in other regions (63)	4.0	37%
3) Enhances networking opportunities for my health agency staff (62)	4.7	60%

Respondents were also asked to rate the extent to which other health directors have been an important resource for their agency (Table 6). A large majority of respondents indicated that they agreed that other health directors served as a resource for identifying innovative solutions, gaining access to best practices, and gaining additional resources. A smaller percentage of respondents thought other health directors served as a resource for improving public health preparedness and enhancing the political influence of their agency, though this is not necessarily the intention of the Incubator program.

Table 6. Extent to Which Other Health Directors Serve as a Resource.

To what extent have other directors in your region been an important resource to you/your agency for:	Mean	Top Two
1) Gaining access to best practices (64)	4.9	70%
2) Identifying innovative solutions (60)	4.8	73%
3) Gaining additional resources (60)	4.6	65%
4) Improving public health preparedness (56)	4.1	43%
5) Enhancing political influence of your agency (62)	4.0	45%

Projects

Seventy-one percent of survey respondents mostly or completely agreed that their Incubator projects have made satisfactory progress towards achieving goals and objectives. In this report, projects are categorized as Intervention Projects or Capacity Projects. Intervention Projects are those that address health outcomes; whereas Capacity Projects address improvements to the functioning of agencies.

Intervention Projects

During Fiscal Year 2008 there were nine Intervention Projects at one of the four of the Incubator Partnerships. Seven of those projects were in implementation mode: Diabetes Sentinel, Touch No Tobacco, HIV/Health in Motion, and Heart Disease and Stroke in the NE Partnership; Project SPARROW in the South Central Partnership; and Cultural Diversity and Health Disparities, and Access to Primary Care in the Northwest Partnership. Two projects were in the planning stage: Senior Health Initiative in the Western Partnership; and the HPV project in the South Central Partnership.

The intervention projects use the following methods to improve the health status of individuals: recruitment of role models/lay health advisors; training; education sessions; support groups;

assessing the health status of individuals; assessing health programs for target populations; promoting health policies in churches, schools, and businesses; and developing coalitions. Table 7 presents project outputs for all of the intervention categories.

Table 7. Total Outputs by Intervention Category

Intervention Category	Intervention Topic	Total	Partnerships
# of Role Models Recruited/Deployed (e.g., Lay Health Advisors/Student Mentors)	Diabetes, Tobacco, Stroke and Heart Disease	1,103	2 – NE, SC
Individuals trained – primarily Role Models	HIV, Diabetes, Tobacco, Stroke and Heart Disease	1,402	2 – NE, SC
Individuals attending information/education sessions/workshops	Same as above	10,889	2 – NE, SC
Support Group	People living with HIV/AIDS	1 group/10 individuals	1 – NE
Individuals health assessed	BMI, physical activity, nutrition, HIV/Syphilis test, A1c	4,341	2 – NE, SC
Programs Assessed	School Systems tobacco, senior program	29	2 – NE, W
Institutions with Policies Passed	Businesses, churches, physical activity, nutrition, tobacco, etc.	79	2 – NE, SC
Coalitions/Workgroups Developed	ECHAP; Senior; Finance Work Group, Dental Work Group, Grant Work Group	5	3 – NE, W, SP

Capacity Projects

During Fiscal Year 2008 there were a total of twenty Intervention Projects at one of the six Incubator Partnerships. Table 8 provides a list of these projects by Partnership.

Table 8. Capacity Projects by Partnership

Partnership	Projects
Central	3 – Health Education and Social Marketing, Development of a Practice Based Research Agenda, Workforce Development
NE	4 – Common Billing Initiative, LEAN QI initiative, GIS Portal, Health Disparities Advisory Council

Partnership	Projects
NW	4 – Best Billing, Organizational Efficiencies, WIC Works Well, Workforce Development
SC	2 – Environmental Health Automation, Health Care Access Expansion
SP	4 – Clinic Efficiencies, Dental Clinic Efficiencies, Grant Writing, Health Information Exchange, HIS Adoption
West	3 – Environmental Health Recruiting, Environmental Health Automation, Handheld

The capacity projects use a variety of methods to improve the infrastructure and practices of individual agencies and Partnerships (Table 9). While many of the methods and outputs are self-explanatory, some bear further explanation. Four of the 16 assessments conducted were clinic efficiency assessments which led to the improvement of family planning, prenatal, WIC, and dental clinics. Other assessments included examining the efficiency of billing practices and patient encounters which led to the development of resources shared within, and at times across, incubators. Four assessments related to environmental health were also conducted, primarily related to workforce development and use of computer technology. These assessments led to a variety of improved practices: training for billing coding and dual role interpreters; environmental health data collection and reporting, use of GIS for environmental permitting, and automation of school health data collection; improved dental clinic practices, and HIS practices.

Table 9. Total Outputs by Capacity Project Category

Capacity Category	Description	Total	Partnerships
Workforce Development Trainings	Environmental Health, Dental Health, Business processes, Cultural competency	601	All except SC
Assessments conducted	Clinic assessments, program, EH staffing and computer hardware/software, workforce development, data prioritization	16	All
Recruitment Initiatives	EH internships, dual-role staff members, application for fellowships, PH summer camp, exploring possible changes in return-to-work legislation, marketing display	6	All but SC, NE
Retention Initiatives	Conducting employee retention	9	All but SC

Capacity Category	Description	Total	Partnerships
	assessments, developing county HR policy inventories, HR staff conferencing, and HR policy changes, training, promotions		
Number of Content Experts Consulted	Academia (8), Private (9), Public (17)	34	All
Forums Conducted	Employee Clinic and Worksite Wellness, Joint Leadership Conference	2	NE, SC
# Participating at Forums	Same as above	205	Same
Additional Grant/Contract Funding	1,235,344 grant funds; 342,091 contract funds, 325,000 grant funds dedicated to joint projects	1,902,335	
# Resources Developed	Manual for Billing Coding, Reference documents for PH information, Templates (human resources, policies and procedures), automated EH data collection system (35 counties), Food & Lodging, Septic & Wells trainings	15	NE, SP, NW, SC
# Improved Practices	Training, EH practices, dental practices, HIS practices	19	NE, SP, W, SC
# of Hardware Purchases	Tablets, printers, CDP mobile, laptop	187	NE, SC, W, NW
# of Software Purchases/Fees	Microsoft, GIS, CDPims, CDP license fees	133	C, NW, NE, SC, W
Total amount of cost savings from collective services and purchases	Software licenses and hardware 275,000; EH technology software training, intern, Dental Work Group	302,300	NE, W, NW, SP

NCIPH Services

Survey respondents were asked the extent to which they agreed that NCIPH staff were meeting their Incubator partnership's needs for support and facilitation [Scale 1 – Not at all agree to 6 – Strongly agree]. Eighty six percent of respondents indicated that they mostly or strongly agreed with that statement. Respondents were then asked to rate the level of effectiveness of NCIPH staff in specific program administration areas (Table 10). [Scale 1 – Not at all effective to 6 – Extremely effective]. Seventy-three percent or more of respondents rated NCIPH staff as very or extremely effective for all ten areas.

Table 10. Ratings of NCIPH Effectiveness

Please rate the effectiveness of NCIPH staff in the following areas:	Mean	Top Two
1) Logistical support (n=52)	5.4	85%
2) Public relations (n=53)	5.3	83%
3) Facilitation of strategic planning sessions (n=53)	5.4	85%
4) Provision of transitional support (n=38)	5.2	82%
5) Assistance with proposal development (n=50)	5.2	84%
6) Overseeing financial and operational status reporting (n=49)	4.9	73%
7) Facilitating access to training (n=49)	5.1	73%
8) Coordination of Incubator Advisory Committee (n=48)	5.5	90%
9) Provision of additional consultation and TA (n=55)	5.3	87%
10) Project coordination for selective Incubator projects (n=52)	5.3	85%

LIMITATIONS

The following are limitations of the findings presented in this report. All data sources are self-reports of participants' experiences with the NC PHIC program. Progress reports were submitted using a new on-line reporting system and some Coordinators/staff members may not have completed reports accurately. Survey limitations include: 1) some participants may not have been completely forthcoming with their opinions of the NC PHICs because of concerns of confidentiality given the fact that evaluation team members are also NCIPH staff members though every effort is made to assure anonymity of respondents; and 2) health directors were the only agency staff surveyed; thus their opinions may not represent the opinions of the agencies they serve.

CONCLUSIONS

For nearly all survey indicators, there were increases in the top two ratings indicating that Incubator partners are even more satisfied with the Incubator Collaborative program than they were last year. The indicators that changed the most include:

- Incubator health directors have helped health directors identify innovative solutions (73% - up from 55%)
- Incubator projects have made satisfactory progress towards achieving goals and objectives (71% - up from 55%)
- NCIPH staff are meeting their Incubator partnership's needs for support and facilitation (86% - up from 72%)
- Regional projects benefit local health agencies (76% - up from 64%)

Areas for Improvement

A majority (56%) of Incubator Collaborative Partnership members mostly or strongly agreed that Incubators effectively identify additional funding sources to meet regional needs. This demonstrates the need for Incubator partners to continue to identify additional funding sources.

More than one-third of Incubator Collaborative Partnership members mostly or strongly agreed that Incubators helped improve their ability to network with peers in other regions (37% - up from 28%). While ratings increased from last year, there is still more opportunity to expand opportunities for collaboration/networking across partnerships. Partnership staff may want to consider presenting resources, tools, and findings from innovative projects at Board meetings of other Incubators as well as continue to post updates and newly developed resources on the Incubator website.

When results were examined by Incubator, there was variation in ratings, with one or two partnerships consistently providing lower ratings for nearly all indicators. NCIPH staff may want to consider reviewing survey results with Partnership members at strategic planning meetings to identify ways to address identified challenges.

For more information, contact NCIPH Evaluation Services Research Associate Molly Cannon at mcannon@email.unc.edu or 919-966-9974 or Director Mary Davis at mvdavis@email.unc.edu or 919-843-5558. For a complete description of the NCLHDA process and participants, please visit the program website at: http://nciph.sph.unc.edu/incubator/.

North Carolina Public Health Incubator Collaboratives

August 2005 – July 2007

Stakeholder Evaluation Report

December 2007

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ACKNOWLEDGEMENTS

This evaluation of the August 2005 – July 2007 North Carolina Public Health Incubator Collaboratives program was conducted by evaluation staff, Molly Cannon, MPH and Mary Davis, DrPH, MSPH, at the North Carolina Institute for Public Health (NCIPH), the service and outreach arm of the School of Public Health at the University of North Carolina at Chapel Hill. This is the same organization that administers the Incubator process, thus the evaluation process should be considered an "internal evaluation."

Dr. John Graham, NCIPH Deputy Director for Outreach and Consultation; Lisa Macon Harrison, MPH, Program Officer; and Erin Ridings, Program Associate, provided valuable ideas on the overall evaluation design, questions to ask, interpretation of the results, and specific stories to highlight in this report.

BACKGROUND

The NC Public Health Incubator Collaboratives (NCPHICs) are teams of local health departments voluntarily working together to address pressing local public health issues using innovative approaches. Six NC PHICs (Western, Northwest, Central, South Central, Southern Piedmont, Northeastern) have been formed representing 82 counties. NC PHICs started their third round of legislative funding in August 2007. This report includes information collected from an on-line survey of Incubator members administered in June 2007 and from Incubator project reports (for projects funded from August 2005 – July 2007) submitted by Incubator coordinators. For more information about the NC PHICs, visit: www.sph.unc.edu/nciph/incubator. NCIPH, is the PHIC Administrator, facilitating Incubator activities and managing the program.

EVALUATION METHODOLOGY

Design

The purpose of the evaluation was to examine the experiences of the six Incubator Collaboratives according to the following two questions: 1) Are Incubators providing value to member health departments; and 2) Is the NCIPH meeting Incubator partnership needs for support and

facilitation. The evaluation involved two components: an on-line survey administered to Incubator members and a review of final progress reports submitted by Incubators. The on-line survey asked about participants' experiences with several aspects of the NC PHICs, including: administration; funding; networking; project implementation; and support received by the NCIPH. Evaluation results will be used to inform the Incubator Collaboratives process in the future (e.g., program changes, strategic planning sessions, technical assistance).

Data Collection Methods and Participants

Table 1 presents survey response rates. The on-line data collection procedures and instrument were submitted to the Public Health-Nursing Institutional Review Board at UNC and determined to be program evaluation and thus not in need of IRB approval. Incubator partnerships were also requested to complete project progress reports for all projects conducted during the two year period. NCIPH Evaluation Services, in consultation with PHIC Administration staff, created a standard progress report template. Four of the six partnerships submitted progress reports in time for inclusion in this report. Data collection activities occurred from June to November 2007.

Table 1. Survey Response Rates.

Participant Group	Response Rate
Overall Incubator Membership	86% (n=71)[a]
- Health Directors	83% (n=54)
- Incubator Managers	100% (n=6)
- DPH	100% (n=6)
- Other	5 respondents

[a] Incubator Partnership response rates ranged from 67% to 100%

Data Analysis

Data from the on-line survey were organized by evaluation question and survey questions to summarize key findings. Data are presented as means which were calculated for continuous variables; and/or top two ratings (i.e., percent of respondents that rated a given indicator a 5 or 6); and lists of responses were prepared for all qualitative survey items. Progress reports were

reviewed in detail and coded according to the six main outcomes identified in the PHIC logic model: 1) Increase Level and Effectiveness of Services Delivered; 2) Increase Shared Resources Across Local Health Departments; 3) Increase Equity of Service Delivery to Incubator Populations; 4) Foster Innovative Projects; 5) Increase Opportunities to Solve Common Problems; and 6) Improved Health Outcomes.

