

NORTH CAROLINA

**PUBLIC HEALTH
IMPROVEMENT
PLAN**

**Final Report
January 15, 2005**



North Carolina Public Health

*Promoting and
Protecting
the Health of
North Carolinians.*



North Carolina Public Health

*Strengthening public health infrastructure is important.
Either we are all protected or we are all at risk.
The Public Health Foundation*

**The North Carolina
Public Health Task Force 2004
PUBLIC HEALTH IMPROVEMENT PLAN
FINAL REPORT**

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Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

January 1, 2005

It is with great pleasure and pride that I commend to you this Public Health Task Force 2004 Final Report. The recommendations in this report provide strategic guidance for our continuing efforts to improve the health of North Carolinians everywhere.

I was inspired to create the Public Health Task Force 2004 by the work of three individuals whose collaborative effort resulted in the drafting and introduction of public health improvement legislation in the 2003 session of the North Carolina General Assembly. Senator Fletcher Hartsell, Ms. Linda Attarian and Mr. John Shaw participated in the Public Health Leadership Institute at the UNC School of Public Health in Chapel Hill. While the legislation they created together, Senate Bill 672, was not enacted into law during this session, their forward thinking laid the foundation for the work of the Public Health Task Force 2004.

I charged the Task Force with developing recommendations on how to strengthen North Carolina's public health system, improve health status for North Carolinians and eliminate health disparities. The Task Force convened five public meetings, held three regional public forums, heard testimony, and reviewed research and lessons from the field during the course of their work. Each of the six committees – Accreditation, Accountability, Workforce Development, Structure & Organization, Planning & Outcomes and Finance – has developed targeted recommendations that address critical needs. I encourage readers of this report to give thoughtful consideration to this work as it will inform future efforts in this area.

In spite of some new resources for our public health infrastructure that have become available as a result of terrorist attacks on our country, and significant support from the North Carolina General Assembly during the 2004 Short Session, North Carolina's public health infrastructure remains critically underdeveloped in a number of important areas. This report is especially important since it will help us make difficult decisions regarding the allocation of scarce resources. We are at the beginning of this process, but I am confident that the proper foundation has been created with this report. I congratulate the members of the Task Force for their hard work and commitment to improve the public's health in North Carolina.

Sincerely,

A handwritten signature in cursive script that reads "Carmen Hooker Odom".

Carmen Hooker Odom, Secretary
North Carolina Department of Health and Human Services



**North Carolina Department of Health and Human Services
Division of Public Health • Office of the State Health Director
1915 Mail Service Center • Raleigh, North Carolina 27699-1915**

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Leah Devlin, DDS, MPH
State Health Director

January 1, 2005

As North Carolina's State Health Director, I want to acknowledge the significant level of work and planning that has gone into the development of this Public Health Task Force 2004 Final Report. Under the leadership of the Secretary of the Department of Health and Human Services, Carmen Hooker Odom, and with the commitment of the members of the Task Force, we now have a comprehensive public health improvement plan to guide our efforts in strengthening North Carolina's public health system, improving health status and eliminating health disparities.

The recommendations in this Final Report are the result of extensive deliberation, research, discussion and debate. Each of the six working committees was faced with developing consensus around critically important issues facing public health in North Carolina. Their process was deliberative, open and informed by current research, best practice and practical experience both at the state and local level. I commend their work to you.

During 2004, significant progress was made on a number of recommendations from the Task Force Interim Report (issued in May 2004). Much credit should be given to the North Carolina General Assembly for their generous support in the areas of Accreditation, Incubator Development, School Health Nursing and HIV/AIDS Drug Assistance.

The issuance of this report represents an important milestone in our efforts to improve North Carolina's public health system. These recommendations are a foundation upon which we can continue to develop creative and effective new strategies for supporting public health work in our state. I hope you will continue to be involved in this process as we move forward.

Finally, I want to extend a special thank you to the Task Force staff from the Division of Public Health and the North Carolina Institute for Public Health at the University of North Carolina at Chapel Hill. Without their support, this work would not have been possible.

Sincerely,

Leah M. Devlin, DDS, MPH
North Carolina State Health Director



EveryWhere. EveryDay. EveryBody.

Location: 1330 St. Mary's Street • Raleigh, N.C. 27605



Introduction

North Carolina's public health system must respond to new and serious public health emergencies, significant changes in population, unacceptable health disparities, decreasing funding and significant variations in public health protection between counties and regions. A reinvestment in the state's public health infrastructure is critical to providing the essential public health services that will assure public health protection for all North Carolinians.

Recent terrorist events, along with outbreaks of new and often fatal infectious diseases, are a wakeup call to North Carolina. The public health system must be strengthened in order to promote and protect the public's health. New federal resources for bioterrorism preparedness have created some additional capacity to detect and respond to certain public health emergencies. The state must support these national preparedness efforts by reinvesting in core infrastructure that will enable the system to respond to all public health emergencies and threats to the health and prosperity of all North Carolinians.

A reinvestment of resources in the state and local public health system by the North Carolina General Assembly will coincide with an increase in public health accountability. This will be achieved through an improved system for identifying the public health needs in each community, prioritizing problems and solutions, and funding public health programs and services on the basis of performance and achievement of desired outcomes. These new systems of accountability, accreditation, and data collection will provide the tools necessary to measure success and allow the state to invest with confidence.

The recommendations of this report are divided into two parts:

1. Core Infrastructure
2. Core Service Gaps

The Mission of North Carolina Public Health

*To promote and contribute
to the highest possible level of health
for the people of North Carolina.*

Mission Statement

3 Public Health Core Functions and 10 Essential Services

I. Assessment

1. Monitor health status to identify and solve community health problems (e.g., community health profiles, vital statistics and health status).
2. Diagnose and investigate health problems and health hazards in the community (e.g., epidemiologic surveillance systems, laboratory support).

II. Policy Development

3. Inform, educate, and empower people about health issues (e.g., health promotion and social marketing).
4. Mobilize community partnerships and action to identify and solve health problems (e.g., convening and facilitating community groups to promote health).
5. Develop policies and plans that support individual and community health efforts (e.g., leadership development and health system planning).

III. Assurance

6. Enforce laws and regulations that protect health and ensure safety (e.g., environmental health rules).
7. Link people to needed personal health services and ensure the provision of health care when otherwise unavailable (e.g., services that increase access to health care).
8. Assure competent public and personal health care workforce (e.g., education and training for health care providers).
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services (e.g., continuous evaluation of public health programs).
10. Research for new insights and innovative solutions to health problems (e.g., links with academic institutions and capacity for epidemiologic and economic analyses).

**Executive
Summary**

**Part 1
Core
Infrastructure**

Accreditation Committee

- 1. Establish a mandatory system of accreditation for local/district health departments.** \$989,000
- 2. Fund local health departments on an ongoing basis for accreditation and related continuous quality improvement activities.** \$4,400,000 annually beginning in year four (4) of program

Accountability Committee

- 3. Establish an Office of Accountability in the Division of Public Health** \$300,000
- 4. Fund local health departments to improve their delivery of the Ten Essential Public Health Services that form the foundation of the Accountability System.** \$15,000,000

Workforce Development Committee

- 5. Assess the needs of the public health workforce by:**
 - Conducting a short-term workforce assessment study; and \$150,000
 - Identifying and disseminating core public health competencies. \$10,000
- 6. Assure an adequately trained public health workforce by:**
 - Developing and implementing an outreach and recruitment plan to ensure an adequate, capable, culturally competent and diverse public health workforce. \$10,000
 - Fully funding necessary maintenance and operational needs of the Public Health Training & Information Network (PHTIN): \$600,000
 - Creating public health internships at the state and local level: \$150,000
 - Creating public health scholarships; and \$200,000
 - Requiring training for Board of Health members. \$100,000

Structure & Organization Committee

Guiding Principle

Collaboration, partnership and voluntary organizational change rather than mandated consolidation of local health departments are inherent in all task force recommendations.

- 7. Create and fund four (4) public health "incubators" to support voluntary and locally driven regional collaboration and economies of scale.** \$2,000,000 one-time funding for local grants.

8. **Reunite the Division of Environmental Health with the Division of Public Health under the leadership of the State Health Director.**
9. **The position of State Health Director shall report directly to the Secretary.**
10. **Promote collaboration of local health departments and any related voluntary structural changes at the local and state level through the accreditation process.**
11. **Perform and distribute a Self-Assessment of the Division of Public Health using National Performance Standards.**

Planning & Outcomes Committee

12. **Improve the data and epidemiology for state and local decision making and allocation of resources.**
 - Establish a common set of core health indicators.
 - Build capacity to conduct the Behavioral Risk Factor Surveillance Survey (BRFSS) to provide county-specific or multi-county data. \$300,000
 - Establish the Child Health Assessment Monitoring Program (CHAMP) to collect and report county-specific or multi-county lifestyle and physical health information such as overweight/obesity and asthma, for children. \$250,000
 - Enhance the opportunities to collect and report county-specific or multi-county behavioral and physical health information on children. Specific examples include greater local school system participation in the Youth Risk Behavior Survey and physical health indicator data surrounding the childhood obesity problem in North Carolina.
 - Identify and analyze existing state and local public health problems, health disparities, and potential threats. \$100,000
 - Identify the best scientific and evidence-based strategies to address identified public health problems at the local level. \$200,000
 - Provide epidemiology training for local partners. \$200,000
13. **Fund local health departments to assess and document community health needs through community partnerships.**
 - Establish a uniform statewide process for community health assessment to be conducted on a four-year cycle (Comprehensive Community Health Assessment) and updated annually (State of the County Report). \$ 1,623,000
 - Require the State Center for Health Statistics (SCHS) to provide county specific health data to local health agencies for the purpose of local planning and priority setting. SCHS will also create a core set of questions to be used for primary data collection statewide. Local partnerships (Healthy Carolinians, Community-based Organizations, and other health agencies) may develop additional questions according to their needs.

**Executive
Summary**

**Part 1
Core
Infrastructure**

13. continued

- Build the capacity of the state Office of Healthy Carolinians/Health Education (OHC/HE) to support local community assessment through local training, technical assistance, and report generation. OHC/HE will compile and report information on local needs, community priorities and action plans to state level programs. \$441,000
- Establish an annual integrated planning cycle to inform state and local decision-makers regarding program priorities and funding allocations. OHC/HE will facilitate the state level planning cycle and develop annual reports.

14. Fund increased information technology capacity at the local level to collect, compile, analyze, and report essential public health data.

- Build local capacity to collect, analyze, and report critical public health information electronically. \$5,160,000
- Assure compliance with HIPAA guidelines.
- Build the local interface with the Public Health Information Network to enhance the ability of local health departments, hospitals, healthcare providers, and community partners to communicate electronically in a secure environment.

Finance Committee

Guiding Principles

- Recommendations of the Public Health Task Force should be fully funded on an ongoing basis.
- Task Force recommendations for the Public Health Improvement Plan should be funded to the fullest extent possible in the short session 2004; however, given the current financial condition of the state, the remaining recommendations should be phased in over the next biennium of the North Carolina General Assembly.

15. Consider the following as possible sources of support for the core infrastructure needs of the public health system:

- a) Empower local health departments (LHDs) statutorily to charge fees commensurate with the local costs of conducting the food and lodging program activity.
- b) Develop a low wealth funding formula to be used to distribute public health program and administrative funds to local health departments.
- c) Seek private funding (philanthropic foundations, trusts and business partners) to enhance public health through creative partnerships.

- d) Secure state appropriations to implement the equipment replacement schedule for the State Laboratory of Public Health.
 - e) Assure that a significant percentage of any new health-related revenues as approved by the General Assembly support public health infrastructure and services in keeping with the Public Health Task Force 2004 Public Health Improvement Plan.
 - f) Assure that a mechanism is developed that allows LHD and Child Development Service Agencies (CDSA) Medicaid Rates to be updated annually to more accurately reflect the cost of providing services in these settings. This would provide an enhanced cash flow of \$12 to \$13 million to the LHDs and CDSAs allowing revenue streams to match expenditures and ensure that full costs are provided (versus only the Federal share) when recouped retroactively in the settlement.
 - g) Dedicate one full-time FTE in the Division of Public Health to the funding issues reflected in the Finance Committee Report: specifically, grants and Medicaid issues and opportunities.
- 16. The state should fund the local Medicaid share and direct that a significant percentage of freed up local revenue be appropriated for local public health core infrastructure and service needs. The transition could begin with the state picking up any county increase, and then phase down county share percentage on an annual basis until the state assumes the local amount.**
- 17. Secure dedicated, reoccurring funding for replacement of hardware and software as well as ongoing maintenance of a new Health Information System (HIS).**

**Executive
Summary**

**Part 1
Core
Infrastructure**

**Executive
Summary**

**Part 2
Core
Service Gaps**

Planning & Outcomes Committee

18. Eliminate funding gaps in critical public health services:

- School Nurse Services \$11,350,000*
- HIV/AIDS Prevention & Control \$3,341,656
- HIV/AIDS Drug Assistance Program (ADAP) \$3,000,000
- Title VI Compliance \$1,156,849
- Chronic Disease Prevention \$7,482,952**
- Injury Prevention \$1,075,000
- Immunizations (Prevnar) \$8,051,664
- Environmental Health \$5,428,111

*Request is for a four year (2005-2008) implementation schedule:

- Year 1: \$ 11,350,000
- Year 2: \$ 25,950,000
- Year 3: \$ 37,300,000
- Year 4: \$ 48,650,000/year ongoing

**Year 1: Request is for a three year (2005-2007) implementation schedule:

- Year 1: \$7,482,952
- Year 2: \$10,873,821
- Year 3: \$27,008,026

Addenda

- Automation Report: Public Health Information Network (PHIN)
- Task Force Membership
- Committee Membership

Part I: Core Infrastructure Recommendations



Part I:
Core Infrastructure
Recommendations

**Committee on
Accreditation**

1. **Establish a mandatory system of accreditation for local/district health departments (provided the funding in second bullet under #2 below is authorized).**
 - Local health departments seeking accreditation shall explore options for meeting the standards including inter-local agreements, partnerships and districting as changes needed to meet the standards, but all such decisions shall be entirely at the discretion of the local agencies involved.
 - Accreditation shall be for a maximum of four years or until the year following their next comprehensive community assessment.
 - An organization outside of the state and local/district health departments shall be selected to serve as Accreditation Administrator (recommended to be the North Carolina Institute for Public Health) to provide staff support to the process and the Accreditation Board.
 - The accreditation process shall consist of three components: a self-study by the local/district health department seeking accreditation; a site visit by a team of experts and peers to clarify, verify and amplify the information in the self-study; and final action on accreditation status by an independent Accreditation Board.
 - Accreditation standards shall address four key areas: agency capacity to carry out core functions and provide essential services*, facilities and administration, staff competencies and training for staff, and governance by the Board of Health or other appropriate oversight body.
 - The Accreditation Board shall be appointed by the Secretary of DHHS (composition to be determined based on results of pilot process now underway).
 - A process for conditional accreditation, with significant progress in meeting conditions and appeal of initial accreditation status, shall be provided for a period up to two years. During the conditional accreditation period every effort will be made to work with the agency to assure that it can meet accreditation standards.
 - Once the two-year conditional accreditation option is exhausted, failure to meet established accreditation standards will result in loss of any further state and federal funds.
 - The Division of Public Health and the North Carolina Association of Local Health Directors shall advocate for and assist in developing a system to accredit State Health Departments with the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the Centers for Disease Control and Prevention (CDC) and other appropriate federal organizations.

2. Fund local health departments on an ongoing basis for accreditation and related continuous quality improvement activities.

- The accreditation system shall be rolled out over a period of four years, beginning in January 2006. Each agency (except pilot counties) will seek initial accreditation in the year following the completion of its comprehensive community assessment. This represents an average of 22 health departments per year.
- Funding sufficient to ensure successful implementation of this accreditation system shall be provided. This provision includes funds for an Accreditation Administrator, support of site visitors and the Accreditation Board, technical assistance and financial support for agencies seeking accreditation and working to achieve conditional status.

* For purposes of Accreditation, core functions and essential services, refer to the following.

Core Functions: Assessment, Policy Development and Assurance Essential Services

- 1) Monitor health status to identify and solve community health problems.
- 2) Diagnose and investigate health problems and health hazards in the community.
- 3) Inform, educate and empower people about health issues.
- 4) Mobilize community partnerships to identify and solve health problems.
- 5) Develop policies and plans that support individual and community health efforts.
- 6) Enforce laws and regulations that protect health and ensure safety.
- 7) Link people to needed personal health services and assure the provision of health care when otherwise unavailable.**
- 8) Assure a competent public health and personal health care workforce.
- 9) Evaluate the effectiveness, accessibility and quality of personal and population-based health services.
- 10) Research for new insights and innovative solutions to health problems.

** It is not the intent of Accreditation to designate a list of essential services that reflects specific programs that must be offered by each local health department. Such decisions are made locally, based on a comprehensive community assessment of health care needs and resources

**Part I:
Core Infrastructure
Recommendations**

**Committee on
Accreditation**

**Part I:
Core Infrastructure
Recommendations**

***Committee on
Accountability***

Need Addressed/Rationale

Accreditation:

- Demonstrates core capacity to respond to public health challenges in their communities;
- Assures all citizens of North Carolina access to a standard of quality in core functions and essential services of public health;
- Improves efficiency and effectiveness of public health services as well as health outcomes across the state;
- Increases accountability for newly emerging diseases; and
- Recognizes that access to an agreed upon minimum standard of quality in delivery of core functions is essential to public health services.

Infrastructure/Capacity Improvement

The accreditation schedule in each county is linked to the timing of comprehensive community health assessment. The pilot system model is based on nationally recognized accreditation standards. There is time provided in the initial round of accreditation for agencies to utilize corrective action plans. All local public health agencies must be accredited by a deadline in order to continue to receive state and federal funds.

Progress Update

- Six local health departments have been accredited through the first pilot: Appalachian District, Buncombe, Cabarrus, Chatham, Dare, and New Hanover.
- The six health directors from these accredited agencies collaborated on development of a video on the benefits of accreditation to the agency.
- There was legislation in the 2004 Short Session to: 1) provide \$50,000 in additional funding to the six accredited agencies for a variety of uses related to accreditation, including mentoring other agencies during the process; and 2) provide \$50,000 in funding to the North Carolina Institute for Public Health to support a Pilot Accreditation Advisory Board to oversee an extension of the pilot to additional agencies and determine the cost of meeting accreditation standards.
- Four additional agencies have been selected in collaboration with the NC Association of County Commissioners for the FY05 pilot process: Cherokee, Craven, Harnett, and Pamlico.
- The first meeting of the Pilot Accreditation Advisory Board was held on September 28, 2004.
- 32 Boards of Health, two Public Health Authorities, and eight Boards of County Commissioners have adopted resolutions in support of accreditation for local health departments as of October 12, 2004.

**Part I:
Core Infrastructure
Recommendations**

Budget	FTEs
<ul style="list-style-type: none"> • \$ 389,000/yr. ongoing for staff to provide technical assistance to local public health agencies during accreditation and periods of conditional accreditation; and • \$ 600,000 ongoing to support the Accreditation Board staff and operating expenses (e.g., site visits) • Local Funding* <ul style="list-style-type: none"> • \$1,500,000 – Year 1 (FY '06) • \$3,000,000 – Year 2 (FY '07) • \$4,500,000 – Year 3 (FY '08) • \$6,000,000 – Year 4 (FY '09 and all subsequent years) 	(11) State (0) Local

* Funding for local health departments/districts. Provides \$50,000 in support to each agency (average of 22/year) beginning in FY '06. In addition, \$400,000 is included each year to cover the additional counties that are part of districts (e.g. a two county district would get an additional \$30,000 for the second county, a three county district would get \$20,000 for the second and third counties, and other districts with more than three counties would get \$10,000 for each of the additional counties) and for agencies demonstrating a significant need in order to meet accreditation standards. This would be recurring money for each health department to support initial accreditation and continuous quality improvement during the remaining three years of the accreditation/community assessment cycle.

***Committee on
Accountability***

Part I:
Core Infrastructure
Recommendations

***Committee on
Accountability***

3. Establish an Office of Accountability in the Division of Public Health that will implement a formal reporting and accountability process for the state and local public health agencies.

- Create a Community Wellness Index that will assess state and county-specific health status—a state and county health report card.
- Create a set of Best Practice Indicators that will provide county-specific data about the effectiveness of efforts to promote population health.
- Compile a set of the State Public Health Performance Measures that funders and other stakeholders use to hold DPH accountable.
- Implement an accountability process that will use accountability data to support and evaluate the effectiveness of state/local efforts to improve the health of the residents of NC.
- Work with the Division of Environmental Health to identify and incorporate appropriate measures of environmental health into the accountability system proposed by the Accountability Committee.