RESULTS

Overview of Survey Results

Selected summary survey results are included in the body of this report. Additional results are presented in Appendix A. Key areas that Incubator partnerships addressed include: workforce development, best practices, organizational efficiencies, health specific interventions, financial reimbursement, and access to care. Overall, the majority (62%) of health directors that responded to the survey mostly or strongly agreed that regional projects benefit local health agencies. When asked what the greatest benefit of the Incubator Collaboratives was to their health department, health directors noted the following: collaboration on projects; opportunities to network; access to resources; the ability to leverage funds; and helping to understand public health problems. One health director described multiple benefits,

> *Smaller counties such as ours have benefited greatly from the shared knowledge gained. It has broadened our horizons and way of thinking...it has helped us improve our business processes and customer service. It makes us also feel proud to be part of the 'bigger public health picture.'*

Approximately 55% of health directors mostly or completely agreed that their Incubator projects have made satisfactory progress towards achieving goals and objectives. As one health director indicated,

> *Our incubator has achieved the goals and objectives set forth for our projects mostly because of funding and the strong desire and need to work collaboratively ...because the group defines projects that are of interest and need to our region.*

The majority of Incubator Collaborative health directors mostly or strongly agreed that:

- Incubator Administrative structure effectively meets member agency needs (70%)
- Incubators appropriately distribute resources among member health agencies (78%)

- Incubators effectively identify additional funding sources to meet regional needs (63%)
- Incubator participation has helped improve their ability to network with peers in their region (69%) and has enhanced networking opportunities for health agency staff (56%)
- NCIPH staff are meeting their Incubator partnership's needs for support and facilitation (75%)

Summary of Projects According to the Six NC PHIC Outcomes

1) Increase Level and Effectiveness of Services Delivered

One of the outcomes of the NC PHICs is to increase the level and effectiveness of services delivered to the Incubator population. Several Incubator projects work toward this outcome, including projects that increase staff capacity and improve organizational efficiencies. Incubators are addressing staff capacity through enhanced environmental health specialist recruitment efforts and provision of additional/enhanced training in the following areas:

- New employee orientation training
- Grant writing training and technical assistance
- Web-based Environmental Health training
- Accreditation training and creation of a guide entitled, "Best Practices for Complying with Public Health Accreditation Standards to Orient New Employees"
- Training on the Use of Environmental Health Hand Held Technology

Some NC PHICs have researched and implemented organizational efficiencies. These organizational efficiencies have led to the following changes in the health department:

- Reduction in the number of routine labs and patient education distributed in family planning clinics
- Improved scheduling by using "Open Access" scheduling in dental clinics

Box 1: Northwest Partnership Example of Increased Level and Effectiveness of Services Delivered

Through a HealthMETRICS study commissioned by the Incubator, it was found that Family Planning Clinics in all eight Incubator counties were using different protocols for initial visits of women seeking oral contraceptives and Depo-Provera injections. In many cases, the number of routine labs conducted and patient education materials distributed exceeded the state's

recommendations, costing the health department financial and human resources. Based on study results, the Incubator formed a Family Planning Workgroup that identified recommendations for how to institute organizational efficiencies. Recommendations included: reduction in number of routine labs, reduction in patient education materials distributed, and the use of new patient history forms. Recommendations have been disseminated to all health departments in the Incubator and are in varying stages of implementation. The Southern Piedmont Incubator has also decided to adopt some of the recommendations. According to Incubator coordinator, Candice DuVernois, such organizational efficiencies could not have been achieved by a single health department,

> *The sharing of information and the energy created by the project across the counties could not have happened if a single health department went through the assessment alone. The comparison of labs and patient education material across the counties was remarkable. It gave the others much needed perspective when considering what labs/materials to reduce.*

2) Increase Shared Resources across Local Health Departments

NC PHICs share financial, material, and human resources to accomplish project goals. During the project period, the six incubators submitted and received grants from numerous agencies (e.g., Kate B. Reynolds, Health and Wellness Trust). An incubator coordinator described the value of partnering with other counties in submitting grants,

> *The expanse of this national project would be difficult for any individual health department to focus on. As a collaborative project, we share workload, challenge each other, brainstorm, and learn together, and ultimately will benefit from the knowledge and expertise brought to the table by each member.*

Participation in Incubator projects has helped the health departments leverage funds and "get more bang for the buck" particularly when the grant activities reach all of the health departments within an Incubator. For some of the smaller health departments, many of the grants would not have been submitted had it not been for the Incubator,

> *Five new grants were written primarily in our most under resourced counties – work that likely would not have been accomplished without this project.*

Regardless, there is still a need for more funding to address needs, particularly since the Incubator program is expanding,

> *With the maturation of several regional Incubators and the numbers increasing, the funding level has not kept up with the growth of the Incubator system. We need a*

separate pot of money for incubator administrative costs and a separate pot of money for innovative new projects. We have leveraged many funding sources and have many independently funded projects. We desperately need the $2 million in additional incubator funding, and we need to carve out one million for incubator administrative infrastructure and two million for innovative projects.

Box 2: Southern Piedmont Partnership Example of Increase Shared Resources across Local Health Departments

Gaston County Health Department, a member of the Southern Piedmont Incubator Collaborative wanted to address the fact that there was no formal employee orientation process that would ensure employees had the tools and resources they needed to be "successful" in their assigned duties. With assistance from the North Carolina Institute for Public Health, the Health Department developed a standardized orientation plan and materials that could be used at all local health departments in the state. As part of this initiative, Gaston County Health Department staff trained 60 individuals from ten Southern Piedmont Partnership counties how to use these orientation materials. Several other partnerships have already adopted the orientation materials developed by the Southern Piedmont Partnership. More information about the orientation is available on-line at: http://nciph.sph.unc.edu/incubator/south_pied/tools.htm. According to Program Coordinator, Cappie Stanley, this initiative has been of great value,

There was tremendous interest in this project and the evaluations of the training clearly indicated the value of the work to those who participated. The adaptation of the curriculum by several counties in an indication of the need for such a project. Staff feedback from the pilot at Gaston County Health Department has rated the product/process very highly.

3) Increase Equity of Service Delivery to Incubator Populations

Incubator Collaboratives are also working toward increasing the equity of service delivery to their populations through addressing high rates of uninsured patients, raising awareness of health disparities, and addressing health disparities through various grant initiatives. Examples of these projects include:

- Working with small businesses to provide health insurance for their employees
- Creation and dissemination of a video addressing social justice and health disparities
- Diabetes Sentinel Project

As one Incubator member said about the video addressing social justice and health disparities,

The video addresses many concerns about access to health care that are difficult to put into words. The film footage speaks volumes about the struggles of people in poverty and/or people with racial or ethnic discrimination...The video would likely not have been

completed if not for the Incubator.

4) Foster Innovative Projects

NC PHICs were designed to foster the creation of innovative solutions to public health problems. In that light, several of the Incubators are developing and implementing truly innovative public health solutions to pressing issues. Examples of these projects include:

- Health Department of the 21st Century
- Health Record Information System
- Recruiting Local Businesses to Provide Insurance for Employees
- Use of Hand Held Technology by Environmental Health Specialists

While most Incubator projects plan to be successful, the innovative nature of some projects lends itself to trial and error before success. As evidenced by one of the coordinators,

> *Working together we still have not attained our goals completely. Working alone individual counties would not have even attempted such a project. We are after all an "an Incubator" and if every project succeeded just as planned on the first attempt, we would not need incubators!*

Box 3: Western Partnership Example of Foster Innovative Projects

Based on a Regional Health Assessment conducted by the Western Partnership and the Mountain Area Health Education Center (MAHEC), the Partnership learned that 10 of the 15 fastest aging counties in North Carolina are located in the Western North Carolina. Expanding on this assessment, the Incubator next undertook an extensive survey of the elderly population within the Incubator to learn about their priority health issues.

This year the Incubator is studying the primary and secondary data collected and comparing the needs identified with the local resources available. By the end of the fiscal year they will have selected a "best practice" intervention model for public health and will fund a pilot program in one or two counties in the second year of the biennial budget.

"With many health departments getting out of the Home Health business, we are losing our primary program link with the elderly population" according to George Bond, Western Incubator Coordinator. The pilot initiative will attempt to answer the question of what is the most appropriate role for public health to play in addressing the health needs of our rapidly aging population.

According to Bond, being a member of the Partnership, "Allows for the creation of a "Virtual Western Public Health District" to address regional needs without any county having to give up

any autonomy. We get many of the benefits of a District without having to deal with any of the potentially thorny issues of governance and structure", said Bond.

5) Increase Opportunities to Solve Common Problems

In the June 2007 survey, approximately 63% of health directors agreed that their Incubator is effectively identifying additional funding sources to meet regional needs. Some of the projects Incubators are working on that address common problems include:

- Conducting a Regional Health Assessment
- Improving Public Health marketing
- Developing and disseminating policies and procedures for ways to increase revenues and decrease expenditures
- Researching and adopting best practices for personnel policies and dental clinic scheduling
- Creating and disseminating an on-line HIPAA (Health Insurance Portability and Accountability Act) training module

An Incubator member described how one of their projects addresses regional needs,

> *Allows opportunities for agencies to implement eligibility, bad debt, and collection policies that are consistent across county lines. This creates an opportunity to "educate" clients of strict adherence to system requirements and enforce rules and regulations.*

6) Improved Health Outcomes

The overarching goal of many of the Incubator projects is to improve health outcomes. There are several projects specifically addressing health problems such as the Diabetes Sentinel Project; Community Obesity Project; Fall Prevention mini-grants; Community Health Grants; and the Teen Tobacco Prevention Initiative. Each of these projects has an evaluation component to collect data that will measure program impact. For specific information related to the Northeast Partnerships' Teen Tobacco Prevention Initiative, visit: http://fammed.unc.edu/TPEP/reports/FINAL%202006-07%20Annual%20Teen%20Report.pdf

LIMITATIONS

The following are limitations of the findings presented in this report. All data sources are self-reports of participants' experiences with the NC PHIC program. Self-reports may have been

challenged by recall bias, as the evaluation included activities that occurred as early as August 2005. Additional survey limitations include: 1) some participants may not have been completely forthcoming with their opinions of the NC PHICs because of concerns of confidentiality the fact that evaluation team members are also NCIPH staff members; and 2) health directors were the only agency staff surveyed; thus their opinions may not represent the opinions of the agencies they serve. Additional progress report limitations include: 1) evaluators did not have completed reports for all partnerships; 2) incubators did not report on consistent indicators; and 3) several coordinators were hired during this project period and thus may not have had the full history of these projects.

CONCLUSIONS

NC Public Health Incubator Collaboratives are providing value to member health departments and are considered to be innovative, as described by one health director, "I think the Incubator Collaboratives have been one of the most innovative ideas that NC Public Health has had in decades". However, additional administrative funding is needed to help the institutionalize Incubators and facilitate more innovative projects.

For more information, contact NCIPH Evaluation Services Research Associate Molly Cannon at mcannon@email.unc.edu or 919-966-9974 or Director Mary Davis at mvdavis@email.unc.edu or 919-843-5558. For a complete description of the NCLHDA process and participants, please visit the program website at: http://nciph.sph.unc.edu/incubator/.

Appendix

- Individual NC Incubator Partnership Profiles
- External Funding for Incubator-sponsored Projects
- 2008 NC Public Health Incubator Collaboratives Stakeholder Evaluation Report
- 2007 NC Public Health Incubator Collaboratives Stakeholder Evaluation Report

Contact
Joanne Eddy | 252.358.7833
joanne.eddy@ncmail.net

Northeastern North Carolina Partnership for Public Health

The Northeastern North Carolina Partnership for Public Health (NENCPPH) includes: Bertie, Beaufort, Camden, Chowan, Currituck, Dare, Edgecombe, Gates, Halifax, Hertford, Hyde, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Tyrrell, Warren and Washington Counties

Vision of the Northeastern Partnership

Exploring an innovative regional approach maximizing effective programs that address the core public health needs of our region and sharing our experience across North Carolina

Mission of the Northeastern Partnership

The mission is to utilize flexible regional partnerships to provide the local public health core functions and essential services that ensure healthier communities by: (1) assessment of community health needs and health issues; (2) addressing those health needs and issues by developing policies and programs; (3) ensuring availability and accessibility of health services to the entire population.

1 Common Billing Initiative

Built on a consultant's assessment of the billing practices of region's 11 local health departments (covering 19 counties) the NENCPPH created an ongoing work group which has established a compendium of best practice policies and procedures to address billing and coding issues and to develop benchmarks on performance and alerts for further action. This process has helped maximize reimbursements and resulted in the creation of a best practice manual used as a resource tool and training vehicle across the region. This initiative continues through a regional work group of billing / office mangers. Policies and procedures are being developed that cover all steps of billing in the agency. Staff will continue to be trained in best billing practices and a monthly reporting package will be used as a management and performance improvement tool.

2 Health in Motion – Mobile Clinic and HIV Outreach

The Northeastern Partnership's Mobile Clinic expands the partners' capacity: 1) to provide health screening throughout the 19 county region, 2) to deliver Primary Medical HIV care at five regional care sites (Bertie, Beaufort, Dare

and Halifax in the NENCPPH and also to Lenoir in the region, 3) to provide HIV prevention education (to 476 individuals in 2007), 4) to provide case management and outreach services to the patients identified, and 5) to sponsor stakeholder meetings to coordinate service efforts. The partnership has recently received additional funding through grants to promote and sustain this initiative including additional case management, non-traditional testing outreach and jail health outreach.

3 Diabetes Sentinel Project

Through this project, the Northeastern Partnership has increased its capacity to prevent, diagnose and medically manage diabetes among African Americans, and seek to reduce health disparities in the 19 county region. The Diabetes Sentinel program is a collaboration of 30 African American churches and public health providers for diabetes prevention, outreach and policy change. Each participating congregation identifies adult and youth leaders for training as lay advisors (Sentinels), creates a committee to support this effort, establishes and implements policies that promote healthy lifestyles, and sponsors workshops on diabetes, nutrition, and exercise. The Northeastern Partnership is working toward developing church-housed Diabetes Prevention Centers in all counties in the region. The Partnership will facilitate replication of this model throughout the state.

4 Touch No Tobacco – Teen Tobacco Initiative

Through this initiative the Northeastern Partnership provided prevention education and other resources in 12 partnership counties to reduce teen tobacco use. Teens participating in this program develop outreach materials and create educational campaigns for local businesses and restaurants and parks and recreational facilities in their region, developing networks of stakeholders and reinforcement for their own awareness of the impact of tobacco use. In addition, to encourage implementation of the 100% Tobacco Free School policy, the partnership has provided cessation resources, compliance assistance, and media campaigns throughout its region. This program is sponsored by the North Carolina Health and Wellness Trust Fund.

5 Geographic Information System (GIS) Portal

The Northeastern Partnership is developing a Geographic Information System (GIS) portal through which spatially-related public health information can be brought together in a single site. In addition, the Partnership will develop a web-based GIS application that would enable the spatial tracking of local environmental health information to increase efficiencies and provide better service throughout the region.

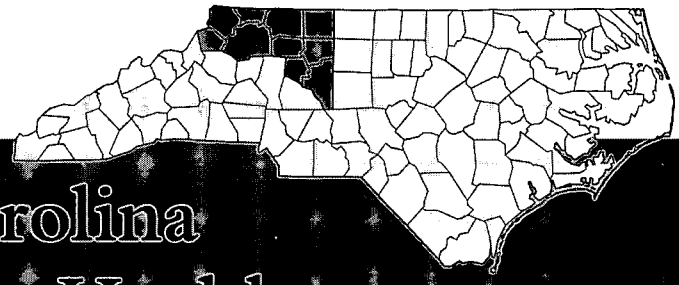
6 Heart Disease and Stroke Initiative

The Northeastern Partnership provides regional leadership to encourage policy and environmental change at three levels throughout the region: 1) the healthcare system, 2) worksites, and 3) local communities. Program activities focus on prevention for heart disease and stroke including controlling blood pressure and cholesterol, recognizing signs and symptoms of heart attack and stroke, improving emergency response for heart attack and stroke, improving quality of care for cardiovascular disease, and eliminating disparities among population groups.

7 Business Insights

In conjunction with consultants, the Northeastern Partnership is currently locating business model assets that can be applied toward solving high priority public health problems and organizational challenges. These models draw on examples such as Lean and Six Sigma to map current business practices and develop teams that can look at tailoring new business practices in ways that address local public health department issues. Examples include billing practices, clinic efficiency, and client satisfaction with services at the local health department.