The public health accountability process will place no new unfunded burden on local health departments unless there is an agreement between the Division of Public Health and the North Carolina Association of Local Health Directors.

Need Addressed/Rationale

North Carolina’s public health system is complex, with organizational units at the state, regional and local levels. Ensuring accountability in the areas of performance and fiscal management requires capacity not only at the program and local agency level, but also at the state, where ultimate responsibility for system accountability resides. There is currently no formal organizational structure to manage a public health accountability plan or comprehensive quality improvement process. There is a clear need to centralize accountability functions within the Division of Public Health.

Infrastructure/Capacity Improvement

Resources requested for this recommendation would support an organizational home for public health accountability in the Division of Public Health in Raleigh. Professional staff employed in this office will be responsible for managing the state’s accountability plan, monitoring quality improvement processes both locally and at the state level, analyzing accountability data and disseminating reports. The public health accountability system recommended by the Accountability Committee aims to hold state and local public health agencies accountable for the funding they have been given at the state and federal level and the responsibilities with which they have been charged by state and federal lawmakers.

**Part I:
Core Infrastructure
Recommendations**

For many health outcomes, the determinants of health status are deeply embedded in social factors that the public health agency cannot adequately address. In other instances, the resources available to a local public health entity to address an important health outcome may be relatively trivial. Recognizing these limitations with respect to measures of local accountability, a public health accountability system should include only those measures which agencies either control or can exert significant influence over.

The committee has proposed the creation of a Community Wellness Index (CWI) which will provide state and county-specific report cards on health status. These will be broad measures such as Maternal and Infant health status, Heart Disease and Stroke morbidity and mortality, and Disparities in Premature Death among different racial and ethnic groups. They will give a good sense of the overall wellness of the residents of each county and the state as a whole. The committee also has worked to identify a set of best practice indicators. These will be less global than the CWI measures and more specifically related to the charge of local health departments. Examples may include: percent of children receiving appropriate immunizations by 24 months of age; percent of women receiving adequate prenatal care; percent of restaurants appropriately inspected, etc. The committee also proposed a system for state public health accountability based on the key measures current stakeholders use to hold DPH accountable. Examples include: percent of infants receiving mandated newborn metabolic screenings; percent of very low birthweight infants born at tertiary care centers, birth rate for teens ages 15-17, etc.

***Committee on
Accountability***

Progress Update

Interviews have been completed for Head of the Office of Accountability and negotiations are underway to fill the position. Additional funding is needed to support the two remaining positions (statistician and management support) as well as to support the operating costs of the office and such activities as the compilation, printing and distribution of accountability reports.

<p>Budget \$243,000 for Accountability office staff, operating costs, reporting and dissemination</p>	<p>FTEs (3) State (0) Local</p>
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**Part I:
Core Infrastructure
Recommendations**

***Committee on
Accountability***

4. Fund local health departments to improve their delivery of the ten essential public health services that form the foundation of the accountability system.

Need Addressed/Rationale

The accountability system will help local public health agencies identify the health needs of their communities. Current, resources are not enough to adequately protect the public’s health. Funding, particularly non-categorical funding, is needed at the local level to improve LHD delivery of the ten essential public health services. In providing these services, LHDs will focus on the core goals of the Task Force: improving locally identified health outcomes and eliminating health disparities.

Infrastructure/Capacity Improvement

Each health department will use these resources to address different aspects of the ten essential services as determined by local priorities and needs. The Task Force goals of improving outcomes and eliminating disparities will be critical factors in allocating these resources.

The Ten Essential Public Health Services

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Enforce laws and regulations that protect health and ensure safety.
4. Inform, educate and empower people about health issues.
5. Mobilize community partnerships to identify and solve health problems
6. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
7. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
8. Assure a competent public health and personal health care workforce.
9. Develop policies and plans that support individual and community health efforts.
10. Research for new insights and innovative solutions to health problems.

<p>Budget \$15,000,000 to local health departments to provide elements of the ten essential public health services most needed in their communities.</p>	<p>FTEs (0) State Local staffing FTEs will vary, based on local need.</p>
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5. Assess the needs of the public health workforce by:

- **Conducting a short-term workforce assessment study; and**
- **Identifying and disseminating core public health competencies.**

Need Addressed/Rationale

The information collected in the learning management system and in the state center’s facility survey should be analyzed for data gaps about the public health workforce. Additional questions/data fields should be added to these existing data collection processes to ensure that needed data on the public health workforce is available. Funding is requested to integrate the two surveys and add missing data fields.

Recent studies have shown that the current public health workforce is unevenly prepared to meet today’s challenges. An estimated 80% of the workforce lacks formal training in public health (CDC-ATSDR, 2001). Changes in technology, biomedical science, informatics, and community expectations will continue to redefine the practice of public health, requiring that current public health practitioners receive training and support to update their skills (Pew Health Professions Commission, 1998).

Progress Update

The Public Health Workforce Development system is an on-line learning management system that gives public health workers a self-assessment tool to identify training needs.. This system is housed at the UNC-School of Public Health, Instructional and Informational Systems unit, North Carolina Institute for Public Health (NCIPH). The system was funded by federal bioterrorism monies. The initial report describes the state of local public health workers in North Carolina. Seventy eight percent of the public health workforce has participated in the assessment. By partnering with the NCIPH and the Office of Public Health Preparedness and Response, the task force has a wealth of new information but additional data is needed. Data needs include: (1) retention, (2) productivity, standards, (3) programmatic training requirements, (4) resources and (5) other items. Funding is needed to complete the task and to incorporate the facilities survey into the findings.

*Committee on
Workforce
Development*

<p>Budget \$ 160,000 to conduct workforce assessment study, develop and disseminate core competencies.</p>	<p>FTEs (0) State (0) Local</p>
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**Part I:
Core Infrastructure
Recommendations**

**Committee on
Workforce
Development**

6. Assure an adequately trained public health workforce by:

- Developing and implementing an outreach and recruitment plan to ensure an adequate, capable, culturally competent and diverse public health workforce*;
- Fully funding necessary maintenance and operational needs of the Public Health Training & Information Network (PHTIN);
- Creating public health internships at the state and local level**;
- Creating public health scholarships***; and
- Requiring training for Board of Health members.

Need Addressed/Rationale

The public health workforce is aging, and many are approaching retirement. The average age of the workforce is 45± years of age. Recruitment is more difficult in public health because of a lack of clarity about what public health does. Turnover in the public health workplace also is a major issue that complicates workforce preparedness planning.

Currently there are 188 public health job titles in the state public health personnel system (DHHS) and 173 in local public health personnel systems. There are also public health classifications within DENR for which numbers are not available at this time. This has created many difficulties in workforce preparation. Often titles differ only in level, not in function, and are simply designed to create a career ladder for public health workers.

As mentioned above, recent studies have shown that the current public health workforce is unevenly prepared to meet the challenges in the practice of public health today.

Infrastructure/Capacity Improvement

This will ensure that all public health practitioners have a basic set of competencies involving general knowledge, skills, and abilities to function as part of their public health organization or system (CDC-ATSDR, 2000; DHHS, 2000; CDC, 2001d).

Progress Update

For the current fiscal year, the contract with UNC for operation of the PHTIN hub has been covered. The “hub” allows a centralized learning facility to communicate, in real time, with satellite learning centers around the state. A source of funding for line charges has not yet been identified. Funding on a recurring basis will be requested in fiscal year 2004-05.

New equipment to enable PHTIN to connect with more sites simultaneously was purchased using federal preparedness funds since much of the recent training and education over PHTIN was on preparedness issues. This reduces recurring annual funding needs by \$463,000.

Budget	FTEs
• \$ 10,000 Recruitment Plan	(0) State
• \$ 463,000 PHTIN	(0) Local
• \$ 150,000 Internships	
• \$ 200,000 Scholarships	
• \$ 100,000 Board of Health Training	

**Part I:
Core Infrastructure
Recommendations**

* NOTE: \$10,000 funding is to develop plan, not directly diversify the workforce.

** NOTE: Funds to be used as a recruitment tool for professionals in other fields, not for students enrolled in a degree program. Three to five people a year would be selected for a limited time exposure to public health professionals in local and/or state agencies. Details for program need to be developed, probably administered by state health division’s office.

*** NOTE: Scholarships do not cover need, but should be considered a starting point. Service to state/local agencies is required in return.

**Committee on
Workforce
Development**

**Part I:
Core Infrastructure
Recommendations**

**Committee on
Structure &
Organization**

Guiding Principle

Collaboration, partnership and voluntary organizational change rather than mandated consolidation of local health departments are inherent in all task force recommendations.

7. Fund and create four public health incubators to support voluntary and locally driven regional collaboration and economies of scale.

Need Addressed/Rationale

The Northeast Regional Partnership was formed in 1999 and is composed of ten local health departments covering an 18 county region. This partnership, which is governed by a board of local health directors and state level representatives, receives administrative support from one department. The Northeast Partnership has secured federal grant funds to support the regional work of an epidemiologist and a health disparities coordinator. This recommendation will seed similar regional collaborations on a one-time basis with ongoing support to come from the participating counties.

Infrastructure/Capacity Improvement

Implementation of this recommendation will result in regional voluntary partnerships to enable local public health agencies to cooperate on service delivery, management, organization, preparedness, and special projects. It is expected that these regional incubators will create a common fund to which the participant health departments will contribute, and they will establish formal fundraising activities to leverage state funds appropriated to the incubators.

Progress Update

In 2004, NC General Assembly gave a one-time appropriation of \$1,125,000.00 to establish public health incubators working through the North Carolina Institute for Public Health. A total of four incubators have been established:

- The Northeastern North Carolina Partnership for Public Health, which includes 19 Northeastern North Carolina counties. This incubator will engage in a number of initiatives to promote economies of scale and the general sharing of resources, with a focus on accreditation. The Partnership includes the following counties: Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Edgecombe, Gates, Halifax, Hertford, Hyde, Martin, Northhampton, Pamlico, Pasquotank, Perquimins, Tyrrell, Warren, and Washington.
- The South Central Incubator, which includes four central counties near the South Carolina border. This Incubator will engage in public health finance collaboration. The counties included are Cabarrus, Rowan, Stanly, and Union counties.