Contact
Candice DuVernois | 828.264.4995
candiced@apphealth.com



Northwest North Carolina Partnership for Public Health

The Northwest North Carolina Partnership for Public Health (NWPPH) includes: Alleghany, Ashe, Davidson, Davie, Forsyth, Stokes, Surry, Watauga, Wilkes, and Yadkin Counties

Vision of the Northwest Partnership

To be the foundation for regional solutions to the public health challenges in North Carolina's Northwest counties

Mission of the Northwest Partnership

To improve the public's health through a collaborative partnership using the combined experience, expertise and resources of the region's health departments

1 Best Billing Practices Model / Regional Medical Coder & Billing Compliance Coordinator

The Northwest Partnership will collaborate to develop an effective billing management model to maximize billing procedure efficiencies and increase health department expense recovery. For this two year initiative the Partnership will hire a regional medical coder to standardize a medical coding system and develop a best billing and compliance practices model based on the new system.

2 Workforce Development: Internship Opportunities for Recruitment and Retention of the Workforce

In the previous funding cycle, the Northwest Partnership assessed wages and benefits, training and education, and application of new practices among environmental health workers in the region. In completing this continuing initiative, the Partnership will evaluate and implement recommendations resulting from the assessment, including pilot testing a regional internship program. Outcomes will be shared with other partnerships to streamline and standardize the public health student internship curriculum.

3 Best Practice Work Groups & Organizational Efficiency

Due to the success of the Northwest Partnership's existing family practice work group model to address best practices in organizational efficiencies, the Partnership will replicate the model to assess both the Special Supplemental Nutrition Program for Women Infants and Children (WIC) and Maternity Care departments in each participating health department. Regional work groups will be established to meet regularly to assist with assessments and provide recommendations for improving organizational efficiencies in their respective departments. Recommendations will be shared statewide.

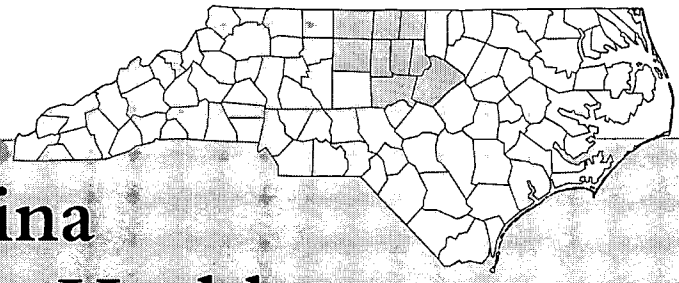
4 Cultural Diversity & Health Disparities

With the previous years' funding, the Northwest Partnership produced a social justice video to communicate three key messages: 1) health disparities exist across cultural economic groups, 2) equal access to health promotion and disease prevention should be available to everyone, and 3) responsibility for reducing health disparities belongs to everyone. The Partnership will use current funds to develop a facilitated discussion model to complement the video. Upon completion, a video premier event will be hosted by the Partnership to provide regional health department staff with training on video facilitation and materials for dissemination. The video and training template will be made available to all interested health departments.

5 Access to Primary Care

As initially proposed in 2005, the Northwest Partnership identified the need for more information to: 1) help define the need for primary care services, 2) assess currently available resources and models, and 3) define the role that public health plays in improving health care access. The Partnership aims to further promote the scope of services public health can provide to respond to unmet community health needs through in-kind resources to disseminate a policy paper, "Local Public Health's Role in Assuring Access to Health Care." This paper will provide health directors with convincing evidence to develop a regionally supported policy statement to increase access to care.

Contact
Kelly Goonan | 336.641.7777
goonan@email.unc.edu



Central North Carolina Partnership for Public Health

The Central North Carolina Partnership for Public Health (CPPH) includes: Alamance, Caswell, Chatham, Durham, Guilford, Orange, Person, Rockingham, and Wake Counties

Vision of the Central Partnership

Mobilizing Diversity to Drive Innovation

Mission of the Central Partnership

To provide leadership to promote healthy lifestyles, assure access to care, and eliminate health disparities by mobilizing diversity to drive innovation

1 Workforce Development: Recruitment & Retention of a Diverse Workforce

The Central Partnership aims to create innovations in implementing a robust pipeline strategy for workforce recruitment and retention. More than half of North Carolina's public health workforce prepares to retire in the coming years while the population of our state grows at an unprecedented rate. To address this problem, the Central Partnership will develop a best practice and performance management policy workbook, will develop materials for career fairs across North Carolina, and will coordinate efforts with local and national programs such as the Association of Schools of Public Health, the Southeast Public Health Training Center, and Area Health Education Centers. In 2009, the Central Partnership will host a statewide summit to disseminate best practices and present findings to human resource directors at the county and state government levels.

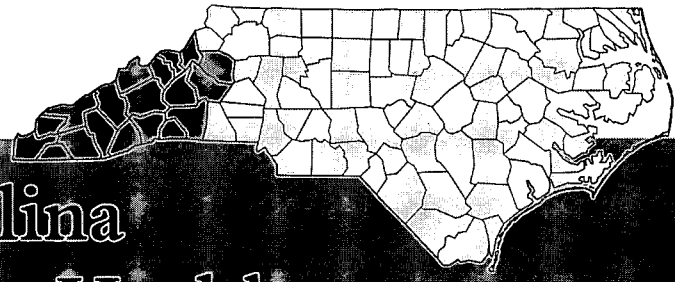
2 Health Education & Social Marketing

For this initiative, the Central Partnership will adopt marketing tools that most effectively educate communities on issues that address health disparities. A Central Partnership Regional Health Education Task Force comprised of health educators and other local health department staff will be established and charged with meeting regularly to identify common health care needs of underserved populations. Materials that highlight prevention messages for health disparities as well as a report of recommendations and strategies for replication will be developed and disseminated across all partnerships.

3 Practice-Based Research Agenda to Eliminate Health Disparities

For this two-year initiative the Central Partnership seeks to build a practice-based research agenda to eliminate health disparities by increasing local health departments' capacity to drive funding priorities on this issue locally, statewide, and nationally. In the first year, energies will focus on building collaborative relationships across multiple public health occupational groups to develop practice-based research agenda networks in local health departments. In the second year, public health worker networks continue to prioritize issues and collect feedback from other public health workers across the state to use for advocacy, intervention, and policy development together with Schools of Public Health and other research partners.

Contact
George Bond | 828.693.1119
georgebond@bellsouth.net



Western North Carolina Partnership for Public Health

The Western North Carolina Partnership for Public Health (WPPH) includes: Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania and Yancey Counties.

Vision of the Western Partnership

Public Health – Building a Healthier Western North Carolina

Mission of the Western Partnership

Improved public health outcomes through regional collaboration and innovation

1 Senior Health Initiative: What is Public Health's Role?

The Western Partnership will test a single county case management/services coordination pilot in Jackson County which will inform public health's role in serving the needs of the elderly population. This pilot project is charged with increasing knowledge of and access to services for the elderly and their families in an effort to enhance the quality of life for both and promote longer self-sufficiency and independence of elderly in the home setting. Together with the Jackson County health director, the Western Partnership will identify appropriate services that reach out to the growing elderly population of North Carolina.

2 Environmental Health Technology

In 2007, the Western partnership set out to to completely automate its environmental health system in order to address existing inefficiencies such as county-to-county variations in data collections, lost permits, records storage problems, inability to quantify and characterize data collected, and administrative approaches. The Partnership used Incubator funds to purchase tablet computers and Food & Lodging software. Currently, training and infrastructure is in place to implement On-site Wastewater & Wells applications. By late Spring 2008, environmental health data collection systems in 15 of 17 Western Partnership counties will be completely automated by July, 2008.

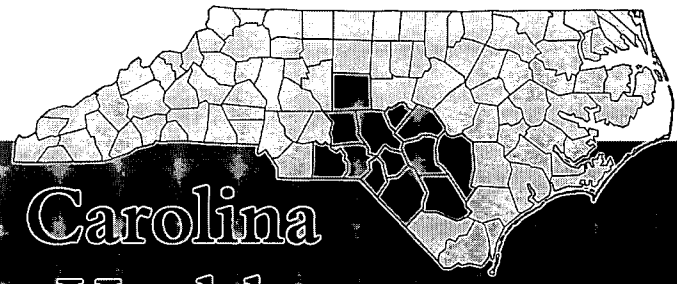
3 Environmental Health Recruiting

The Western Partnership will collaborate with the Northwest Partnership to streamline internship opportunities for college-aged students (both in traditional and non-traditional fields) interested in public health. In the first year of this two year initiative, the partnership will work to bridge the academic and the practice training gap by developing a curriculum of credit courses for Centralized Intern Training (CIT). In the second year, in collaboration with the Northwest Partnership, six substantial scholarships will be provided for students who will not only work at the local department but also attend Centralized Intern Training during their traineeship.

4 Handheld Technology for Public Health

In order to address the increasing need for regional Geographic Information System (GIS) capabilities for public health, the Western Partnership purchased thirty multipurpose handheld units to be shared among the staff of the region's health departments. Additional handheld unit memory, software and training will be purchased with current funds to meet increasing demands in the region. The Partnership will collaborate with the state's Public Health Regional Surveillance Team (PHRST) for training and overall program support.

Contact
Rick Steeves | 910.277.7319
normas@carolina.net



South Central North Carolina Partnership for Public Health

The South Central North Carolina Partnership for Public Health (SCPPH) includes: Anson, Bladen, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, Robeson, Sampson, and Scotland Counties

1 Health Care Access Expansion

2 HPV / Cancer Prevention Social Marketing Campaign

3 Environmental Data Collection Automation

4 Project SPARROW

Vision of the South Central Partnership

Healthy people through Innovation and Collaboration

Mission of the South Central Partnership

Working together to collectively address public health issues through sharing best practices and securing resources

1 Health Care Access Expansion

A model for innovation in public health, the mission for health care access expansion is to build on the Lee Primary Care Plus (LPCP) program and adapt the concept in other counties within the South Central Partnership. LPCP is a grassroots effort to provide affordable basic primary and preventative care and workplace health promotion plans to low wage employees of small businesses within the region. Based on marketing research recommendations and additional primary care clinic pilot testing, a new site will be established at the Anson County health department.

To complement this project, a Primary Care Access and Worksite Wellness Expansion Task Force comprised of South Central Partnership health department staff will hold a forum to highlight examples of successful county employee based primary care clinics. The forum to be held in the South Central region in June, 2008, will include health directors, county commissioners, county managers, and others who will benefit from hearing what works and what challenges exist in offering a primary care clinic for county employees. After the forum, a report outlining the findings from the region will be compiled

and presented at a November statewide worksite wellness symposium at the Friday Center in Chapel Hill. After November, the task force will focus on implementing what works best in both primary care access and worksite wellness for county employees.

2 HPV / Cancer Prevention Social Marketing Campaign

With a new vaccine available to address cancer prevention among women who could contract Human Papillomavirus (HPV), a cervical cancer precursor, the South Central Partnership seeks to be part of the solution to preventing cervical cancer and promoting health and wellness in young adults. This regional effort aims to provide more effective educational information to all ages and cultural groups, with a particular emphasis on addressing cultural disparities in cervical cancer incidence. For this two year initiative, the partners will identify specific needs of the target audience, and develop a feasible and effective implementation plan for the educational campaign and vaccine distribution. The Partnership will collaborate with public health researchers, individual counties and state and private partners.

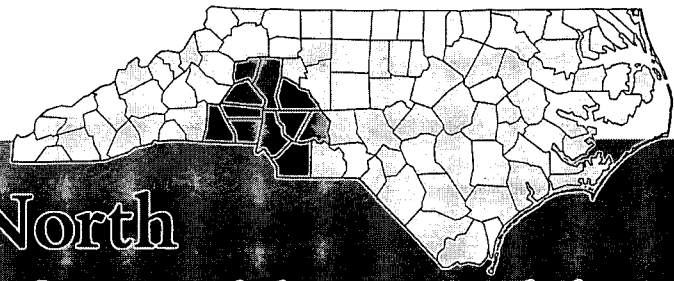
3 Environmental Data Collection Automation

For this continued initiative, the South Central Partnership will move to completely automate its environmental health data collection systems in order to improve capacity to better respond to community needs. Partnership counties used year-end funds to purchase software and training for food and lodging modules, in addition to a limited number of tablet personal computers and printers to initiate the automation of these activities. In moving forward, the Partnership will provide much needed hardware and software for all participating counties. Training and implementation of onsite wells and wastewater applications for environmental health will also be provided as a next step. The South Central Partnership anticipates the complete automation of its environmental health data collection systems by Summer 2008.

4 Project SPARROW

The South Central partnership voted to continue support of Project SPARROW, a three year multi-county cardiovascular disease (CVD) and stroke education, prevention, and management initiative targeting at-risk African Americans. This program was developed in response to the limited health infrastructure and significant need in this partnership region. The project is funded by the Health and Wellness Trust Fund, however the partnership will oversee its completion and assist with publishing and disseminating results.

Contact
Cappie Stanley | 704.920.1341
clstanley@cabarrushealth.org



Southern Piedmont North Carolina Partnership for Public Health

The Southern Piedmont North Carolina Partnership for Public Health (SPPPH) includes: Alexander, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union Counties

Vision of the Southern Piedmont Partnership

Collaborating to Improve Public Health Practice

Mission of the Southern Piedmont Partnership

The Southern Piedmont Partnership for Public Health is a flexible, synergistic, innovative collaborative committed to improving public health practice

1 Addressing Clinic Efficiencies

This two-year project will provide an opportunity for each health department to work with paid or state consultants to identify, develop and implement effective medical models of clinical efficiency to improve public health practice, and ultimately, better serve our communities. A final report will be developed and disseminated to the other Incubator Collaboratives through the Incubator website and conferences.

2 Finance & Dental Work Groups

The Southern Piedmont Partnership will continue funding regular meetings of its regional Finance and Dental work groups. Future discussion will focus on issues related to 1) uncompensated care, 2) financing of clinical public health services, 3) analysis of family planning services outcomes, and 4) assessment and recommendations for local health department readiness for the new statewide Health Information System (HIS). Both workgroups will develop processes for generating revenue and sustaining financial independence, and propose to integrate their efforts with the clinic efficiency project (see Addressing Clinic Efficiencies).

3 Grant-Writing Work Group

In 2006, the Southern Piedmont Partnership established a grant-writing work group whose function was to increase regional collaboration and capacity for developing grant proposals to sustain the work of the partnership. This work group will continue for the next two years focusing specifically on funding opportunities including 1) technology-focused applications for public health practice, 2) infant mortality rate reduction, and 3) increasing Internet access for patients and providers in rural areas. This work group also will develop a regional application seeking the services of a CDC fellow. Products and processes developed by the work group will be shared widely with public health, academic, and private sector partners and colleagues.

4 Accreditation – Regional Support

Due to tremendous response to its initial accreditation support initiative, the Southern Piedmont Partnership will continue to collaboratively develop a "train the trainer" style model through which accredited health departments provide technical assistance to those agencies yet to undergo the accreditation process.

External Funding for Incubator-Sponsored Projects[1]

How Incubator Projects are leveraged for additional funds.

ant/contract	Funding Source	Amount	Comments
een Tobacco	Health Wellness Trust Fund	1,945,367	Teen tobacco prevention and cessation, serving 11 counties
Sentinel Project	Health Wellness Trust Fund	800,000	Diagnose & manage diabetes among African Americans for Northeastern partnership
College Tobacco	Health Wellness Trust Fund	170,730	Area college tobacco prevention and cessation
Sparrow Project	Health Wellness Trust Fund	660,000	South Central cardiovascular disease (CVD) and stroke intervention
MLC III	Robert Wood Johnson Foundation	25,000	Quality initiative for the Central Partnership
Common Grounds S. Piedmont	Robert Wood Johnson Foundation	600,000	Train practitioners in workflow analysis & design, design regional health information exchange
Common Grounds S. Central	Robert Wood Johnson Foundation	30,000	Train practitioners in workflow analysis & design, design HIS related business process
TeleHealth project	Federal Communications Commission	6,000,000	Providing high-speed, redundant Internet Access to local health department and Free Clinics
NE Partnership Administration	U.S. Health Resources and Services Administration	600,000	Provide core admin support for NE Partnership
lth in Motion bile Enhance.	Kate B. Reynolds Charitable Trust	207,069	Make enhancements to the mobile HIV van to expand screening capabilities
Practice-Based Research Network	Robert Wood Johnson Foundation	90,000	Promote research that more readily meets the needs of the practice community
Subtotal[2]		**11,128,166**	
PHTIN Node	Year-end CDC/Preparedness Funding	515,000	Place a PHTIN node in ARHS for Partnership training and communications
Disparity Gap Program	NC Office of Minority Health	240,000	Link local health department health educators to coordinate disparities projects
Health in Motion Mobile Van	HIV/Aids Branch	190,000	Purchase mobile van for screening and treatment
HIV Jail Health	HIV/Aids Branch	60,874	Serving jails in Hertford, Martin, and Bertie counties
Nontraditional Testing HIV	HIV/Aids Branch	230,000	Coordinates mobile outreach regional HIV activities for local health departments and nonprofits
HIV Clinic Continuation Expansion	HIV/Aids Branch	495,000	Delivers HIV medical care, screening, for Northeastern partnership counties
HOPWA	CDC	9,269	Coordinates HIV mobile van activities
ECHAP	HIV/Aids Branch	191,217	Regional staffing for case management
cer	NC Office of Minority Health	4,500	
Heart Disease/Stroke Prevention/CDC	NC Heart Disease and Stroke Branch	300,000	Improving emergency response for stroke

Grant/contract	Funding Source	Amount	Comments
Disparity Gap Advisory Council	NC Office of Minority Health	20,000	
ltural Sensitivity pplement	NC Office of Minority Health	6,000	
Subtotal [3]		**2,261,860**	
CATCH	Kate B. Reynolds Charitable Trust	200,000	Community assessment data warehouse construction
Diabetes Umbrella Project	Kate B. Reynolds Charitable Trust	300,000	Secure ADA certification to enable local health department diabetes management
Subtotal[4]		**500,000**	
CDP discounts		275,000	Software license discount for collective purchase of licenses
Subtotal [5]		**275,000**	
Total		**14,165,026**	

1 These funds supplement the legislative funds provided by the NC Legislature. They support individual incubator projects or compliment incubator seed money for joint projects.

2 Grant funds dedicated to incubator projects.

3 Contract funds principally from DPH directly or as pass-through funds from the CDC.

4 Grant funds dedicated to joint projects for which Incubators provided seed money to initiate the projects.

vings realized through collective purchasing enabled by incubator collaboration.

North Carolina Public Health Incubator Collaboratives

Fiscal Year 2008

Excerpts from:

Stakeholder Evaluation Report

November 2008

UNC
SCHOOL OF PUBLIC HEALTH

NCIPH

BACKGROUND

The NC Public Health Incubator Collaboratives (NCPHICs) are teams of local health departments voluntarily working together to address pressing local public health issues using innovative approaches. Six NC PHICs (Western, Northwest, Central, South Central, Southern Piedmont, Northeastern) have been formed representing 81 counties. This report includes information collected from an on-line survey of Incubator members administered in June 2008 and from Incubator project reports (for projects funded from July 2007 to June 2008) submitted by Incubator coordinators and staff. For more information about the NC PHICs, visit: www.sph.unc.edu/nciph/incubator. NCIPH, the NCPHIC Administrator, facilitates Incubator activities and manages the program.

EVALUATION METHODOLOGY

Design

The purpose of the evaluation was to examine the experiences of the six Incubator Collaboratives according to the following two questions: 1) Are Incubators providing value to member health departments through specific projects at a regional level?; and 2) Is the NCIPH meeting Incubator partnership needs for support and facilitation?. Evaluation results will be used to inform the Incubator Collaboratives process in the future (e.g., program changes, strategic planning sessions, technical assistance).

Data Collection Methods and Participants

The evaluation involved two components: an on-line survey administered to Incubator members and a review of mid-year and final progress reports submitted by Incubators in an on-line reporting system. The on-line survey asked about participants' experiences with several aspects of the NC PHICs, including: administration; funding; networking; project implementation; and support received by the NCIPH. For all rating questions, respondents were asked to rate their level of agreement on a scale from 1 – Not at all agree to 6 – Strongly agree.

Data Analysis

Data from the on-line survey were organized by evaluation question and survey questions to summarize key findings. Data are presented as means which were calculated for continuous

variables; and/or top two ratings (i.e., percent of respondents that rated a given indicator a 5 or 6); and lists of responses were prepared for all qualitative survey items. Progress reports were reviewed in detail and analyzed according to the three main components of the NCPHIC logic model: Incubator Functioning; Intervention Projects; and Capacity Projects.

RESULTS

Response Rates

The overall response rate for the on-line survey was 85%, with 88% of health director partners responding (Table 1).

Table 1. Survey Response Rates.

Participant Group	Response Rate
Overall Incubator Membership	85% (n=79)[a]
- Health Directors	88% (n=67)
- Incubator Managers	100% (n=6)
- DPH	33% (n=6)

[a] Incubator Partnership response rates ranged from 77% to 100%

Incubator Functioning

Table 2 provides a summary of staffing and specific project areas for Fiscal Year 2008. Variation in staffing levels exists across the Partnerships. Most staff is funded through grants.

Table 2. NCPHIC Staffing and Project Information Summary.

Staffing Categories	Description	Total
# of Full Time Staff	3 partnerships: NW, NE, and C. NE has 22, nearly all of whom are funded through grants.	25
# of Part Time Staff	4 partnerships: NE, SC, C, W	7
# of Interns	NE, SC, C, NW, SP	8
# of Consultants	2 partnerships: NW, W	3

Other evaluation results related to Incubator Functioning come from the survey. Overall, the majority (76%) of respondents mostly or strongly agreed that regional projects benefit local health agencies. When asked what the greatest benefit of the Incubator Collaboratives was to their health department, health directors noted the following: collaboration on projects; working on standardized policies and procedures and gaining access to best practices; access to resources; regionalization; and innovation. One health director described the benefit of gaining access to resources,

> *Identifying innovative ways to address old public health issues confronting our region while sharing limited funds/resources to accomplish the task.*

Administrative – Survey respondents were asked to rate their level of agreement with five statements related to the administrative functions of their Incubator (Table 3). Seventy-one percent or higher of all Incubator members mostly or strongly agreed with these statements.

Table 3. Administrative Statements Regarding Incubators.

Administrative Statements	Mean	% Rating 5 or 6
1) Current structure effectively meets need (63)	4.9	73%
2) Appropriately distributes resources among members (61)	5.1	75%
3) Clear about roles and responsibilities (63)	5.2	84%
4) Partners can manage conflict (61)	5.0	71%
5) I have a say in decisions (63)	5.3	81%

Funding – Survey respondents were asked to rate the extent to which their Incubator provides funding that meets the need of their agency, community, and region's population (Table 4). Between 63% and 67% of respondents mostly or strongly agreed that their Incubator met such needs. Fifty-six percent of respondents mostly or strongly agreed that their Incubator is effectively identifying additional funding sources to meet regional needs.

Table 4. Funding Statements Regarding Incubators.

Provides funding that meets the need of my:	Mean	Top Two
1) Agency (63)	4.7	67%
2) Community (62)	4.6	63%
3) Region's Population (63)	4.8	67%
4) My Incubator is effectively identifying additional funding sources to meet regional needs (62)	4.5	56%

Networking – Survey respondents were asked to rate the extent to which their Incubator helped improve networking ability with their peers and staff (Table 5). Eighty six percent of respondents mostly or strongly agreed that it helped improve their ability to network with peers within their region; whereas just 37% provided such ratings for improving networking with peers in other regions. Sixty percent indicated such agreement for enhancing networking opportunities for health agency staff.

Table 5. Networking Statements Regarding Incubators.

Networking	Mean	Top Two
1) Helped improve my ability to network with peers within my region (63)	5.3	86%
2) Helped improve my ability to network with peers in other regions (63)	4.0	37%
3) Enhances networking opportunities for my health agency staff (62)	4.7	60%

Respondents were also asked to rate the extent to which other health directors have been an important resource for their agency (Table 6). A large majority of respondents indicated that they agreed that other health directors served as a resource for identifying innovative solutions, gaining access to best practices, and gaining additional resources. A smaller percentage of respondents thought other health directors served as a resource for improving public health preparedness and enhancing the political influence of their agency, though this is not necessarily the intention of the Incubator program.

Table 6. Extent to Which Other Health Directors Serve as a Resource.

To what extent have other directors in your region been an important resource to you/your agency for:	Mean	Top Two
1) Gaining access to best practices (64)	4.9	70%
2) Identifying innovative solutions (60)	4.8	73%
3) Gaining additional resources (60)	4.6	65%
4) Improving public health preparedness (56)	4.1	43%
5) Enhancing political influence of your agency (62)	4.0	45%

Projects

Seventy-one percent of survey respondents mostly or completely agreed that their Incubator projects have made satisfactory progress towards achieving goals and objectives. In this report, projects are categorized as Intervention Projects or Capacity Projects. Intervention Projects are those that address health outcomes; whereas Capacity Projects address improvements to the functioning of agencies.

Intervention Projects

During Fiscal Year 2008 there were nine Intervention Projects at one of the four of the Incubator Partnerships. Seven of those projects were in implementation mode: Diabetes Sentinel, Touch No Tobacco, HIV/Health in Motion, and Heart Disease and Stroke in the NE Partnership; Project SPARROW in the South Central Partnership; and Cultural Diversity and Health Disparities, and Access to Primary Care in the Northwest Partnership. Two projects were in the planning stage: Senior Health Initiative in the Western Partnership; and the HPV project in the South Central Partnership.

The intervention projects use the following methods to improve the health status of individuals: recruitment of role models/lay health advisors; training; education sessions; support groups;

assessing the health status of individuals; assessing health programs for target populations; promoting health policies in churches, schools, and businesses; and developing coalitions. Table 7 presents project outputs for all of the intervention categories.

Table 7. Total Outputs by Intervention Category

Intervention Category	Intervention Topic	Total	Partnerships
# of Role Models Recruited/Deployed (e.g., Lay Health Advisors/Student Mentors)	Diabetes, Tobacco, Stroke and Heart Disease	1,103	2 – NE, SC
Individuals trained – primarily Role Models	HIV, Diabetes, Tobacco, Stroke and Heart Disease	1,402	2 – NE, SC
Individuals attending information/education sessions/workshops	Same as above	10,889	2 – NE, SC
Support Group	People living with HIV/AIDS	1 group/10 individuals	1 – NE
Individuals health assessed	BMI, physical activity, nutrition, HIV/Syphilis test, A1c	4,341	2 – NE, SC
Programs Assessed	School Systems tobacco, senior program	29	2 – NE, W
Institutions with Policies Passed	Businesses, churches, physical activity, nutrition, tobacco, etc.	79	2 – NE, SC
Coalitions/Workgroups Developed	ECHAP; Senior; Finance Work Group, Dental Work Group, Grant Work Group	5	3 – NE, W, SP

Capacity Projects

During Fiscal Year 2008 there were a total of twenty Intervention Projects at one of the six Incubator Partnerships. Table 8 provides a list of these projects by Partnership.

Table 8. Capacity Projects by Partnership

Partnership	Projects
Central	3 – Health Education and Social Marketing, Development of a Practice Based Research Agenda, Workforce Development
NE	4 – Common Billing Initiative, LEAN QI initiative, GIS Portal, Health Disparities Advisory Council

Partnership	Projects
NW	4 – Best Billing, Organizational Efficiencies, WIC Works Well, Workforce Development
SC	2 – Environmental Health Automation, Health Care Access Expansion
SP	4 – Clinic Efficiencies, Dental Clinic Efficiencies, Grant Writing, Health Information Exchange, HIS Adoption
West	3 – Environmental Health Recruiting, Environmental Health Automation, Handheld

The capacity projects use a variety of methods to improve the infrastructure and practices of individual agencies and Partnerships (Table 9). While many of the methods and outputs are self-explanatory, some bear further explanation. Four of the 16 assessments conducted were clinic efficiency assessments which led to the improvement of family planning, prenatal, WIC, and dental clinics. Other assessments included examining the efficiency of billing practices and patient encounters which led to the development of resources shared within, and at times across, incubators. Four assessments related to environmental health were also conducted, primarily related to workforce development and use of computer technology. These assessments led to a variety of improved practices: training for billing coding and dual role interpreters; environmental health data collection and reporting, use of GIS for environmental permitting, and automation of school health data collection; improved dental clinic practices, and HIS practices.

Table 9. Total Outputs by Capacity Project Category

Capacity Category	Description	Total	Partnerships
Workforce Development Trainings	Environmental Health, Dental Health, Business processes, Cultural competency	601	All except SC
Assessments conducted	Clinic assessments, program, EH staffing and computer hardware/software, workforce development, data prioritization	16	All
Recruitment Initiatives	EH internships, dual-role staff members, application for fellowships, PH summer camp, exploring possible changes in return-to-work legislation, marketing display	6	All but SC, NE
Retention Initiatives	Conducting employee retention	9	All but SC

Capacity Category	Description	Total	Partnerships
	assessments, developing county HR policy inventories, HR staff conferencing, and HR policy changes, training, promotions		
Number of Content Experts Consulted	Academia (8), Private (9), Public (17)	34	All
Forums Conducted	Employee Clinic and Worksite Wellness, Joint Leadership Conference	2	NE, SC
# Participating at Forums	Same as above	205	Same
Additional Grant/Contract Funding	1,235,344 grant funds; 342,091 contract funds, 325,000 grant funds dedicated to joint projects	1,902,335	
# Resources Developed	Manual for Billing Coding, Reference documents for PH information, Templates (human resources, policies and procedures), automated EH data collection system (35 counties), Food & Lodging, Septic & Wells trainings	15	NE, SP, NW, SC
# Improved Practices	Training, EH practices, dental practices, HIS practices	19	NE, SP, W, SC
# of Hardware Purchases	Tablets, printers, CDP mobile, laptop	187	NE, SC, W, NW
# of Software Purchases/Fees	Microsoft, GIS, CDPims, CDP license fees	133	C, NW, NE, SC, W
Total amount of cost savings from collective services and purchases	Software licenses and hardware 275,000; EH technology software training, intern, Dental Work Group	302,300	NE, W, NW, SP

NCIPH Services

Survey respondents were asked the extent to which they agreed that NCIPH staff were meeting their Incubator partnership's needs for support and facilitation [Scale 1 – Not at all agree to 6 – Strongly agree]. Eighty six percent of respondents indicated that they mostly or strongly agreed with that statement. Respondents were then asked to rate the level of effectiveness of NCIPH staff in specific program administration areas (Table 10). [Scale 1 – Not at all effective to 6 – Extremely effective]. Seventy-three percent or more of respondents rated NCIPH staff as very or extremely effective for all ten areas.