**Part I:
Core Infrastructure
Recommendations**

- The Western North Carolina Incubator which includes the seventeen western-most North Carolina counties. This incubator will focus on a rapid needs assessment developed in collaboration with all member public health agencies, with the regional hospital network, with the area AHEC, and with regional universities. The WNC incubator includes the following counties: Avery, Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Vance counties.
- The Region III Incubator includes ten north central counties. This incubator will establish a regional community assessment and develop capacity to meet accreditation standards. The counties included are Alleghany, Ashe, Davie, Davidson, Forsyth, Stokes, Surry, Watauga, Wilkes and Yadkin.

Budget \$875,000 one-time funding to support four (4) regional incubators.	FTEs (5.5) State (0) Local
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8. Reunite the Division of Environmental Health with the Division of Public Health under the leadership of the State Health Director.

Need Addressed/Rationale

In 1997, state public health functions were divided when much of public health joined DHHS. The environmental health services (onsite water and wastewater, pest management, radiation protection, restaurant inspection, and other services) remained in DENR. Since then, delivery of local public health services has required coordination between two state agencies. North Carolina’s public health policy development and rule making are complicated by this separation of responsibilities, which has local implications. It was the clear consensus of the committee that local service delivery would be greatly enhanced by reuniting the two divisions in one Department under the State Health Director.

Infrastructure/Capacity Improvement

Consolidation of environmental and public health services would greatly improve coordination of service delivery, particularly at the local level.

Progress Update

The State Health Director and the director of the Division of Environmental Health are now meeting monthly. and the secretaries of the two departments are now meeting quarterly to provide better coordination.

Budget No new funding required	FTEs (0) State (0) Local
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**Committee on
Structure &
Organization**

Part I:
Core Infrastructure
Recommendations

Committee on
Structure &
Organization

9. The position of State Health Director shall report directly to the Secretary.

Need Addressed/Rationale

The position of State Health Director has traditionally reported to the Secretary of the Department(s) until recent years. Given the critical impact of many public health issues on potentially all residents of North Carolina, this direct reporting relationship is significant.

Infrastructure/Capacity Improvement

This would result in enhanced management of public health services, resources and programs and improved integration of public health and related human services.

Progress Update

The State Health Director now reports to the Secretary of the Department of Health and Human Services.

Budget No new funding required	FTEs (0) State (0) Local
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10. Promote collaboration of local health departments and any related voluntary structural changes at the local and state level through the accreditation process.

Need Addressed/Rationale

During the past 30 years efforts have been made to consolidate local health departments. North Carolina's strong tradition of local control has always resulted in the decision to maintain county health departments with the exception of a few, well established district health departments. After thorough discussion it was the unanimous decision of the committee that efficiency, effectiveness and possible structural change should be a part of accreditation. Committee members voiced strongly the need for maintaining autonomous, individual departments in counties, unless a structured accreditation and competent follow-up proves that the individual agency cannot provide quality essential services for the county's residents.

Infrastructure/Capacity Improvement

This recommendation is a new approach, which will allow locally determined collaborations to evolve to include the creation of new district health departments.

Budget No new funding required	FTEs (0) State (0) Local
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11. Perform and distribute a Self-Assessment of the Division of Public Health using National Performance Standards.

Need Addressed/Rationale

No national accrediting body exists for state level public health agencies. The Centers for Disease Control and Prevention has developed national performance standards that the state can use as a benchmark for evaluating the Division of Public Health’s ability to fulfill its role in providing effective public health services.

Infrastructure/Capacity Improvement

This will link quality improvement efforts at the state level with national standards and align the state’s quality improvement process with local efforts.

Progress Update

The new Office of Accountability chief will lead DPH in a self-assessment using the national performance standards.

<p>Budget No new funding required</p>	<p>FTEs (0) State (0) Local</p>
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**Part I:
Core Infrastructure
Recommendations**

**Committee on
Structure &
Organization**

**Part I:
Core Infrastructure
Recommendations**

**Committee on
Planning &
Outcomes**

12. Improve the data and epidemiology to guide state and local decision-making and allocation of resources.

Need Addressed/Rationale

Public health covers many fronts and is challenged in many ways. This breadth of responsibilities often makes public health difficult to define for the public and state/local leaders. Without a common set of indicators, it is difficult to monitor the State’s health, identify gaps and priorities, develop and implement statewide plans, and adequately correlate resources to high priority issues. Establishing a common set of indicators will provide a clear statement for public health business and can be used to monitor the health of the state and manage state/local resources.

Infrastructure/Capacity Improvement

Implementation of this recommendation will:

- Establish a common set of core health indicators.
- Build capacity to conduct the Behavioral Risk Factor Surveillance Survey (BRFSS) to provide county-specific or multi-county data.
- Establish the Child Health Assessment Monitoring Program (CHAMP) to collect and report county-specific or multi-county health risk behavior and physical health information of children, such as overweight/obesity and asthma.
- Enhance the opportunities to collect and report county-specific or multi-county behavioral and physical health information on children. Specific examples include greater local school system participation in the Youth Risk Behavior Survey and physical health indicator data surrounding the childhood obesity problem in North Carolina.
- Identify and analyze existing state and local public health problems, health disparities, and potential threats.
- Identify the best scientific and evidence-based strategies to address identified public health problems at the local level.
- Provide Epidemiology training for local partners.

<p>Budget</p> <ul style="list-style-type: none"> • \$300,000 BRFSS • \$250,000 CHAMS • \$100,000 PH problem and threat assessment • \$200,000 Best Practices • \$200,000 Epidemiology training 	<p>FTEs</p> <p>(6.5) State (0) Local</p>
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13. Fund local health departments to assess and document community health needs and provide critical information for state and local health planning.

Need Addressed/Rationale

Community Health Assessment (CHA) is a public health core function. Community Health Assessment is also a critical part of the accreditation of public health agencies. Local public health agencies are mandated to conduct a collaborative, comprehensive CHA every four years that must include a review and analysis of secondary data, collection of primary data, and development of community action plans. Primary data collection is key in engaging community members in the discussion and planning for community health improvement. There are no state funds to support this critical function at either the state or local level. Without funding, public health is compromised in conducting quality CHA. The CHA system informs each county of its health status, provides information for planning both at the local and state levels, supports accountability and continuous quality improvement in public health, and enables the local health agency to be accredited. Providing a uniform set of core questions for primary data collection enables data to be compared across the state.

North Carolina's public health system needs a comprehensive, collaborative process for planning that includes valuable input from local public health agencies and Healthy Carolinians Partnerships as well as a wide variety of state agencies and public health programs. This collaborative process will foster good communication within the public health community, coordination of programs and services, and cooperation toward health improvement outcomes. A collective process will support good fiscal management and avoid duplication of services and careful articulation of gaps and emerging issues.

Infrastructure/Capacity Improvement

Implementation of this recommendation will:

- Establish a uniform statewide process for community health assessment to be conducted on a four-year cycle (comprehensive Community Health Assessment) and updated annually (State of the County Report). Develop and implement a collaborative four-year State Public Health Plan, which will be updated annually.
- Require the State Center for Health Statistics (SCHS) to provide county specific health data to local health agencies for the purpose of local planning and priority setting. The State Center will also establish a core set of questions to be used for primary data collection statewide. Local partnerships (Healthy Carolinians Partnerships, Community-based Organizations and other health agencies) may develop additional questions according to their needs.

Part I: Core Infrastructure Recommendations

Committee on Planning & Outcomes

**Part I:
Core Infrastructure
Recommendations**

13. continued

- Build capacity of the state Office of Healthy Carolinians/Health Education (OHC/HE) to support local community assessment through local training, technical assistance, and report generation. OHC/HE will compile and report information on local needs, community priorities, and action plans to state level programs.
- Establish an annual integrated planning cycle to inform state and local decision-makers regarding program priorities and funding allocations. OHC/HE will facilitate the state level planning cycle and develop annual reports.

**Committee on
Planning &
Outcomes**

Budget	FTEs
<ul style="list-style-type: none"> • \$ 1,623,000 Community Health Assessment <ul style="list-style-type: none"> • \$ 75,000 state • \$ 1,548,000 local • \$ 441,000 Healthy Carolinians <ul style="list-style-type: none"> • \$ 225,000 state • \$ 216,000 local 	(3) State (0) Local

14. Fund increased information technology capacity at the local level to collect, compile, analyze, and report essential public health data.

Need Addressed/Rationale

Technology capacity is critical for all phases of public health practice, especially community health assessment. The need to collect, compile, analyze, report data is key to fully providing the essential services required by public health. Because technology capacity has been left to community resources, it is not uniform across the state. With accreditation, required community assessment, and other reporting requirements, it is critical to assure that all local public health agencies have a minimum standard of technology capacity.

Infrastructure/Capacity Improvement

- Build local capacity to collect, analyze, and report critical public health information electronically.
- Assure compliance with HIPAA guidelines.
- Build the local interface with the Public Health Information Network to enhance the ability of local health departments, hospitals, healthcare providers, and community partners to communicate electronically in a secure environment.

* This funding will provide each local health department with an IT position to support connectivity at the local level and assure that the PHIN is fully operational - specifically the HAN (Health Alert Network) and NC EDSS (N.C. Electronic Disease Surveillance System). Often local health departments are totally reliant on county IT resources, which provide whatever support they can. These critical public health emergency alerting and surveillance components cannot be compromised locally or the entire statewide system could fail.