Table 10. Ratings of NCIPH Effectiveness

Please rate the effectiveness of NCIPH staff in the following areas:	Mean	Top Two
1) Logistical support (n=52)	5.4	85%
2) Public relations (n=53)	5.3	83%
3) Facilitation of strategic planning sessions (n=53)	5.4	85%
4) Provision of transitional support (n=38)	5.2	82%
5) Assistance with proposal development (n=50)	5.2	84%
6) Overseeing financial and operational status reporting (n=49)	4.9	73%
7) Facilitating access to training (n=49)	5.1	73%
8) Coordination of Incubator Advisory Committee (n=48)	5.5	90%
9) Provision of additional consultation and TA (n=55)	5.3	87%
10) Project coordination for selective Incubator projects (n=52)	5.3	85%

LIMITATIONS

The following are limitations of the findings presented in this report. All data sources are self-reports of participants' experiences with the NC PHIC program. Progress reports were submitted using a new on-line reporting system and some Coordinators/staff members may not have completed reports accurately. Survey limitations include: 1) some participants may not have been completely forthcoming with their opinions of the NC PHICs because of concerns of confidentiality given the fact that evaluation team members are also NCIPH staff members though every effort is made to assure anonymity of respondents; and 2) health directors were the only agency staff surveyed; thus their opinions may not represent the opinions of the agencies they serve.

CONCLUSIONS

For nearly all survey indicators, there were increases in the top two ratings indicating that Incubator partners are even more satisfied with the Incubator Collaborative program than they were last year. The indicators that changed the most include:

- Incubator health directors have helped health directors identify innovative solutions (73% - up from 55%)
- Incubator projects have made satisfactory progress towards achieving goals and objectives (71% - up from 55%)
- NCIPH staff are meeting their Incubator partnership's needs for support and facilitation (86% - up from 72%)
- Regional projects benefit local health agencies (76% - up from 64%)

Areas for Improvement

A majority (56%) of Incubator Collaborative Partnership members mostly or strongly agreed that Incubators effectively identify additional funding sources to meet regional needs. This demonstrates the need for Incubator partners to continue to identify additional funding sources.

More than one-third of Incubator Collaborative Partnership members mostly or strongly agreed that Incubators helped improve their ability to network with peers in other regions (37% - up from 28%). While ratings increased from last year, there is still more opportunity to expand opportunities for collaboration/networking across partnerships. Partnership staff may want to consider presenting resources, tools, and findings from innovative projects at Board meetings of other Incubators as well as continue to post updates and newly developed resources on the Incubator website.

When results were examined by Incubator, there was variation in ratings, with one or two partnerships consistently providing lower ratings for nearly all indicators. NCIPH staff may want to consider reviewing survey results with Partnership members at strategic planning meetings to identify ways to address identified challenges.

For more information, contact NCIPH Evaluation Services Research Associate Molly Cannon at mcannon@email.unc.edu or 919-966-9974 or Director Mary Davis at mvdavis@email.unc.edu or 919-843-5558. For a complete description of the NCLHDA process and participants, please visit the program website at: http://nciph.sph.unc.edu/incubator/.

North Carolina Public Health Incubator Collaboratives

August 2005 – July 2007

Stakeholder Evaluation Report

December 2007

UNC
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North Carolina Institute for Public Health

ACKNOWLEDGEMENTS

This evaluation of the August 2005 – July 2007 North Carolina Public Health Incubator Collaboratives program was conducted by evaluation staff, Molly Cannon, MPH and Mary Davis, DrPH, MSPH, at the North Carolina Institute for Public Health (NCIPH), the service and outreach arm of the School of Public Health at the University of North Carolina at Chapel Hill. This is the same organization that administers the Incubator process, thus the evaluation process should be considered an "internal evaluation."

Dr. John Graham, NCIPH Deputy Director for Outreach and Consultation; Lisa Macon Harrison, MPH, Program Officer; and Erin Ridings, Program Associate, provided valuable ideas on the overall evaluation design, questions to ask, interpretation of the results, and specific stories to highlight in this report.

BACKGROUND

The NC Public Health Incubator Collaboratives (NCPHICs) are teams of local health departments voluntarily working together to address pressing local public health issues using innovative approaches. Six NC PHICs (Western, Northwest, Central, South Central, Southern Piedmont, Northeastern) have been formed representing 82 counties. NC PHICs started their third round of legislative funding in August 2007. This report includes information collected from an on-line survey of Incubator members administered in June 2007 and from Incubator project reports (for projects funded from August 2005 – July 2007) submitted by Incubator coordinators. For more information about the NC PHICs, visit: www.sph.unc.edu/nciph/incubator. NCIPH, is the PHIC Administrator, facilitating Incubator activities and managing the program.

EVALUATION METHODOLOGY

Design

The purpose of the evaluation was to examine the experiences of the six Incubator Collaboratives according to the following two questions: 1) Are Incubators providing value to member health departments; and 2) Is the NCIPH meeting Incubator partnership needs for support and

facilitation. The evaluation involved two components: an on-line survey administered to Incubator members and a review of final progress reports submitted by Incubators. The on-line survey asked about participants' experiences with several aspects of the NC PHICs, including: administration; funding; networking; project implementation; and support received by the NCIPH. Evaluation results will be used to inform the Incubator Collaboratives process in the future (e.g., program changes, strategic planning sessions, technical assistance).

Data Collection Methods and Participants

Table 1 presents survey response rates. The on-line data collection procedures and instrument were submitted to the Public Health-Nursing Institutional Review Board at UNC and determined to be program evaluation and thus not in need of IRB approval. Incubator partnerships were also requested to complete project progress reports for all projects conducted during the two year period. NCIPH Evaluation Services, in consultation with PHIC Administration staff, created a standard progress report template. Four of the six partnerships submitted progress reports in time for inclusion in this report. Data collection activities occurred from June to November 2007.

Table 1. Survey Response Rates.

Participant Group	Response Rate
Overall Incubator Membership	86% (n=71)[a]
- Health Directors	83% (n=54)
- Incubator Managers	100% (n=6)
- DPH	100% (n=6)
- Other	5 respondents

[a] Incubator Partnership response rates ranged from 67% to 100%

Data Analysis

Data from the on-line survey were organized by evaluation question and survey questions to summarize key findings. Data are presented as means which were calculated for continuous variables; and/or top two ratings (i.e., percent of respondents that rated a given indicator a 5 or 6); and lists of responses were prepared for all qualitative survey items. Progress reports were

reviewed in detail and coded according to the six main outcomes identified in the PHIC logic model: 1) Increase Level and Effectiveness of Services Delivered; 2) Increase Shared Resources Across Local Health Departments; 3) Increase Equity of Service Delivery to Incubator Populations; 4) Foster Innovative Projects; 5) Increase Opportunities to Solve Common Problems; and 6) Improved Health Outcomes.

RESULTS

Overview of Survey Results

Selected summary survey results are included in the body of this report. Additional results are presented in Appendix A. Key areas that Incubator partnerships addressed include: workforce development, best practices, organizational efficiencies, health specific interventions, financial reimbursement, and access to care. Overall, the majority (62%) of health directors that responded to the survey mostly or strongly agreed that regional projects benefit local health agencies. When asked what the greatest benefit of the Incubator Collaboratives was to their health department, health directors noted the following: collaboration on projects; opportunities to network; access to resources; the ability to leverage funds; and helping to understand public health problems. One health director described multiple benefits,

> *Smaller counties such as ours have benefited greatly from the shared knowledge gained. It has broadened our horizons and way of thinking...it has helped us improve our business processes and customer service. It makes us also feel proud to be part of the 'bigger public health picture.'*

Approximately 55% of health directors mostly or completely agreed that their Incubator projects have made satisfactory progress towards achieving goals and objectives. As one health director indicated,

> *Our incubator has achieved the goals and objectives set forth for our projects mostly because of funding and the strong desire and need to work collaboratively ...because the group defines projects that are of interest and need to our region.*

The majority of Incubator Collaborative health directors mostly or strongly agreed that:

- Incubator Administrative structure effectively meets member agency needs (70%)
- Incubators appropriately distribute resources among member health agencies (78%)

- Incubators effectively identify additional funding sources to meet regional needs (63%)
- Incubator participation has helped improve their ability to network with peers in their region (69%) and has enhanced networking opportunities for health agency staff (56%)
- NCIPH staff are meeting their Incubator partnership's needs for support and facilitation (75%)

Summary of Projects According to the Six NC PHIC Outcomes

1) Increase Level and Effectiveness of Services Delivered

One of the outcomes of the NC PHICs is to increase the level and effectiveness of services delivered to the Incubator population. Several Incubator projects work toward this outcome, including projects that increase staff capacity and improve organizational efficiencies. Incubators are addressing staff capacity through enhanced environmental health specialist recruitment efforts and provision of additional/enhanced training in the following areas:

- New employee orientation training
- Grant writing training and technical assistance
- Web-based Environmental Health training
- Accreditation training and creation of a guide entitled, "Best Practices for Complying with Public Health Accreditation Standards to Orient New Employees"
- Training on the Use of Environmental Health Hand Held Technology

Some NC PHICs have researched and implemented organizational efficiencies. These organizational efficiencies have led to the following changes in the health department:

- Reduction in the number of routine labs and patient education distributed in family planning clinics
- Improved scheduling by using "Open Access" scheduling in dental clinics

Box 1: Northwest Partnership Example of Increased Level and Effectiveness of Services Delivered

Through a HealthMETRICS study commissioned by the Incubator, it was found that Family Planning Clinics in all eight Incubator counties were using different protocols for initial visits of women seeking oral contraceptives and Depo-Provera injections. In many cases, the number of routine labs conducted and patient education materials distributed exceeded the state's

recommendations, costing the health department financial and human resources. Based on study results, the Incubator formed a Family Planning Workgroup that identified recommendations for how to institute organizational efficiencies. Recommendations included: reduction in number of routine labs, reduction in patient education materials distributed, and the use of new patient history forms. Recommendations have been disseminated to all health departments in the Incubator and are in varying stages of implementation. The Southern Piedmont Incubator has also decided to adopt some of the recommendations. According to Incubator coordinator, Candice DuVernois, such organizational efficiencies could not have been achieved by a single health department,

> *The sharing of information and the energy created by the project across the counties could not have happened if a single health department went through the assessment alone. The comparison of labs and patient education material across the counties was remarkable. It gave the others much needed perspective when considering what labs/materials to reduce.*

2) Increase Shared Resources across Local Health Departments

NC PHICs share financial, material, and human resources to accomplish project goals. During the project period, the six incubators submitted and received grants from numerous agencies (e.g., Kate B. Reynolds, Health and Wellness Trust). An incubator coordinator described the value of partnering with other counties in submitting grants,

> *The expanse of this national project would be difficult for any individual health department to focus on. As a collaborative project, we share workload, challenge each other, brainstorm, and learn together, and ultimately will benefit from the knowledge and expertise brought to the table by each member.*

Participation in Incubator projects has helped the health departments leverage funds and "get more bang for the buck" particularly when the grant activities reach all of the health departments within an Incubator. For some of the smaller health departments, many of the grants would not have been submitted had it not been for the Incubator,

> *Five new grants were written primarily in our most under resourced counties – work that likely would not have been accomplished without this project.*

Regardless, there is still a need for more funding to address needs, particularly since the Incubator program is expanding,

> *With the maturation of several regional Incubators and the numbers increasing, the funding level has not kept up with the growth of the Incubator system. We need a*

separate pot of money for incubator administrative costs and a separate pot of money for innovative new projects. We have leveraged many funding sources and have many independently funded projects. We desperately need the $2 million in additional incubator funding, and we need to carve out one million for incubator administrative infrastructure and two million for innovative projects.

Box 2: Southern Piedmont Partnership Example of Increase Shared Resources across Local Health Departments

Gaston County Health Department, a member of the Southern Piedmont Incubator Collaborative wanted to address the fact that there was no formal employee orientation process that would ensure employees had the tools and resources they needed to be "successful" in their assigned duties. With assistance from the North Carolina Institute for Public Health, the Health Department developed a standardized orientation plan and materials that could be used at all local health departments in the state. As part of this initiative, Gaston County Health Department staff trained 60 individuals from ten Southern Piedmont Partnership counties how to use these orientation materials. Several other partnerships have already adopted the orientation materials developed by the Southern Piedmont Partnership. More information about the orientation is available on-line at: http://nciph.sph.unc.edu/incubator/south_pied/tools.htm. According to Program Coordinator, Cappie Stanley, this initiative has been of great value,

There was tremendous interest in this project and the evaluations of the training clearly indicated the value of the work to those who participated. The adaptation of the curriculum by several counties in an indication of the need for such a project. Staff feedback from the pilot at Gaston County Health Department has rated the product/process very highly.

3) Increase Equity of Service Delivery to Incubator Populations

Incubator Collaboratives are also working toward increasing the equity of service delivery to their populations through addressing high rates of uninsured patients, raising awareness of health disparities, and addressing health disparities through various grant initiatives. Examples of these projects include:

- Working with small businesses to provide health insurance for their employees
- Creation and dissemination of a video addressing social justice and health disparities
- Diabetes Sentinel Project

As one Incubator member said about the video addressing social justice and health disparities,

The video addresses many concerns about access to health care that are difficult to put into words. The film footage speaks volumes about the struggles of people in poverty and/or people with racial or ethnic discrimination...The video would likely not have been

completed if not for the Incubator.

4) Foster Innovative Projects

NC PHICs were designed to foster the creation of innovative solutions to public health problems. In that light, several of the Incubators are developing and implementing truly innovative public health solutions to pressing issues. Examples of these projects include:

- Health Department of the 21st Century
- Health Record Information System
- Recruiting Local Businesses to Provide Insurance for Employees
- Use of Hand Held Technology by Environmental Health Specialists

While most Incubator projects plan to be successful, the innovative nature of some projects lends itself to trial and error before success. As evidenced by one of the coordinators,

> *Working together we still have not attained our goals completely. Working alone individual counties would not have even attempted such a project. We are after all an "an Incubator" and if every project succeeded just as planned on the first attempt, we would not need incubators!*

Box 3: Western Partnership Example of Foster Innovative Projects

Based on a Regional Health Assessment conducted by the Western Partnership and the Mountain Area Health Education Center (MAHEC), the Partnership learned that 10 of the 15 fastest aging counties in North Carolina are located in the Western North Carolina. Expanding on this assessment, the Incubator next undertook an extensive survey of the elderly population within the Incubator to learn about their priority health issues.