**Committee on
Planning &
Outcomes**

<p>Budget</p> <ul style="list-style-type: none"> • \$ 5,160,000* (\$60,000 per LHD) local information management personnel • Division of Public Health will work with LHDs to determine local needs and costs for Information Technology and will request these funds in the future. 	<p>FTEs</p> <p>(0) State (86) Local Information Technology Specialists</p>
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**Part I:
Core Infrastructure
Recommendations**

**Committee on
Finance**

Guiding Principles

- Recommendations of the Public Health Task Force should be fully funded on an recurring basis as needed. (Consistently applied through report)
- Task Force recommendations for the Public Health Improvement Plan should be funded to the fullest extent possible in the short session 2004 (note funding referenced through other sections of report where funding was approved by North Carolina General Assembly (NCGA) in 2004). Given the current financial condition of the state, the remaining recommendations should be phased in over the next biennium of the NCGA. (PH Improvement Plan to be the road map for proposed legislative activity for the 05-07 Biennium)

15. Consider the following as possible sources of support for the core infrastructure needs of the public health system:

(Note: Individual summaries follow)

- a) Empower local health departments to charge fees commensurate with the local costs of conducting the food and lodging program activity.
- b) Develop a low wealth funding formula to distribute public health program and administrative funds to local health departments.
- c) Seek private funding (philanthropic foundations, trusts and business partners) for the enhancement of public health through creative partnerships.
- d) Secure state appropriations to implement the equipment replacement schedule for the State Laboratory of Public Health.
- e) Assure that a significant percentage of any new health-related revenues as approved by the General Assembly be directed to support public health infrastructure and services in keeping with Public Health Task Force 2004 Public Health Improvement Plan.
- f) Assure that a mechanism is developed that allows LHD and CDSA Medicaid Rates to be updated annually to more accurately reflect cost of providing services in these settings. This will provide an enhanced cash flow of \$12 to \$13 million to the LHDs and CDSAs, allowing revenue streams to match expenditures and ensure that full cost are provided versus only the federal share when recouped retroactively in the settlement.
- g) Secure a dedicated staff resource within DPH to concentrate full attention on the funding issues reflected in the Finance Committee Report – specifically grants and Medicaid issues and opportunities.

15a. Empower local health departments to charge fees for food and lodging program activities at local level to help cover operational costs. DHHS and DENR should also develop an action plan and work with the NC County Commissioners Association and the North Carolina General Assembly to bring appropriate state funding to local health departments for these essential Environmental Health Services and not rely solely on local fees and appropriations or increased state fees.

Need Addressed/Rationale

Local health directors and county commissioners on the finance committee highlighted the tremendous local burden that environmental health services/ programs place on county governments. It is clear from several of the documents reviewed, as well as the review of DPH funding, that the amount of funding that the state provides to local health departments to support environmental health is extremely small.

Local health departments are allowed to charge a fee to support the on-site sewage program (septic tank permitting) in their counties. This fee is set by the Board of Health and varies by health department. However, it is the local option to determine how much fee base they choose to have and how much local appropriations they use to support this activity.

In contrast, local public health agencies are currently prohibited by state statute to charge a fee to support the Food and Lodging Program. Each food establishment is charged a \$50 annual state fee. Those funds come to the state and are redistributed to locals according to a base of \$5,500 with an additional amount provided if 100% of the county’s restaurants are inspected the appropriate number of times. The total amount that any health department receives is significantly below the cost of the program – ranging from .07 to .66 cents per capita.

At the public hearings on the Draft PH Improvement Plan in 2003, the North Carolina Restaurant Association spoke against increasing fees at every hearing across the state. No other public comments were made in the negative and most Boards of Health and local public health staff voiced strong support.

Infrastructure/Capacity Improvement

Legislative action is required to allow local health departments to charge fees for food and lodging activity. State fees could be eliminated if local fee options were implemented, but additional state appropriations would be needed to replace the funding that DENR-EH retains for state activity.

Budget No new funding requested	FTEs (0) State (0) Local
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**Committee on
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**Part I:
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15b. Develop a low wealth funding formula to be used to distribute public health program and administrative funds to local health departments.

Need Addressed/Rationale

North Carolina counties vary greatly in their ability to pay for essential public services. This concept has been recognized in the public school funding to enable students across the state to have a more equal educational opportunity.

Low wealth status of counties was factored into the school health nurses distribution formula. Components of this formula could be used as a starting point for consideration in awarding other funds obtained for public health since it does include the concept of ability to pay (low wealth) in the calculation.

Residents from Murphy to Manteo deserve consistent high quality public health services. In some areas, it clearly costs more to provide the same services well. Some counties have more funding available for essential and optional services.

To provide for consistent public health services, additional targeted funding must be obtained and a distribution methodology must be identified and implemented to account for these low wealth differences.

Infrastructure/Capacity Improvement

Public schools funding models could be used to develop appropriate public health funding models in disadvantaged areas where health disparities are often the greatest. The PH school nursing funding formula also includes low wealth as a concept for allocation of scarce resources.

This study should to be done in concert with local public health, county commissioners and state officials. Sources of good data include hospital uncompensated care data, the school funding formula, and the new school health nurse funding formula for distribution of funds in poorer counties.

Budget	FTEs
No new funding requested	(0) State (0) Local

15c. Seek private funding to enhance public health services from public grant sources as well as private foundations, trusts, and business partners.

Need Addressed/Rationale

Public health at the local and state level cannot exist and accomplish its goals in a vacuum. The future success of improving the health and well being of residents will only be accomplished through partnerships between local and state government, private non-profit organizations, hospitals, community based organizations, the faith based community and the public. The local and state public health community must reach out and partner in new and creative ways with traditional health care providers and other organizations. Resources exist in these segments of the private sector that could be tapped if the need and the benefit are clearly articulated and ownership of the solution for the future public health condition is appropriately shared.

State and local public health staff are so busy with day-to-day operations that grants development – or even knowing about grant opportunity – is not possible. If an individual is charged with this activity at the state level (perhaps placed in Office of Local Technical Assistance and Training) there could be regular notification of opportunities as well as grant writing training and support on actual proposal development. This individual would need to pull from across DPH for consultant time and energy for this purpose.

Infrastructure/Capacity Improvement

Appropriate non-governmental trusts and foundations must be developed to enable private industry and community partners to contribute to benefit public health while retaining appropriate fiscal and policy control of the uses and expected outcomes of these contributions.

- Work with Institute for Public Health to train and enhance local health department staff’s grant writing skills and abilities.
- Use DPH consultants throughout DPH sections as resource for such activity.

Budget No new funding requested	FTEs (0) State (0) Local
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**Part I:
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15d. Secure state appropriations to implement the equipment replacement schedule for the State Laboratory of Public Health.

Need Addressed/Rationale

The State Public Health Laboratory has developed a five-year equipment replacement schedule. Funding has never been provided for this purpose and the lab does not have resources to provide for needed equipment replacement. Due to the state’s severe financial crisis there has been inadequate continuation funding and no expansion funds to equip the State Lab.

As the state’s only public health laboratory, the State Lab must cover emergencies such as Bioterrorism threats, SARS, West Nile Virus, Avian Flu, as well as provide routine testing support for public health services, hospitals and physicians across North Carolina. Due to the fast pace of improvements in lab diagnostics and their integration with automation, the lab must upgrade its lab diagnostic equipment, computer hardware and related software to take advantage of the new technologies. It must also have resources to purchase upgrades. Since many mandated services – especially services required during natural disasters, terrorist attacks or communicable disease outbreaks – are required regardless of the costs, the State Lab must have a dependable source of state funding to maintain required levels of expertise and laboratory equipment. While some activities, such as services during a natural disaster, may later earn federal revenues to reimburse the state, the lab must first be equipped to answer emergencies to protect the public safety. This requires upfront recurring state funding.

It is critical that Legislative action occurs to assure that funds for critical current or emerging PH functions are available on an ongoing basis as needed.

Infrastructure/Capacity Improvement

Will require legislative action to provide additional funds.

Budget	FTEs
Increase beyond State Continuation Budget in the amount of: <ul style="list-style-type: none"> • \$680,447 (Year 2) • \$804,647 (Years 3-5) 	(0) State (0) Local

15e. Assure that a significant percentage of any new health related revenues generated by the General Assembly support public health infrastructure and services in keeping with the Task Force 2004 Public Health Improvement Plan and subsequent statewide health plans.

Need Addressed/Rationale

The Finance Committee gave near unanimous support to the taxation of products whose consumption negatively impacts health. These funds could be used to counteract the economic impact of preventable health problems associated with such products and improve the health of North Carolina’s people. If such user fees are passed by the General Assembly, a significant percentage of the revenue should support essential public health services and fill critical service gaps.

Infrastructure/Capacity Improvement

Revenues will be directed to priorities of the Public Health Task Force 2004 - Public Health Improvement Plan. Providing ongoing funding for information technology requirements will ensure that both state and county governments can document performance and accountability for public funds. Equitable state/county funding for environmental health services will ensure consistent, reliable funding to protect the state’s environment for all citizens. This will require legislative action.

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Budget	FTEs
No new funding required	(0) State (0) Local

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15f. Assure that a mechanism is developed that allows LHD and CDSA Medicaid Rates to be updated annually to more accurately reflect the cost of providing services in these settings.

Need Addressed/Rationale

Medicaid rates paid to Local Health Departments (LHDs) for covered services are grossly below current documented costs. This causes LHDs to not generate the Medicaid receipts/revenues in keeping with the cost of providing services. Medicaid rate adjustments for these services are not on any routine schedule for updating. This combined situation costs LHDs and CDSAs \$12 to \$13 million dollars per year. These receipts would be available to LHDs and CDS to cover operational costs. These dollars would also free up funding for essential Public Health services.

Infrastructure/ Capacity Improvement

Provide local health departments the support they need to produce the data required in cost studies as well as enhance the capabilities for documentation of associated costs and services.

Staff in DPH, DMA and the Controller’s Office will work collaboratively on this project.

**Committee on
Finance**

Budget	FTEs
<ul style="list-style-type: none"> • \$11,050,000 (state) • \$ 1,950,000 (local) 	<ul style="list-style-type: none"> (0) State (0) Local

15g. Dedicate one DPH staffer to the funding issues reflected in the Finance Committee Report: specifically, grants and Medicaid issues and opportunities.

Need Addressed/Rationale

State and local health department level public health staff are so busy in the day-to-day activities that grants development – or even knowing about grant opportunities – is not possible. If an individual is charged with this activity at the state level there could be regular notification of opportunities as well as grant writing training and support on actual proposal development. This individual would need to pull from across DPH for consultant time and energy for detailed proposal input and development once sources are identified and needs/agencies linked with grant purpose.

The DPH interface with the Division of Medical Assistance is growing more and more complex. The Division of Public Health provides policy and content area consultation to LHDs and DMA. This coordination is requiring more and more time. This dedicated resource could identify funding opportunities and track policy issues.

Infrastructure/ Capacity Improvement

One FTE at a high level could provide the expertise and energy for both the grant and Medicaid activity with direct supervision in the Administrative, Local and Community Support Section (ALCS). This person would interface with the division management team for issues, concerns and hot topics on Medicaid policy and impact on DPH.