This year the Incubator is studying the primary and secondary data collected and comparing the needs identified with the local resources available. By the end of the fiscal year they will have selected a "best practice" intervention model for public health and will fund a pilot program in one or two counties in the second year of the biennial budget.

"With many health departments getting out of the Home Health business, we are losing our primary program link with the elderly population" according to George Bond, Western Incubator Coordinator. The pilot initiative will attempt to answer the question of what is the most appropriate role for public health to play in addressing the health needs of our rapidly aging population.

According to Bond, being a member of the Partnership, "Allows for the creation of a "Virtual Western Public Health District" to address regional needs without any county having to give up

any autonomy. We get many of the benefits of a District without having to deal with any of the potentially thorny issues of governance and structure", said Bond.

5) Increase Opportunities to Solve Common Problems

In the June 2007 survey, approximately 63% of health directors agreed that their Incubator is effectively identifying additional funding sources to meet regional needs. Some of the projects Incubators are working on that address common problems include:

- Conducting a Regional Health Assessment
- Improving Public Health marketing
- Developing and disseminating policies and procedures for ways to increase revenues and decrease expenditures
- Researching and adopting best practices for personnel policies and dental clinic scheduling
- Creating and disseminating an on-line HIPAA (Health Insurance Portability and Accountability Act) training module

An Incubator member described how one of their projects addresses regional needs,

> *Allows opportunities for agencies to implement eligibility, bad debt, and collection policies that are consistent across county lines. This creates an opportunity to "educate" clients of strict adherence to system requirements and enforce rules and regulations.*

6) Improved Health Outcomes

The overarching goal of many of the Incubator projects is to improve health outcomes. There are several projects specifically addressing health problems such as the Diabetes Sentinel Project; Community Obesity Project; Fall Prevention mini-grants; Community Health Grants; and the Teen Tobacco Prevention Initiative. Each of these projects has an evaluation component to collect data that will measure program impact. For specific information related to the Northeast Partnerships' Teen Tobacco Prevention Initiative, visit: http://fammed.unc.edu/TPEP/reports/FINAL%202006-07%20Annual%20Teen%20Report.pdf

LIMITATIONS

The following are limitations of the findings presented in this report. All data sources are self-reports of participants' experiences with the NC PHIC program. Self-reports may have been

challenged by recall bias, as the evaluation included activities that occurred as early as August 2005. Additional survey limitations include: 1) some participants may not have been completely forthcoming with their opinions of the NC PHICs because of concerns of confidentiality the fact that evaluation team members are also NCIPH staff members; and 2) health directors were the only agency staff surveyed; thus their opinions may not represent the opinions of the agencies they serve. Additional progress report limitations include: 1) evaluators did not have completed reports for all partnerships; 2) incubators did not report on consistent indicators; and 3) several coordinators were hired during this project period and thus may not have had the full history of these projects.

CONCLUSIONS

NC Public Health Incubator Collaboratives are providing value to member health departments and are considered to be innovative, as described by one health director, "I think the Incubator Collaboratives have been one of the most innovative ideas that NC Public Health has had in decades". However, additional administrative funding is needed to help the institutionalize Incubators and facilitate more innovative projects.

For more information, contact NCIPH Evaluation Services Research Associate Molly Cannon at mcannon@email.unc.edu or 919-966-9974 or Director Mary Davis at mvdavis@email.unc.edu or 919-843-5558. For a complete description of the NCLHDA process and participants, please visit the program website at: http://nciph.sph.unc.edu/incubator/.

The Public Health Study Commission

Co-Chairs, Sen. (Dr.) Bill Purcell
Sen. (Dr.) Bob England

December 2, 2008

Essential Services at the Local Level

Dr. Rosemary Summers
NC Association of Local Health Directors
Orange County Department of Health

Arabian Proverb

He who has health has hope and he who has hope has everything.

Legislative Action

- 2007 Legislative Session
  - $2 million in General Aid to County Funds
- 2008 Legislative Session
  - $4.8 million in General Aid to County Funds

Essential Services at the Local Level
How Were The New Funds Used?

- Health Departments with $15,000 allocation in 2007
  - Used primarily to conduct projects or buy equipment and supplies

Essential Services at the Local Level
How Were The New Funds Used?

- Examples—
  - Produced DVD in Karin language to reduce interpreter costs during required refugee communicable disease screening
  - 16 counties supported the community health assessment process
  - 16 enhanced website with educational information for residents
  - 14 created earned media on prevention/health issues
  - 13 either implemented exercise & fitness programs or developed walking trails

Essential Services at the Local Level
How Were The New Funds Used?

- Health Departments with $35,000 allocation in 2007
  - Used primarily to hire or supplement staff salaries

Essential Services at the Local Level
How Were The New Funds Used?

- Examples—
  - 3 increased staff support for vital records
  - 10 increased staff support in communicable disease
  - 7 supported work to implement NCIR in the community
  - 10 increased environmental health staff or supplemented complaint investigations
  - 5 added laboratory services
  - 7 increased cancer screenings
  - 13 hired or contracted additional staff with appropriate credentials
  - 9 added MD/mid level provider hours

Essential Services at the Local Level
How Were The New Funds Used?

- 2008 Funding is in progress
- Examples—
  - Using funds to supplement reductions in funds from federal pass through for public health emergency preparedness
  - Hired additional health educators to organize and collaborate with community partners to reduce obesity
  - Hired additional nurses to provide core services such as immunizations

Essential Services at the Local Level

The real power is in the stories of the lives of our NC citizens that have been affected.

Ruby's Story

Bob's Story

Paul's Story

Adele's Story

Essential Services at the Local Level
Why Do We Need MORE Money?

- Federal Reductions in Funds
  - Preparedness funds that are passed to locals
  - Reimbursements for services (child service coordination, other case management)
  - Children's Health Insurance Program
- Economic State of Affairs
  - Loss of jobs statewide, especially in urban areas
  - Individual difficulties in meeting daily/monthly expenses

Essential Services at the Local Level
Why Do We Need MORE Money?

- State Reductions
  - Division of Public Health reductions
  - $3.2 million local share from cost settlement funds
- Local Reductions
  - Reduced sales taxes, slowing economy means less growth in property taxes
  - Loss of local jobs in all sectors (private and public)

Essential Services at the Local Level
Why More Funds for Public Health?

- Some new record highs across state
  - Emergency assistance applications
  - Food stamp applications
- Unemployment is growing
- Mortgage foreclosures leading to more homeless

Essential Services at the Local Level
Why More Funds for Public Health?

- Local public health is the true safety net
  - Uninsured populations growing—in Orange County the uninsured (not Medicaid) increased to 60% of the patients we serve
- Prevention services vs. care of sick
  - Residents will sacrifice preventive services they can't afford....immunizations, well child check-ups, family planning services, prenatal care.....

Essential Services at the Local Level
Why More Funds for Public Health?

- Waiting rooms are full
- Waiting lists for some services
- Departments are already redirecting staff to critical service needs
- Sacrificing outreach, community education, collaboration, follow-up
- What happens when the next outbreak occurs?

Essential Services at the Local Level

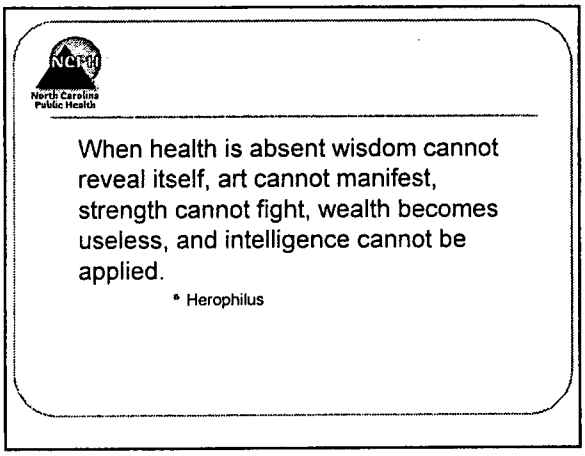
- ✓ Monitor & assess health status & solve community health problems
- ✓ Diagnose & investigate health problems & health hazards
- ✓ Inform, educate & empower people about health issues
- ✓ Mobilize community partnerships & action to identify & solve health problems

Essential Services at the Local Level

- ✓ Develop policies & plans that support individual & community health efforts
- ✓ Enforce laws & regulations that protect health & ensure safety
- ✓ Link people to needed personal health services & ensure the provision of health care when otherwise unavailable

Essential Services at the Local Level

Without additional funds, we believe the health and safety of all North Carolinians are at risk....


NCPH
North Carolina Public Health
When health is absent wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied.
* Herophilus

NORTH CAROLINA

Childhood Obesity Prevention Demonstration Project

In fiscal year 2008, the NC General Assembly appropriated $2 million in non-recurring funding for "demonstration projects to address childhood obesity". In July 2008, the NC Division of Public Health announced the Request for Applications (RFA) for grant funds through the Childhood Obesity Prevention Demonstration Project. The purpose of this project is to demonstrate that strengthening partner linkages within community sectors increases the utilization and effectiveness of childhood obesity prevention and control efforts. Grants of $380,000 each were awarded to five health departments to support implementation of recommended strategies to reduce the rates of childhood overweight and obesity.

The Childhood Obesity Prevention Demonstration Project consists of interventions in preschools, schools, healthcare organizations, faith organizations, community organizations, and the community at large. The Project ensures intense technical assistance with comprehensive programming to create:

- Stronger community partnerships to support sustainable healthy environments
- Improved awareness and education on the value of nutrition and physical activity through social marketing campaigns
- Increased physical activity on greenways, trails, and sidewalks built as part of Bicycle/Pedestrian Master Plans
- Healthier pre-school environments
- More accurate data on childhood obesity rates to help guide continued efforts
- Coordinated clinical and community interventions for children at high risk for diabetes
- Enhanced clinical pediatric obesity tools and training for medical practices
- Expanded hospital employee worksite wellness programs

The Physical Activity and Nutrition Branch in the NC Division of Public Health is responsible for the administration of these grant funds. Assistance and support for the interventions is provided by the North Carolina Hospital Association, WakeMed Health and Hospitals, the North Carolina Alliance for Athletics, Health, Physical Education, Recreation, and Dance (NCAAHPERD), Community Care of North Carolina, the NC Partnership for Children, NC Healthy Schools, NC DPH Diabetes Prevention and Control Branch, NC DPH Women's and Children's Health Section, Healthy Carolinians, NC DPH Chronic Disease and Injury Section, NC DPH Physical Activity and Nutrition Branch, and others.

Examples of activities carried out through the Project grants include:

The Appalachian District Health Department and the Watauga County Healthy Carolinians will increase access to fruits and vegetables in schools through the "Farm to School" program. The program includes a monthly featured fruit or vegetable, taste testing, and learning activities to encourage children to eat more fruits and vegetables.

The Cabarrus Health Alliance and Healthy Cabarrus will expand a program to increase physical activity and healthy eating for children at preschools and child care centers. The Nutrition and Physical Activity Self-Assessment (NAP-SACC) will be implemented at 8 additional child care centers in the county, reaching 320-345 children.

The Dare County Department of Public Health and the Healthy Carolinians of the Outer Banks will work with local health care providers and the Outer Banks YMCA to replicate the ENERGIZE! Dare program. Health care providers will refer children ages 10-18 who are at risk for Type 2 Diabetes to the program, which includes a 12-week course at the YMCA.

The Henderson County Health Department and Partnership for Health will create a social marketing campaign to encourage county residents to eat smart and move more. Henderson County has seen dramatic growth in Hispanic/Latino residents (466% over the past 10 years). Media outlets such as the Hispanic/Latino newspaper La Voz will be used to reach this growing population.

The Moore County Health Department will work with the partnership MooreHealth to build a new sidewalk and update an existing trail to create a safe route for children to walk to school and for residents to access Cannon Park. Improvements will include new sidewalks, a crosswalk, and signs. The project will connect the Village Acres neighborhood with Cannon Park and Pinehurst Elementary School.

NORTH CAROLINA

Childhood Obesity Prevention Demonstration Project

Marcus Plescia, MD MPH
Chief, Chronic Disease and Injury Section
NC Division of Public Health
December 2, 2008

nc department of health and human services

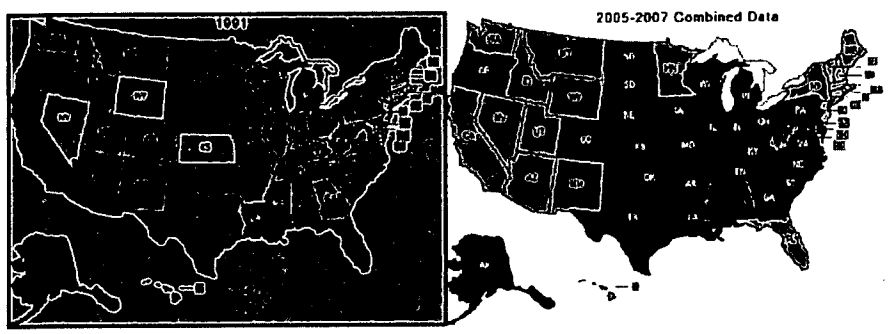
PHYSICAL ACTIVITY & NUTRITION BRANCH
NC DIVISION OF PUBLIC HEALTH

NCPH North Carolina Public Health

OBESITY TRENDS* AMONG U.S. ADULTS

BRFSS, 1991 and 2005-2007 Combined Data

(*BMI >30, or about 30 lbs overweight for 5' 4" person)



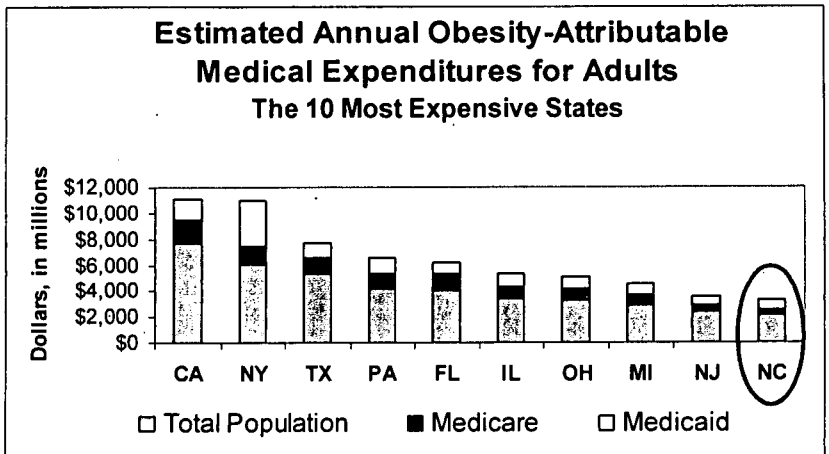
Source: Behavioral Risk Factor Surveillance System, CDC.

NC ranks 5th worst in Childhood Obesity

States with Highest Rates of Obese 10- to 17-Year Olds		
Ranking	States	Percentage of Obese 10- to 17-Year Olds
1	D.C.	22.8%
2	West Virginia	20.9%
3	Kentucky	20.6%
4	Tennessee	20.0%
5	North Carolina	19.3%
6	Texas	19.1%
7	South Carolina	18.9%
8	Mississippi	17.8%
9	Louisiana	17.2%
10	New Mexico	16.8%

Trust for America's Health. F as in Fat: how obesity policies are failing in America, 2008. Washington, DC.
2003-2004 National Survey of Children's Health Data.

N.C. has the 10th Highest Obesity-Attributable Costs in the Nation



Finkelstein EA., Fiebelkorn IC, Wang G. State-level estimates of annual medical expenditures attributable to obesity. Obes Res. 2004; 12: 18-24.

Childhood Obesity Prevention Demonstration Projects

Purpose:

To reduce rates of childhood overweight and obesity

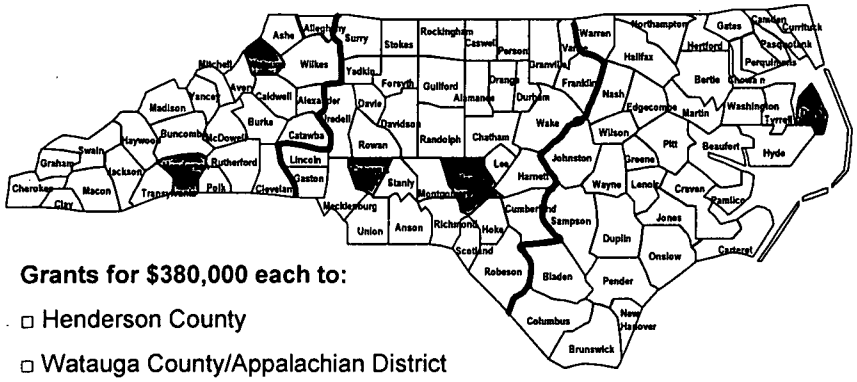
Approach:

- Multi-level, multi-sector interventions
- Evidence-based or promising practices
- Community partnerships, including non-traditional partners

Funding from NC Legislature

- Demonstration projects to address childhood obesity
- Awards to 5 counties for $380,000 each
- $100,000 for evaluation
- Non-recurring

State Funding 2008-2009
Childhood Obesity Prevention
Demonstration Project Grants



Grants for $380,000 each to:

- Henderson County
- Watauga County/Appalachian District
- Cabarrus Health Alliance
- Moore County
- Dare County

Required Components

- Community Partnership Development
- Health Communication/Social Marketing Campaign
- Bicycle/Pedestrian Master Plan Implementation
- Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC)
- In-School Prevention of Obesity and Disease (ISPOD) Initiative
- WakeMed ENERGIZE! Program
- Clinical Pediatric Obesity Tools and Training for Medical Practices
- Hospital Worksite Wellness

Optional Components

- Coordinated School Health
  - School Worksite Wellness
- Farmers Markets/Farm Stands
- Faith Community Intervention

Health Communication / Social Marketing Campaign

Promote physical activity and nutrition through consistent and targeted messages.

- Use the Eat Smart, Move More key messages
- Promote the project interventions
- Utilize multiple media formats

WakeMed ENERGIZE! Program

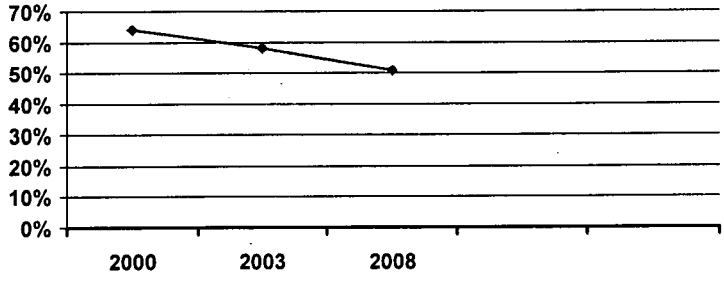
Prevent onset of Type 2 diabetes.

- Train providers/practices on screening and referral process
- Enroll children and families in 12-week program at community center
  - Education and behavior change
  - Physical activity
  - Parental involvement
- Collect child and family behavior surveys at beginning and end
- Conduct medical follow up at 6 and 12 months

NC State Employees Worksite Wellness

Wellness programming for NC state agencies, public universities, and community colleges

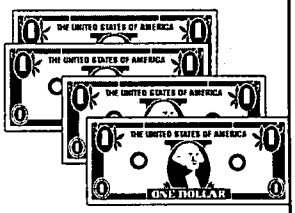
Why Wellness for State Employees?



% of Healthy NC State Health Plan Members

*NC State Health Plan's *The State of Member Health 2004: Health trends and implications for Plan members and North Carolina.* June 2004.

The High Cost of Chronic Disease



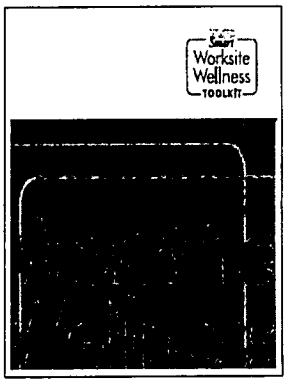
- 70% of all NC State Health Plan care costs are for preventable chronic diseases.
- Average annual NC State Health Plan medical claims for
  - Healthy Plan member **is $800**
  - Member with a chronic disease **is $7,400**

Obesity

GUIDE TO COMMUNITY Preventive Services

Worksites

- Multi-component Interventions aimed at diet, physical activity and cognitive change



Program Background

- Developed in 2004 as a component of the larger NC Health*Smart* Initiative.
- Partnership between NC Division of Public Health and NC State Health Plan.
- More intensive demonstration project since 2005 targeting all NC DHHS employees.

North Carolina Public Health

North Carolina State Health Plan
for Teachers and State Employees
www.shpnc.org

DHHS Wellness Program

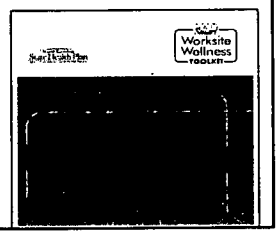
- Department Wellness Director
- Wellness Council to advise Secretary on wellness policy
- Wellness Representatives & Wellness Committees in each agency created policies and changes in the workplace social and physical environment
- Annual surveys to drive planning and evaluate progress

Statewide Program

Designed to address the needs of the NC State Health Plan members at risk of developing or already living with chronic disease

Addresses poor nutrition, physical inactivity, tobacco use and unmanaged stress

Based on best practices



Current Focus: 2008-09

DPH asked by Office of State Personnel and State Health Plan to provide oversight and assistance to ensure compliance with the OSP Worksite Wellness Policy

- Policy enacted February 2008, applies to state agencies and public universities
- Each state agency and university must develop employee wellness programs that address the primary components of a healthy lifestyle

Current Focus: 2008-09

- Division of Public Health's role in the OSP Worksite Wellness Policy
  - Assist agencies in identifying appropriate wellness infrastructure
  - Provide training for designated Wellness Leaders and Wellness Committees
  - Assist in the planning and development of wellness programs
  - Identify, create, and distribute beneficial resources and tools
  - Provide ongoing technical assistance and assist in monitoring the effectiveness of wellness programs.

School Pilot

- Developed to reach State Health Plan members employed in the NC public school system
- First such pilot program in the nation
- School staff wellness is in high demand for NC school districts

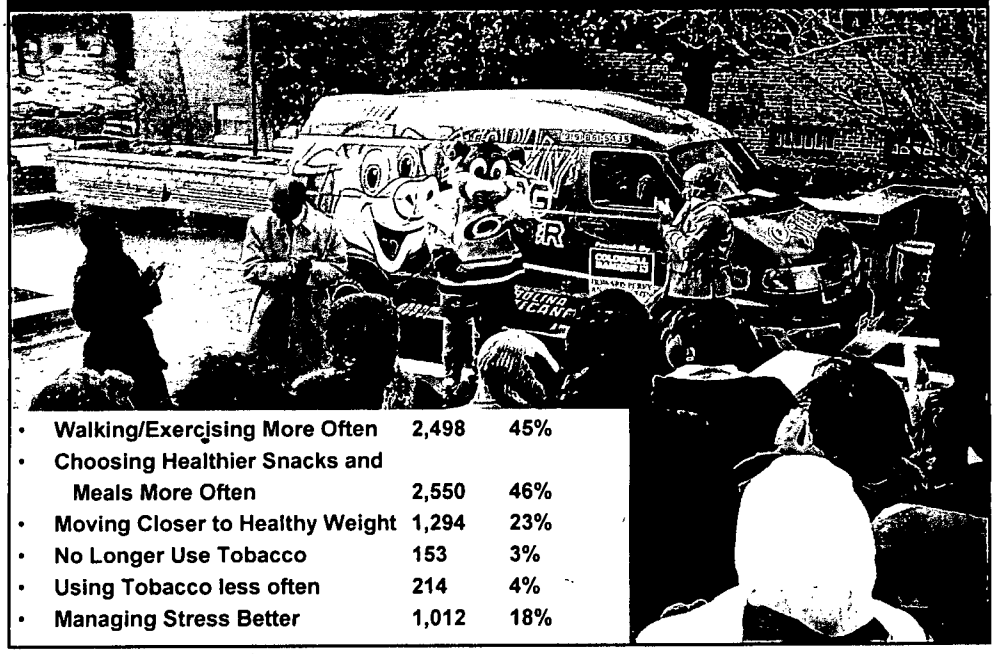
Quick Facts

Distributed ~1000 print copies
Web version: In FY 07/08 ~9000 visitors from over 59 countries/territories

100% Universities
91% Agencies
87% Community Colleges

Respond to >100 requests/yr
Maintain contact directory with >250 contacts
Host webinars and conference calls
Develop newsletters, success stories, and other resources

Changes Reported by DHHS Employees After 1 year



• Walking/Exercising More Often	2,498	45%
• Choosing Healthier Snacks and Meals More Often	2,550	46%
• Moving Closer to Healthy Weight	1,294	23%
• No Longer Use Tobacco	153	3%
• Using Tobacco less often	214	4%
• Managing Stress Better	1,012	18%

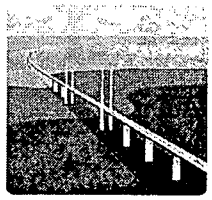
Communicable Disease Control

1. HIV Bridge Counselors ($209,138)
2. Chlamydia Screening for Males ($349,182)

Jeffrey Engel, M.D.
Epidemiology Section Chief

Bridge Counselors

- A bridge counselor acts as a "bridge" between the client and organizations providing care.
- The bridge counselor actively helps HIV positive clients get into care and ensures the client remains in care.



Bridge Counselors

- One-third of HIV positive people in North Carolina are not in care.
- On November 1, 2008, the Department of Corrections implemented expanded HIV testing for all prisoners upon entry and release
  - More prisoners with known HIV+ status will be released
  - National figures indicate that the prevalence of HIV in prisons is 3.8%
- If newly identified HIV+ patients access appropriate care and treatment, they will be less likely to develop AIDS and less likely to transmit the virus to others.

Bridge Counselors

- The need: $209,138
  - Three bridge counselors located regional offices: Charlotte, Raleigh and Greenville.
  - Work with DOC staff to know when and where an HIV+ inmate is being released.
  - Follow up on community referrals from regional disease investigative staff.
  - Ensure that an HIV positive person gets to a care giver, and provide short term support until the client's situation is stable.
  - Provide field visits to high-risk persons that fail to keep their first physician appointment and follow-up with patients that have dropped out of care.

Chlamydia Screening

- *Chlamydia trachomatis* (CT) is the most commonly reported STD in NC and US
  - Over 30,000 cases reported in NC in 2007
- CT is easily treated with antibiotics
- Approximately 75% of all females and 50% of males infected with chlamydia have no symptoms

Chlamydia Screening

- CT is found most commonly in the younger age groups (15-24)
- CT is a disease of disparity
  - Rates among Black males 9-10 times that of White males
  - Rates among Black females 6-7 times that of White females
  - Rates among Hispanics 3-4 times that of Whites

Chlamydia

Impact on Women and Newborns

- 40% of women with untreated CT will develop pelvic inflammatory disease
- CT is the number one cause of female infertility in the US
- Women with untreated CT are up to five times more likely to contract HIV
- Chlamydia is a leading cause of infant pneumonia and conjunctivitis

Current CT Screening in NC

- The State Lab performs 115,000 female CT screening tests/year submitted from local health department STD clinics
  - Under 25 years old and/or
  - Pregnant, high risk history, IUD, sex partner referral, 3-month retest in previously positives (infertility prevention)
- Funding; 62% receipts; 38% federal grants
- Limited funding for male CT screening
  - Approximately $60,000 (all federal funds)
- The State Lab has capacity (personnel and equipment) to add 30,000 additional male tests per year (urine-based test)

Male CT Screening

- CDC recommends screening the following groups of men for CT
  - Men attending STD clinics
  - Men in Job Corps
  - Men under 30 entering jails
- Males are not routinely screened for CT in NC local health department STD clinics due to a lack of funding
- Special projects have identified male CT rates of 14% in Davidson County STD clinic, 14% in selected college campuses and 11% in juvenile detention facilities

Male CT Screening

- We propose to screen men under age 30 who visit NC LHD STD clinics (CDC screening criterion)
- Need: 30,000 additional test per year
  - $395,000 to purchase the test kits needed to test these men
  - Less $46,000 in receipts (mainly juvenile males on Medicaid)
  - Total need = $349,182
- Added benefit: test kit also screens for gonorrhea

Attachment 6

Women's and Children's Health Initiatives

Kevin Ryan, MD, MPH

- *"Working for a healthier and safer North Carolina"*

WCH Initiatives

1. Promote School Health
2. Improve Birth Outcomes
3. Influenza Immunization
4. Support Early Intervention

"Working for a healthier and safer North Carolina"

WCH Initiative

1. Promote School Health
   - Good health a key to academic success
   - Improve the school nurse:student ratio to 1:750
   - Pursue coordinated school health approach

"Working for a healthier and safer North Carolina"

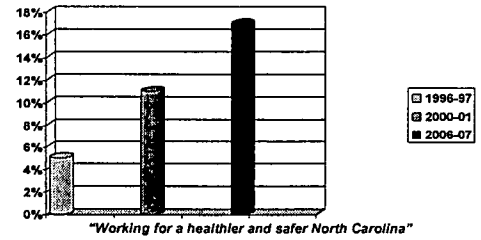
WCH Initiative – Needs Identified

1. **Promote School Health**
   - Unhealthy habits that lead to chronic diseases often established in childhood
   - Coordinated SH programs prepare students for lifetime of healthy choices
   - Rigorous studies show that SH programs can reduce risky behaviors in school kids (CDC)

"Working for a healthier and safer North Carolina"

WCH Initiative – Needs Identified

Percent of Students with Chronic Health Conditions Across The Decade



"Working for a healthier and safer North Carolina"

WCH Initiative – Needs Identified

Recommendation

- Fund 83 new school nurses ($5,000,000,R)

"Working for a healthier and safer North Carolina"

WCH Initiative – Needs Identified

2. Improve Birth Outcomes

- IMR 8.5 per 1,000 live births
- 2.3x greater risk for minority babies
- No single silver bullet available