<p>Budget Total: \$76,000 \$64,000 (Salary \$50,000, Fringes \$14,000); Travel and operating (\$12,000)</p>	<p>FTEs (1) State – PublicHealth Program Manager II (Grade 75) (0) Local</p>
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**Part I:
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16. The state should fund the county Medicaid share and direct that a significant percentage of freed up county revenue be appropriated for local public health core infrastructure and service needs. Transition could begin with the state picking up any county increase and then phase down county share percentage on an annual basis until the state assumes the local amount.

Need Addressed/Rationale

County commissioners and local health directors on the Finance Committee repeatedly stressed the burden that the local Medicaid match inflicts on county government, denying adequate funding to support many critical services needed by local residents.

The majority of committee members agreed that this burden should be relieved by the state. There was no consensus on whether a percentage of the resulting county funds should be designated by the state for public health purposes. Or, if a percentage were to be designated, there was no consensus on what percentage should be designated.

Final consensus was that all agencies of county government would benefit from this relief, including public health, and that this Task Force must recommend that a significant percentage of the local revenue freed up be directed to local public health for infrastructure and core service gaps. North Carolina is one of only five states with a county Medicaid match.

Estimated cost from research done by various Legislative Committees and stated in multiple legislation that has been introduced for this purpose is approximately \$500,000,000 per year.

Infrastructure/Capacity Improvement

This issue is not new and been discussed in the General Assembly. State assumption of the local (county) Medicaid match is the number one goal of the NC Association of County Commissioners. Public health would benefit greatly from local government’s improved fiscal conditions. This will require legislative action.

Budget Exact costs to be determined.	FTEs (0) State (0) Local
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17. Secure dedicated, recurring funding for replacement of hardware and software as well as ongoing maintenance of a new Health Information System (HIS).

Need Addressed/Rationale

The state’s Health Services Information System (HSIS) is totally outdated and does not meet state or local health department needs.

Sixty-five county departments are totally dependent on HSIS for all reporting and billing activities. These departments provide one third of the total services reported/billed to the state from local public health. The remaining 20 departments, which are larger and better funded, have purchased proprietary software applications that provide them a much more robust management information system. But, those departments must send their statistics to the state DPH through an interface with HSIS, the only system that DPH has for this activity.

The seven individual vendor applications of these health departments must interface with HSIS and are essential for the state and local health departments. It is becoming more and more difficult to get the HSIS state system to appropriately interface with these newer systems. If failed transmissions of data occur for whatever reason, it impacts county Medicaid cash flow and requires a extensive staff time to resolve and resend the information.

Local health departments have already begun to provide funding to the state in support of this project. Two other divisions in DHHS have been involved in the development of detailed business requirements and may participate in its funding.

**Committee on
Finance**

<p>Budget It is difficult to assign a state budget figure at this time since DPH is in the development of detailed business requirements for this system and the issuance of a RFP for system development. DPH will work with the department and the legislature to provide adequate state resources to fulfill the state’s share of this partnership.</p>	<p>FTEs (0) State (0) Local</p>
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Part II: Core Service Gap Recommendations



18. Eliminate funding gaps in critical public health services:

- **School Nurse Services**
- **HIV Prevention/Control**
- **AIDS/ADAP Title VI Compliance**
- **Chronic Disease Prevention & Control**
- **Injury and Violence Prevention**
- **Immunizations (Prevnar)**
- **Environmental Health**

Need Addressed/Rationale

See individual service gap need statements that follow.

Infrastructure/Capacity Improvement

See individual service gap improvements in proposals that follow.

Public Health Service Gaps	Budget
• School Nurse Services	\$ 11,350,000*
• HIV Prevention/Control	\$ 3,341,656
• AIDS/ADAP	\$ 3,000,000 at 200% Federal Poverty Level
• Title VI Compliance	\$ 1,156,849
• Chronic Disease Prevention	\$ 7,482,952**
• Injury Prevention	\$ 1,075,000
• Immunizations (Prevnar)	\$ 8,051,664
• Environmental Health	\$ 5,428,000

*Year 1: Request is for a four year (2005-2008) implementation schedule:

- Year 1: \$ 11,350,000
- Year 2: \$ 25,950,000
- Year 3: \$ 37,300,000
- Year 4: \$ 48,650,000/year ongoing

**Year 1: Three-year (2005-2007) implementation schedule:

- Year 1: \$7,482,952
- Year 2: \$10,873,821
- Year 3: \$27,008,026

**Part II:
Core Service Gap
Recommendations**

**Committee on
Planning &
Outcomes**

**Part II:
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Recommendations**

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SCHOOL NURSE SERVICES

Need Addressed/Rationale

The health needs of students have changed dramatically in the past 10 years, creating increased demands for appropriate care from school nurses. Yet the ratio of school nurses to students in North Carolina remains far below national and state recommendations.

The North Carolina Annual Survey for Public Schools for 2003 reported that 10 percent of students had chronic illnesses or special health care needs. More than 12,000 students needed one or more invasive procedures performed during the school day and six percent of students received medication while at school. School nurses are often responsible for supervising the care of children whose illnesses (e.g. acute asthma and diabetes) were managed in a hospital setting prior to the restructuring of the health care system that reduced hospitalizations and/or length of stay.

In addition to the growing numbers of children with complex health problems, the prevalence of high-risk behaviors in schools continues to be elevated. The new social morbidities include substance abuse, homicide, suicide, child abuse/neglect, and developmental problems. Preventive health programs have become a greater focus in schools as the obesity epidemic is affecting children and youth at earlier and earlier ages. One in four North Carolina teens and one in five children, 5 to 11 years, are now overweight. School nurses play important roles in meeting all these needs. Yet the North Carolina statewide school nurse to student ratio averaged 1:1897 in 2003-04.

Infrastructure/Capacity Improvement

Set a state-funding ratio for school nurse positions to meet the national recommendation of 1:750. In FY 2003-04 there were 691 school nurses in North Carolina, 323 of which were from state expenditures. Assuming there is no loss of positions from local resources or foundation funding and that school enrollments do not increase, it is estimated that an additional 972 nurses will be needed to meet the 1:750 ratio. Because 65 positions are time limited, state funding will be needed in 2006-07. This program proposes that state funding be provided through the Division of Public Health and local health departments.

Progress Update

- Eighty permanent and 65 two-year school nurse positions provided by the General Assembly in HB 1414 improved the nurse to student ratio to 1:1568 assuming no increase in student enrollment in 2004-05.

- The new funding from the General Assembly and Title V – MCH Block Grant over the next two years increased the number of school systems meeting the 1:750 ratio from 10 systems to 24. It will also ensure that there is no school system in the state without a school nurse and that no school system has a ratio higher than 1:4633.

Budget

- Average statewide school nurse salary and fringe: \$50,000
- Estimated additional FTE’s needed to meet 1:750 ratio: 973
- Proposal would meet ratio by adding 227 positions each year for 4 years, plus 65 in 06-07.

	Current Year 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10
Additional FTEs	-----	227	292	227	227	-----
Total FTEs	145	372	664	891	1118	1118
Title V Funding	\$3,250,000	\$3,250,000				
State Funding	\$4,000,000	\$11,350,000	\$25,950,000	\$37,300,000	\$48,650,00	\$48,650,000
Total Funding:	\$7,250,000	\$14,600,000	\$25,950,000	\$37,300,000	\$48,650,000	\$48,650,000

**Part II:
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HIV/AIDS PREVENTION AND CONTROL

Need Addressed/Rationale

The number of new HIV and AIDS cases reported in North Carolina has increased annually since 2000. Although great strides have been made, much remains to be done. HIV/STDs disproportionately affect minority populations. Local health departments, community-based organizations, historically black colleges and universities and HIV care consortia provide the most direct, appropriate and effective links to the communities and populations at highest risk. These organizations and agencies are not adequately funded, equipped or staffed to provide the variety and magnitude of services required to effectively slow the spread of the disease in the affected communities and populations. African Americans currently comprise 71% of the persons living with HIV/AIDS in NC; the rate of HIV infection among Hispanics has increased from 4.1 per 100,000 in 1998 to 25.4 per 100,000 in 2003.

Infrastructure/Capacity Improvement

This multi-faceted initiative will increase the capacity of local health departments, community based organizations, including HIV care consortia and historically black colleges & universities, and the state agency charged with HIV and STD prevention and care. Existing community based organizations will receive funding to increase their outreach, case management, counseling, staffing and infrastructure. Additional community based organizations and non-traditional testing and counseling sites (NTSs) in underserved high-incidence areas and serving high-risk populations will receive financial support for the first time. Local health departments in high-impact areas will receive funding to provide enhanced outreach, counseling and case management services and to support the hiring of disease intervention specialists. These specialists will work at the local level in health departments providing direct follow-up to persons with HIV/STD and their partners. They will train additional clinical, educational and management staff to provide training, consultation and monitoring/quality assurance for the new and existing prevention-focused agencies and programs. The HIV/STD Prevention and Care Branch will hire a behavioral epidemiologist to track, analyze and disseminate relevant data and a public health program consultant II to perform evaluation activities for the prevention program.

<p>Budget Total funds required: \$3,341,656</p> <ul style="list-style-type: none"> • \$2,000,000 for community-based organizations, especially those serving minority populations and historically black colleges & universities • \$1,232,064 for local health departments. • \$109,592 to the HIV/STD Prevention and Care Branch to support two (2) Full Time Equivalentents – a behavioral epidemiologist and a program consultant/evaluation specialist – and including travel and other operating expenses required to support the new prevention initiative. 	<p>FTEs</p> <p>(2) State (0) Local</p>
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TITLE VI COMPLIANCE - LANGUAGE SERVICES

Need Addressed/Rationale

In August 2000, the President signed Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency.” The Executive Order requires federal agencies to examine the services they provide, identify any need for services to those with Limited English Proficiency (LEP), and create a system to provide those services. The Executive Order also requires that federal agencies work to ensure that recipients of federal financial assistance (like public health departments) provide meaningful access to their LEP clients. Title VI of the Civil Rights Act says that a program receiving federal dollars cannot discriminate against any client because of race, color or national origin. The courts have held that Title VI prohibits recipients of Federal financial assistance from denying LEP persons access to programs, on the basis of their national origin. North Carolina has a diverse population – 21.4% African Americans, 4.7% Hispanic/Latinos, 1.4% Asian, and 1.2% American Indians and. According to 2000 U.S. Census figures, the Latino population in North Carolina is estimated to be 387,963 residents. North Carolina’s Latino population grew by 394% between 1990 and 2000, the largest increase of any state in the country. The demand for providers in the health and human service fields who are culturally and linguistically qualified has increased.. The growing number of Latinos in North Carolina has presented new challenges to health and human service providers. Language is the most significant barrier to providing adequate care for Latino clients. In a December 2003 assessment of local health departments and community based organizations, the need for cultural diversity training and interpreters were identified as resources needed to support their efforts to provide effective services to clients.