"Working for a healthier and safer North Carolina"

WCH Initiative

Recommendations

- Support 17P to prevent preterm birth ($97,000,R)
- Reduce SIDS, promote Safe Sleep ($150,000,R)

"Working for a healthier and safer North Carolina"

WCH Initiative – Needs Identified

3. Influenza Immunization

"Vaccinations are one of the top 10 greatest public health achievements of the 20th century." - CDC

- Immunizations are among the most cost-effective activities engaged in by government.
- Savings up to $15 for each $1 spent (CDC)
- Universal provision of vaccine is a cost-saving investment

"Working for a healthier and safer North Carolina"

WCH Initiative – Needs Identified

Big Effects: Pre-1990 Vaccines

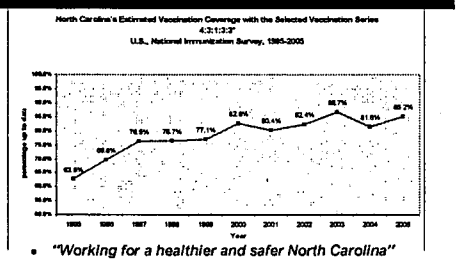
Disease	20th Century Estimated Annual Morbidity †	2004 Reported Cases ††
Smallpox	29,005	0
Diphtheria	21,053	0
Measles	4,000,000	37
Mumps	162,344	258
Pertussis	200,752	25,827
Polio (paralytic)	16,316	0
Rubella	47,745	10
Congenital Rubella Syndrome	152	0
Tetanus	580	34

† Unpublished CDC data, reported December 2005

††CDC. *MMWR* August 12, 2005. 54(31); 770 and CDC. *MMWR* December 2, 2005. 54(47);1214

WCH Initiative – Needs Identified

North Carolina's Proud Record on Immunizations



- *"Working for a healthier and safer North Carolina"*

WCH Initiative – Needs Identified

3. Influenza Immunization

- Each year 5-20% are infected with the flu
- 200,000 hospitalizations
- 36,000 deaths

"Working for a healthier and safer North Carolina"

WCH Initiative – Needs Identified

Recommendation

- 2009-10 Provide flu vaccine universally to 5 and 6 year olds ($709,296)
- 2010-11 Provide flu vaccine universally to 5, 6, 7 and 8 year olds ($1,418,592,R)

"Working for a healthier and safer North Carolina"

WCH Initiative – Needs Identified

4. Support Early Intervention

- Services to infants/toddlers with developmental delays
- Serving more than ever before
  - 2003-04: 5,000 referrals
  - 2007-08: 19,690 referrals
- Marked reduction in Medicaid TCM rates

"Working for a healthier and safer North Carolina"

WCH Initiative

Recommendation

- Replace lost receipts
  - 2009-10: $6.88M, NR
  - 2010-11: $1.82M, R

"Working for a healthier and safer North Carolina"

Making North Carolina the Healthiest State in the Nation: The Charge to a Newly Created Department of Public Health

North Carolina's health status indicators stack up poorly in comparison to other states. Just a few examples: North Carolina ranks

40th in years of life lost per 100,000,
44th in infant mortality deaths
45th worst in childhood obesity and in infant mortality,
36th overall in 20 health rankings.

In almost any other indicator, North Carolina ranks in the lowest third to quartile in the nation.

The changing demographics of North Carolina also present new challenges as the fastest growing segment is the older population. Health care costs double in people over the age of 65 and double again for those over 85. The nation spends $2.2 trillion dollars nationally on health care and this figure will double by 2016. The percentage of the gross national product that is spent on health care is 16%--that figure will rise to 20% by 2016. In North Carolina, the percentage of the economy devoted to healthcare is 18%.

Much of this cost is driven by chronic disease which contributes to 2/3 of all health care expenditures and 60% of all deaths. **Many times these diseases are preventable.** Furthermore of these preventable deaths, ¾ can be attributed to tobacco, physical inactivity and nutrition—the other major contributor is alcohol use. And, it is important to note that 9 out of 10 adults have at least one of these risk factors.

Chronic disease is not just an issue for adults—indeed it is a LIFESPAN issue. The risk factors for these chronic diseases actually begin in children—by age 10, 20% of children already have at least one risk factor.

Chronic disease is also a LIFECYCLE issue as we have growing concern that chronic disease and related risk factors in women of childbearing age are contributing to the **stagnated infant mortality rates in our state.**

Julie Gerberding, the director of the CDC has said that "domestic extremes such as aging, poor nutrition and lack of fitness create URGENT realities—chronic diseases, injuries, disabilities and infections. Time matters. Lives are at stake. Fast enough action is essential."

A sense of urgency about the importance of investing in prevention and health protection is critically important. Prevention saves lives just like medical treatment saves lives. It may not be as dramatic or immediate, but make no mistake, **PREVENTION SAVES LIVES.**

We are never going to be able to serve or treat-- person by person--- our way out of poor health status and high costs. We have to focus on health as well as health care. We have to move beyond the common dialogue of "find it and fix it" or "triage and treat it" to PREVENT, PROMOTE and PROTECT health. **A mix of prevention strategies is essential.** It is critical to help create in North Carolina a strategic set of sound health policies, community engagements and healthier, better built environments to effect change.

To truly accomplish the goal of making North Carolina the healthiest state in the nation, the state must make the following commitments.

First, it is time to rebalance the prevention scorecard. There are enormous opportunities to implement evidence based prevention strategies that will lead to better health in our state. We do not take full advantage of them. While, there are imbalances in policy, in personal behaviors and in community strategies, the most illuminating example of the imbalance is financial. **We spend 95 cents of the health care dollar on illness and 5 cents on prevention. That's 95 cents on health care which, on a population basis, contributes to only 10 percent of health status.**

We absolutely need to successfully provide health care for everyone and take that issue off the table. We have to also get serious about investing in prevention strategies that really lead to improved health for North Carolina.

There are some terrific examples in North Carolina of how prevention pays—when Charlotte fluoridated its water supply in 1949 it became the largest city in the world to fluoridate—community water fluoridation reduces tooth decay by 50% and the return on investment is $28 dollars for every $1 dollar. We still have 42% of our kindergarteners entering school with tooth decay so investment in other prevention strategies such as sealants and varnishes is critically important.

Another example of prevention, **the 75% reduction in neural tube defects in western North Carolina** over a 5 year period is attributed in large part to a folic acid campaign targeting preconceptional and pregnant women.

Raising the cigarette tax to 30 cents resulted in a drop in cigarette consumption of 18% in the first year alone--our tax at 35 cents is still well below the national average of $1.14 cents—

clearly there is dramatic room for improvement in this particular strategy.

"Click it or ticket", developed in North Carolina in 1993, has been a hugely successful prevention program implemented by the Highway Patrol---we have gone from 58.1 percent seatbelt usage in 1993 to 86.7 percent—if we could get to 90 percent, an additional 37 fatalities and 600 serious injuries would be prevented.

The "Get Alarmed" effort to place working smoke alarms in homes (undertaken by a fire department and public health partnership) **saved an estimated 90 lives over 7 years.**

Childhood vaccines that prevent 16 different diseases are incredibly cost effective—the return is $27 for every $1 invested. The Hepatitis vaccine is a great example of impact. Ten years after implementing the 6th grade vaccine program in 1995, the new cases of Hept B dropped from 8.3 to 1.92 per 100,000 populations-- a 77% decline. And consider that the full benefit (in cost and health) of lower Hepatitis B rates will not be fully evident until these individuals age and are able to avoid liver infections, cancers and other complications that would have resulted from earlier infections with Hep B.

Secondly, we must fully institutionalize health in all policies. The underlying determinates of health are founded in broader issues such as poverty, lack of education and how we build communities. A broader focus on these issues and their role in health status will eliminate the disparities for those who have the greatest burden of death and disease.

To illustrate, a newly released study showed that while life expectancy for the nation as a whole has increased, the gap between affluent Americans and others has widened. This

socioeconomic inequity is evident in life expectancy at birth as well as throughout every stage of life. In 1980, those in the most affluent group lived an average of 2.8 years longer than people in the most economically deprived group. By 2000 the affluent group was living 4.5 years longer. The researchers suggested the following reasons for this health inequity:

People with more money are able to take greater advantage of new medical advances in cancer and heart disease.

Smoking has declined more in people with greater education and income.

Poorer people are less likely to have insurance and therefore access needed health care later when the consequences to their health are worse.

The neighborhoods of lower income people are often less safe and may have greater exposure to environmental risks.

Lower income people are less likely to engage in healthy behaviors.

In North Carolina, in every health status indicator from infant mortality, communicable diseases to heart disease, these health disparities are very real.

Thirdly, a leadership call from all sectors of society is essential to improve health outcomes for all people. For example, it is absolutely essential that **business leaders** are focused on prevention. The average cost of each employee to business is $18,000 per year in medical and lost productivity. A severely obese worker files 2 times as many workers comp claims, costs 7 times as much in medical costs and misses 13 times more work

days. Two thirds of health care costs to a company are in lost productivity so it is important to keep workers well and on the job.

The same is true **for academic leaders.** If students aren't healthy enough to be at school and to pay attention, they are less likely to be successful in school. They are then less likely to graduate and go on as successful adults contributing to the economy, participating in the employer supplied health insurance and having the financial wherewithal to engage in healthy lifestyle choices for themselves and their families. It has been said that the most important thing a person can do for their health is "don't get born into a poor family"!

Nonprofit, community leaders play a vital role in being nimble and less fettered by the trappings of beauocracies. They can fill niche roles and can be strong advocates on controversial but important health issues.

Leaders in health care and insurance all have special obligations to collaborate with us to ensure that we are most effectively addressing together, not just clinical services, but personal behavior change, health policy and community environmental changes. We have some exciting collaborations in our state underway and we need to do more together.

It is critically important to educate and then support elected and appointed officials at all levels of government specially since they must address multiple stakeholder issues that don't always support their own personal commitment to improved health. Their role in advancing health for all is absolutely essential to moving North Carolina to the being the healthiest state in the nation.

Lastly, improving the health of North Carolinians requires a clear and strong commitment to improved accountability from

every level of government. State leadership can provide the way. Every North Carolinian deserves to know what we, in government are doing to keep them healthy and safe.

The North Carolina Institute of Medicine is hosting a Task Force on Prevention that is funded through a unique collaboration between the Duke Endowment, Kate B. Reynolds Trust, BCBS Foundation and the Health and Wellness Trust Fund. The Task Force is charged with developing a Prevention Plan for North Carolina. Government accountability for implementing this exciting plan is going to be critical for success.

Other states are moving to set a strong prevention oriented agenda as well. As an example, here is one state's 10 point prevention agenda:

Have a regular doctor— a medical home
Be tobacco free
Keep your heart healthy
Know your HIV status
Get help with depression
Live free of alcohol and drugs
Get checked for cancer
Get the immunizations you need
Have a safe and healthy home
Have a healthy baby

In summary, a newly created Department of Public Health could lead the way in North Carolina to make our state the healthiest in the nation by fulfilling these four commitments to:

1. Rebalance the prevention scorecard
2. Assure health in all policies
3. Engage all community leaders
4. Assume responsibility for transparent accountability

FUNCTIONS THAT COULD BE CONSOLIDATED INTO A NEW DEPARTMENT OF PUBLIC HEALTH:

Division of Public Health (DHHS)
Office of Rural Health (DHHS)
Substance Abuse (DHHS)
Emergency Medical Services (DHHS)
Division of Environmental Health (DENR)

Benefits:

Increases accountability by clearly charging one lead agency with health improvement responsibilities

Positions North Carolina for an increased focus on prevention which will improve health as the population ages and becomes more diverse

Enhances efforts to reduce health care costs

Ensures health protection as a growing population creates new environmental challenges and lives in closer proximity to potential environmental hazards

Integrates state government's role in food protection

Strengthens state government's role in preparedness to all hazards

Simplifies the working relationships with local government

Rebalances the work of state government into a more manageable structure in order to accomplish goals efficiently and effectively

Challenges:

Requires a reconfiguration of state government

Assure that the new department has the resources from respective agencies to adequately support its business operations

Requires legislative action

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2009

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BILL DRAFT 2009-RDz-2 [v.1] (12/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/1/2008 2:12:57 PM

Short Title: Fund High Priority Public Health Initiatives. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO IMPLEMENT HIGH PRIORITY PUBLIC HEALTH INITIATIVES, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of thirty-five million five hundred seventeen thousand five dollars ($35,517,05) for the 2009-2010 fiscal year, and thirty-one million one hundred forty-five thousand nine hundred seventy-two dollars ($31,145,972) for the 2010-2011 fiscal year. Funds appropriated by this act shall be used to supplement and not supplant existing State, federal, county, or other funds allocated for the identified purpose. These funds shall be used to implement high priority initiatives of the Public Health Study Commission, and shall be allocated by the Department of Health and Human Services, Division of Public Health, in the following amounts for the purposes indicated:

(1) $18,200,000 in the 2009-2010 fiscal year and $18,200,000 in the 2010-2011 fiscal year for noncategorical General Aid to County funds to build capacity for the 10 essential public health services in local health departments statewide.

(2) $3,829,454 in the 2009-2010 fiscal year and $3,829,454 in the 2010-2011 fiscal year for Childhood Obesity Prevention to continue funding interventions in preschools, schools, communities, faith organizations, and healthcare settings that promote and support physical activity and healthy eating; and continue funding worksite chronic disease/obesity prevention programs for State employees.

(3) $209,138 in the 2009-2010 fiscal year and $199,304 in the 2010-2011 fiscal year for counselors for HIV-positive inmates released from State prisons to ensure that they are referred to HIV provider agencies for case management.

(4) $5,000,000 in the 2009-2010 fiscal year and $5,000,000 in the 2010-2011 fiscal year to hire 83 additional school nurses to work toward the goal of achieving a Statewide school nurse to student ratio of 1:750.

(5) $247,000 in the 2009-2010 fiscal year and $247,000 in the 2010-2011 fiscal year to improve birth outcomes by expanding utilization of 17-Alpha Hydroxy Progesterone Caproate for low income women to reduce recurrent pre-term births; and by expanding and strengthening current statewide initiatives addressing SIDS risk reduction, Safe Sleep, and secondhand smoke exposure for women of reproductive age and their families.

(6) $709,296 in the 2009-2010 fiscal year and $1,418,592 in the 2010-2011 fiscal year to maintain compliance with the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices in providing protection for children against influenza as part of the State's universal immunization program.

(7) $86,756 in the 2009-2010 fiscal year and $86,756 in the 2010-2011 fiscal year to continue screening, public awareness, and other preventive efforts of the Diabetes and Kidney Programs.

(8) $6,883,179 in the 2009-2010 fiscal year and $1,815,684 in the 2010-2011 fiscal year to hold the Early Intervention Program harmless for the loss of revenues associated with the rate reduction of Targeted Case Management services.

(9) $352,182 in the 2009-2010 fiscal year and $349,182 in the 2010-2011 fiscal year for gonorrhea/chlamydia testing among men in local health department Sexually Transmitted Disease clinics.

SECTION 2. This act becomes effective July 1, 2009.