Infrastructure/Capacity Improvement

Since 1998, the Office of Minority Health and Health Disparities in the NC Department of Health and Human Services has collaborated with NC Area Health Education Centers (AHEC) Program, the University of North Carolina at Chapel Hill School of Public Health, and the AHEC Office at Duke University to implement the Spanish Language and Cultural Training Initiative (SLCTI). The initiative’s ultimate goal is to increase the availability of culturally based and linguistically appropriate programs and services for North Carolina’s increasingly diverse population. Training and resources have been offered across the state of North Carolina to front-line health practitioners and interpreters. The SLCTI will help local health departments and human service agencies reduce the potential for liability and assure compliance with Title VI.

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<p>Budget \$3,000,000 in State appropriations is required to increase eligibility to 200% FPL.</p>	<p>FTEs (0) State (0) Local</p>
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HIV/AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Need Addressed/Rationale

The NC AIDS Drug Assistance Program (ADAP) has been largely closed to new enrollees since December 2001. Although the list was opened up briefly during that time, it quickly had to close due to lack of funding. At one point more than 300 people were on the waiting list. Individuals who do not receive coverage through ADAP are likely to seek care from other public programs like Medicaid. By the time they qualify for Medicaid, they are usually sicker and their care will be more expensive. Providing drug assistance early will save public dollars.

HIV prevention efforts are also hindered when infected people can't get medicine, contributing to the continuing and further spread of HIV disease. People who can't get medicine are less productive because they are too sick to work. This may increase their dependence on unemployment insurance and other public programs.

Infrastructure/Capacity Improvement

Increased funding is required in order for the state to serve all low-income (below 200% of the Federal Poverty Level) HIV+ individuals and to assure ongoing and permanent access to medications to those individuals that are most seriously affected and most in need.

Progress Update

- Increase of \$2,765,000 in state appropriations for ADAP by General Assembly in 2004.
- 585 clients were moved from the Waiting List on September 1, 2004.
- President Bush announced a special initiative in June 2004 with the goal to eliminate the state ADAP waiting lists that were in effect at that time in ten states throughout the country. Although all the details for this program have yet to be announced, North Carolina expects its current waiting list to be eliminated by November 2004 and recurring, increased federal funding to be allocated to the state in the next budget period of the Ryan White Title II grant (4/1/05-3/31/06). Although the exact amount of the increase is unknown, it is expected to be at least \$8 million – an amount that will support continuation of an open Program (no Waiting List). Receipt of these funds will also allow the state to move closer to addressing its low eligibility criterion for the Program.

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Budget	State	Local
\$1,156,849		
• Interpreter Training	\$ 273,551	(1) State
• Spanish Language Training for Health Professionals	\$ 292,000	(5.4) Local
• Cultural Competency Training	\$ 181,298	
• Spanish Language and Cultural Training Website	\$ 20,000	
• Mental Health and Substance Abuse Training	\$ 18,000	
• Staffing and Logistical Fees	\$ 372,000	

*Additional FTEs are requested to support the Spanish Language and Cultural Training Initiative. One (1) FTE would be housed in DHHS and will serve as the training coordinator and liaison to the 9 AHECs. The remaining 5.4 FTEs will be based in the 9 AHECs with each local AHEC receiving .6 FTE.

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CHRONIC DISEASE - PREVENTION & CONTROL

Need Addressed/Rationale

Tobacco use, physical inactivity and unhealthy eating habits are the three leading preventable causes of death in both North Carolina and the United States. Together, they are responsible for the deaths of 15,000 North Carolinians each year. This represents 35% of all the deaths in the state.

Tobacco use continues to be the leading preventable cause of mortality in NC, resulting in more than 14,000 deaths annually (NC SCHS, 2002). Tobacco is highly addictive, and most tobacco users start at age 12 - 14. North Carolina has the 11th highest smoking rate in the nation (MMWR, 2004). Tobacco users lose on average 14 years of life. For every tobacco-related death there are 20 more people who are sick due to tobacco.

In North Carolina two-thirds of our adult population are overweight and one-third of those are obese. Obesity begins in childhood, and because of obesity the generation of youth now in school may be the first to have a shorter life expectancy than their parents. (JAMA 2003; 187-19). Regular physical activity reduces the risk of obesity and other chronic diseases. Only 18% of adults in North Carolina reported engaging in regular and sustained physical activity in 2000, and only five states in the nation have a lower prevalence. Unhealthy food choices are recognized as a major risk factor for cardiovascular disease and some cancers. Low fruit and vegetable intake is associated with obesity and various cancers, yet in 2000, only 22% of North Carolina’s adults reported eating at least five servings of fruit and vegetables- the 17th lowest in the nation.

Minority communities have higher rates of chronic disease. The death rate for stroke among African Americans is 30% - 40% higher than for whites. African Americans and American Indians are two times more likely to die from diabetes than whites in North Carolina. Low-income populations are more likely to use tobacco and have less access to tobacco use treatment.

Tobacco use, physical inactivity and poor nutrition cost the state and its employers. Conservative estimates from CDC show that NC’s excess medical costs due to tobacco are \$1.9 billion and \$600 million alone for Medicaid. NC Prevention Partners published this “price tag” based on CDC data for what these three leading risk factors cost employers in medical care costs plus lost productivity each year in our state.

	North Carolina	Per Employee	Per Resident
Tobacco Use	\$4.75 billion	\$1,429	\$582
Nutrition, Overweight and Obesity	\$4.9 billion	\$1,474	\$600
Physical Inactivity	\$6.2 billion	\$1,865	\$759
TOTAL	\$15.85 billion	\$4,768	\$1,941

Proposed Program Solutions

The Guide to Community Preventive Services strongly recommends preventive interventions that are evidence based and cost effective; see www.thecommunityguide.org. This proposal phases in evidence based intervention strategies for the leading preventable causes of death such that all communities (geographic and diverse populations) have access to funding for effective and cost saving interventions. The proposal also recommends reaching out to appropriate private sector partners to provide matching funds.

Budget and Justification - Chronic Disease Prevention and Control

Budget	FY 04-05	FY 05-06	FY 06-07
Local Funding	\$3,962,709	\$5,170,948	\$9,300,000
Public Education Campaign Development	\$3,000,000	\$5,000,000	
Public Education Campaign Implementation			\$16,500,000
Technical Assistance	\$456,847	\$605,608	\$736,412
Accountability	\$ 63,396	\$ 97,265	\$471,614
Totals	\$7,482,952	\$10,873,821	\$27,008,026

This proposal is designed to meet documented service gaps and proposes funding levels that are effective in preventing the leading preventable cause of deaths and lowering health care costs.

Local Funding is evidence based and in demand in NC:

- This budget allows each county in NC to reach a minimum capacity level of one FTE (valued at \$50,000) and program expenses (valued at \$20,000) in FY 04-05. This builds upon existing statewide health promotion program funds.
- While the Health and Wellness Trust Fund provides for teen tobacco prevention, there is no similar source of funds for adult services. Counties that had applied for \$4 million in tobacco prevention and control funds but were turned away due to lack of funds will be funded in FY 05-06. We expect local demand to grow as health care costs grow and disparities widen.
- Counties that applied for \$675,192 in physical activity funds but were turned away due to lack of funds will be funded in FY 05-06. We expect local demand to grow as health care costs grow and disparities widen.
- Local programs will provide evidence-based interventions that aim to eliminate disparities.
- Counties or multi-county collaboratives with large or disparate populations will have the opportunity to apply for additional funds in FY 06-07.

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Proposed Program Solutions continued

Public education is a necessary component of any behavior change/social norm change or policy change strategy.

- Public education campaigns for tobacco and physical activity work when combined with local interventions. CDC's Best Practices for Comprehensive Tobacco Control Programs recommended spending a minimum of \$1.00 per capita and an upper estimate of \$3.00 per capita on tobacco prevention and control public education campaigns.
- FY 04-05 and 05-06 funding will be used to develop, test and evaluate effective, focused paid media campaigns that are enhanced by local initiatives, and to promote earned media, which is the strategic use of events such as rallies to generate favorable news coverage.
- FY 06-07 will be used to implement best practices for countermarketing campaigns for tobacco, physical activity and nutrition.
- Private matching funds will be sought for tobacco control for the American Legacy Foundation's Co-op Program and other appropriate sources.

INJURY & VIOLENCE PREVENTION

Need Addressed/Rationale

Injury is the leading cause of death in North Carolina for people aged 1 - 44, and the fifth leading cause of death for all North Carolinians. Between 1999 and 2003 there were 26,033 deaths from injury – most were unintentional (17,476). During these five years there were more deaths from suicides (4,734) than homicides (3,113), and the majority of these deaths occurred from firearms (5,209). In general, injuries occurred more frequently in men than in women, and among African American males than white males. For example, between 1999 and 2003, the rate per 100,000 population of fatal unintentional injuries was higher for black males (68.5) than white males (58.7), and for homicides (28.7 for black males vs. 5.3 for white males). In contrast, the percent of self-reported violence against women from the NC Behavioral Risk Factor Surveillance System is consistent for African American and white women. The mortality rates from falls, motor vehicle crashes, motor cycle crashes, and poisonings have increased over the past five years. In 1999, an Institute of Medicine report called for significantly increased funding to strengthen the public health infrastructure in injury prevention by developing core injury prevention programs in each state. A state and territorial injury prevention director's association team conducted an assessment of North Carolina's injury and violence prevention program in 2003 and concluded that there is a clear need for the development of injury prevention infrastructure at the state and local level. Injuries and deaths range from poisonings, drowning, motor vehicle crashes, falls, etc. to injury and death that result from violence such as suicide, rape, child abuse, violence against women, assault, and homicide. In North Carolina, many of these issues are being addressed by task forces and study groups that call for public health participation in identifying and implementing effective interventions. The ability of public health workers to become involved in injury prevention varies greatly at both the state and local level. The ability to perform the essential services/core functions of public health is greatly compromised because local infrastructure for an effective public health approach to injury and violence prevention is non-existent and there is no state support to local health departments for core injury and violence prevention programs.

Infrastructure/Capacity Improvement

- Develop and apply health communication strategies (including social marketing) for informing and influencing individual/community decision-making to prevent injuries and violence.
- Build state leadership and technical assistance capacity for supporting local efforts to conduct core elements of injury programs: needs assessment, program development/evaluation, staff training, local data surveillance, and other technical assistance.

Part II: Core Service Gap Recommendations

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Injury and Violence Prevention, Cont'd

- Build infrastructure and staff capacity at the local level to implement effective intervention strategies by supporting a lead local health department within six regions in NC and two local health departments (LHDs) to provide leadership and capacity building for minority/special populations.

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Budget <ul style="list-style-type: none"> • \$182,946 for 4 FTEs (Health Communication Specialist, Program Coordinator, Program Evaluator, and Office Assistant) • \$92,054 for program development/evaluation support, equipment, and operational expenses • \$800,000: \$100,000 for each of the 6 lead LHDs and \$100,000 for each of the two minority/special population focused LHDs 	State \$ 275,000	FTEs (4) State (0) Local
	Local \$ 800,000	

CHILDHOOD IMMUNIZATIONS: PNEUMOCOCCAL CONJUGATE VACCINE (PREVNAR)

Need Addressed/Rationale

Streptococcus pneumoniae bacteria harm more people in the United States each year than all the other vaccine-preventable disease combined. The pneumococcal bacteria causes invasive disease (mostly blood infection or bacteremia) and meningitis (inflammation of the brain and the spinal cord covering). It is the leading cause of bacterial meningitis in the U.S.; hitting children < 1 year of age hardest. The burden of pneumococcal-related diseases is about 5,013,900 reported cases per year nationwide. These diseases cause 25%-40% of middle ear infections in children. About 200 American children die each year from pneumococcal disease. In North Carolina the pneumococcal conjugate vaccine (PCV7) was licensed in early 2000, targeting seven pneumococcal serotypes. As a result of this preventative action, there were 170 fewer total hospital discharges between 1999 and 2001. Even though the number of children hospitalized during this period was reduced, there were still a high number of unvaccinated children who were hospitalized. It would have cost \$3,694,132 to vaccinate children in North Carolina between 1999-2001. The difference between the total costs of the disease (\$5,908,252) and the cost to vaccinate all the children at that time would have provided an estimated saving's of \$2,214,120. Demand for the universal distribution of Prevnar is high among parents and physicians.

Infrastructure/Capacity Improvement

Purchase and distribute pneumococcal conjugate vaccine (Prevnar) for children. CDC's National Immunization Program will cover the cost for vaccinating 68.2% of the eligible population. An estimated 31.8% of the children are not covered by federal funding sources and will receive this vaccine through this request.

Budget	FTEs
<ul style="list-style-type: none"> \$8,051,664 in State appropriations for the purchase of pneumococcal conjugate vaccine. No local funding is requested. 	(0) State (0) Local

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ENVIRONMENTAL HEALTH

Secure state appropriations to increase the number of environmental health specialists (FTEs) in local health departments.

Need Addressed/Rationale

The Division of Environmental Health and local health departments administer and enforce the NC General Statutes and the sanitation rules of the Commission of Health Services. These mandated programs serve to protect the public health in the areas of: (a) Child-Care Centers, (b) Childhood Lead Poisoning Prevention, (c) Food, Lodging and Institutions, (d) Migrant Housing (MH), (e) On-Site Wastewater (OSWW), (f) Public Swimming Pools, and (g) Tattoos. As North Carolina grows, there is a direct relationship in the increased workload in local health departments. The burden of funding this increased workload and enforcement has impacted county finances. Additional state support is needed at the local level. Funding is requested to provide each county with an additional environmental health specialist.

Infrastructure/Capacity Improvement

Will require legislative action to provide additional funds. Each county will receive one additional environmental health specialist (1 FTE) to meet community needs. An increase in local capacity also is requested, with resource needs determined on a \$50,000/county basis.

Budget	FTEs
<ul style="list-style-type: none"> • \$ 428,111 - Office of Accreditation Support & Accountability 	(7) State
<ul style="list-style-type: none"> • \$ 5,000,000 - Local Environmental Health Core Services 	(100) Local

Addenda

- **Automation Report: Public Health Information Network (PHIN)**
- **Task Force Membership**
- **Committee Membership**



Addenda

**Automation Report:
Public Health
Information Network
(PHIN)**

**Report to the North Carolina Public Health Task Force 2004
Public Health Information Network (PHIN)**

Improved information technology is one of the most critical infrastructure capacity improvements that the public health system must undertake. The North Carolina Division of Public Health has several information technology initiatives currently under development that will significantly enhance the state's ability to monitor, manage, and respond to the health needs of its citizens. These systems are being developed as a part of the North Carolina Public Health Information Network (NC-PHIN). These statewide systems will be developed using state and federal resources with the exception of the Health Information System, which will be developed in partnership with local health departments. These systems will provide new functionality and linkages to all local users. Below is a synopsis of each initiative and projected timeline for development and/or implementation.

- **North Carolina Public Health Information Network (NC-PHIN)**
NC-PHIN is a set of enterprise level standards of functionality and security under which critical information systems can be developed and shared appropriately. To paraphrase John W. Loonsk, M.D., Associate Director for Informatics, Center of Disease Control and Prevention, "...public health needs to assume its role as a major component of national defense. ... public health is being tested by new needs for preparedness and response, it is time to advance a public health information network that brings together functions and organizations that are public health." The NC Division of Public Health has developed a base technology infrastructure that supports NC-PHIN. Minor enhancements will be required as new systems are implemented.
Estimated Implementation: Enhancements only as needed
- **Health Alert Network (HAN)**
The North Carolina Health Alert Network was the first component built using the NC-PHIN standards. It was funded by the CDC Bioterrorism Grant Program. NC-HAN was deployed October 2002. It allows secure Internet browser-based communications among key public health officials and their partners on information about public health emergencies confirmed or suspected communicable diseases, and other health threats. It does notification by phone, fax, pager and e-mail. This system has already proved invaluable in dealing with issues like SARS, E-Coli and West Nile virus. NC-HAN also has a public web site (www.nchan.org) that provides timely and accurate information about public health threats to citizens.
Implementation: October 2002

Addenda

- **Health Information System (HIS)**

This initiative will provide an automated means of capturing, monitoring, reporting and billing services provided in Local Health Departments (LHDs), Child Development Service Agencies (CDSAs) and the State Laboratory of Public Health (SLPH). It will allow for interfaces to LHD owned systems. It will replace the outdated Health Services Information System (HSIS). The initiative is in the process of requirements gathering and RFP development. Subsequent vendor selection, system development, and implementation efforts will follow.

Estimated Implementation: Winter 2005

- **NC Immunization Registry (NCIR)**

An automation improvement effort is underway to replace the current NCIR with a web-based system. North Carolina selected the proven software from the Wisconsin Immunization Registry (WIR) as the basis for its new system. The software will be modified and customized to meet the needs of North Carolina. The new NCIR system will contain a single consolidated immunization record for each North Carolina child, regardless of how many immunization providers have treated the child. This information is shared, as required by state law, among immunization providers and other authorized organizations and is used to assure timely and appropriate treatment and to provide official documentation of immunizations given.

This consolidated record will help to assure timely and accurate administration of needed vaccines and prompt access in the event of an outbreak, vaccine recall and other situations that require rapid identification of immunizations administered. The NCIR will also provide information that will facilitate the safe practice of vaccine service delivery through the analysis of side effects and contraindications specific to the patient.

An RFP was issued and a contract was awarded to a vendor in July 2004. System development is now underway. A three-month pilot of the system will begin in mid-February 2005. The four counties participating in the pilot are Henderson, Pitt, Cabarrus, and Chatham. Estimated statewide deployment will begin in June 2005.

Estimated Statewide Implementation: Summer 2005

**Automation Report:
Public Health
Information Network
(PHIN)**

Addenda

Automation Report: Public Health Information Network (PHIN)

- **Vital Records (VR)**
The Vital Records Automation Project will improve the birth registration process, along with associated efficiencies in data base management. Further improvements are expected in the death registration process along with associated reporting. The RFP was posted for bid in April 2004. Vendor selection process is underway.
Estimated Implementation: Summer 2005
- **Laboratory Information Management System (LIMS)**
To share lab centric data to authorized recipients requires a secure well-defined method of messaging (HL7). Adoption of such a messaging capability for the State Laboratory of Public Health is essential to being able to share LIMS information to various authorized data users.
Estimated Implementation: Spring 2005
- **North Carolina Emergency Department Database Project (NCEDD)**
This CDC funded pilot project did the initial work with NC hospital emergency departments to understand how information can be collected, stored, analyzed and shared appropriately. This landmark work done under contract with the UNC School of Medicine, Department of Emergency Medicine was the basis for subsequent development of the North Carolina Bioterrorism and Emerging Infection Prevention System (NCBEIPS). This new system will incorporate several data streams including hospital ED data from the North Carolina Hospital Emergency Surveillance System (NCHES). NCEDD will continue to provide database management and data integration services for the NC Division of Public Health on an ongoing basis.
- **North Carolina Hospital Emergency Surveillance System (NCHES)**
North Carolina Hospital Emergency Surveillance System (NCHES) is a system to electronically collect, report, monitor, and investigate emergency department (ED) and hospital data in near-real time from all participating hospitals in North Carolina. Data from NCHES will allow public health professionals to detect unusual trends and public health emergencies earlier than current reporting systems so that appropriate action can be initiated. This system is being developed in partnership with the North Carolina Hospital Association. NCHES will allow hospitals to fully comply with the newly passed mandatory hospital reporting law effective January 1, 2005.
Estimated Implementation: January 2005

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- **NC - Electronic Disease Surveillance System (NC-EDSS)**

NC-EDSS is the North Carolina version of the National Electronic Disease Surveillance System. It will allow local health departments, laboratories, hospitals, and individual providers to electronically notify the NC Division of Public Health whenever a case of a reportable disease or condition occurs in NC. The system will assist healthcare providers in complying with existing NC disease reporting laws. The timeliness, reliability, and accuracy of reportable disease data in NC will improve significantly. NC-EDSS will be fully integrated with the state's Health Alert Network. Defining the system requirements is underway. An RFP for system development is expected to be out by January 2005.

Estimated Implementation: January 2006

***Automation Report:
Public Health
Information Network
(PHIN)***

**Task Force
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