

NORTH CAROLINA

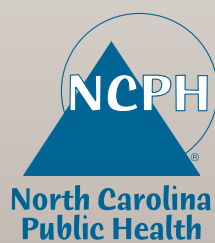
Public Health Improvement Plan

Public Health Task Force 2008

FINAL REPORT



January 2008





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Michael F. Easley, Governor

Dempsey Benton, Secretary

December 19, 2007

It is a privilege to offer to you this Final Report of the **North Carolina Public Health Task Force 2008**. The report's recommendations form the foundation of the current North Carolina Public Health Improvement Plan.

It was so impressive to see so many stakeholders participate for the third time to add their thinking and their voices to this unique planning effort. Your recommendations provide strategic guidance for our continuing efforts to improve the health of North Carolinians everywhere, through increased capacity in core public health infrastructure and essential public health services as well as a focus on eliminating health disparities.

With the support of the North Carolina General Assembly and a coordinated effort from our public health system and its many partners, significant progress was made in 2004 and in 2006. These accomplishments are outlined in the beginning of this 2008 report. The current recommendations follow, many of which continue to build on the work that has been undertaken but not yet completely accomplished.

Four committees--Chronic Disease & Injury, Healthy Children & Families, Communicable Disease & Preparedness and an Executive Committee guided the work of the Task Force. Also included are opportunities to provide revenues to support these critical services and the critical capacities of state and local public health departments.

Congratulations and thank you to the members of the Task Force and the Committees for their hard work and commitment to improve the public's health in North Carolina. I ask your assistance in helping us to make their hard work a reality as we move forward together.

Sincerely,

Handwritten signature of Dempsey Benton in black ink.

Dempsey Benton
Secretary

Handwritten signature of Leah Devlin in black ink, including the initials "DDS, MPH".

Leah Devlin, DDS, MPH
State Health Director



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INTRODUCTION

The good news for North Carolina is what we have collectively been able to achieve in terms of strengthening public health capacity in North Carolina through the Public Health Task Forces 2004 and 2006. A short summary of the accomplishments directly attributable to the work of individuals on the two previous Task Forces is included in this report. Significant improvements have been made in the areas of accreditation, accountability, structure and organization of public health as well as progress in closing some important gaps in core public health services. However, challenges remain. There is still much work to be done and we are optimistic that the Public Health Task Force 2008 (PHTF) can help us accomplish this important work.

Dempsey Benton, Secretary of the NC Department of Health and Humans Services, agreed to chair the Public Health Task Force 2008 to ensure that we continue to build on past accomplishments. The PHTF 2008 is made up of state and local leaders representing many of the significant stakeholder groups who share the goal of improving health of all residents of the State. The Task Force also includes members of the North Carolina General Assembly. Specifically, Secretary Benton charged the Public Health Task Force 2008 to:

- Assess progress to-date on important public health issues;
- Identify remaining unmet needs as well as new, critical emerging needs; and
- Develop a set of recommendations for improvement.

The PHTF 2008 seeks to provide a unified voice for policy makers and public health advocates to understand the most important programs and policies that will move North Carolina forward with respect to improving the public's health. The Task Force work was divided into three broad committees; 1) Healthy Children and Families, 2) Chronic Disease, and 3) Communicable Diseases and Preparedness. Each Committee examined a number of cross-cutting issues including eliminating health disparities, workforce development, and broad system organizational issues. The Executive Committee took the recommendations from each Committee and merged them into a single set of comprehensive recommendations. These recommendations will serve as a guide for important actions over the next two years that can improve the public's health for generations to come.

THE MISSION OF NORTH CAROLINA PUBLIC HEALTH

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

THREE 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).

NC General Statute: Article 130A – 1.1



Public Health Task Force 2008 to Build on 2004-2006 Accomplishments

Strengthening the Public Health System Through State Level Investments and Innovations

Standardizing Public Health Capacity

- The first mandatory system of accreditation for local/district health departments in the country has been established. Initial legislation provided \$700,000 per year in recurring funds for the accreditation process. Of the 85 local county health departments, 30 have been accredited as of July 2007.
- The first state level Pilot Accreditation effort nationally was successfully completed in February 2007. Based on the recommendations of the site visit team, performance improvement teams have been established to address the findings and recommendations.
- For the first time in over 30 years, state level public health funds to support provision of the ten essential public health services provided by local health departments was increased by \$2 million.

Increasing Collaborations

- The North Carolina General Assembly (NCGA) budgeted \$1,000,000 in recurring funds to establish and support seven public health incubators to support regional collaboration and innovation.

- The NCGA appropriated \$1,400,000 for local Healthy Carolinians partnerships for capacity development.

Building New Facilities

- \$101 million was approved to build a new Public Health Laboratory and Medical Examiner Office. The groundbreaking will occur in late 2007 at a site close to the N.C. State University College of Veterinary Medicine.

Implementing New Technology

- The statewide Health Information System (HIS) is being implemented supported by a state and local contribution of \$15 million. Full implementation of this system will occur by the end of 2008.

Protecting Health

- The excise tax on “spit” tobacco products and cigars was increased from 2% to 3% of the actual cost. The tobacco tax was increased from 5¢ to 35¢ in 2005.
- New legislation prohibits smoking in buildings owned, leased or occupied by state government and authorizes local governments to regulate smoking in buildings owned or leased by local governments. Another legislative success was making all North Carolina public school grounds tobacco free campuses.
- Over 300 new school nurse positions improved the nurse to student ratio from 1:1897 in the 2003-04 school year to 1:1260 in school year 2007-08. 37 of 155 LEAs now meet the recommended 1:750 ratio in 2006-07.
- The NCGA increased state support for the universal vaccine program by appropriating \$5,526,095 to support the provision of influenza and Tdap vaccines.
- The regulation of private wells has been added as a mandated program.

- The NCGA has provided an additional \$12 million appropriation to provide for early intervention to select children 0-3 years.
- The Division of Public Health was designated as the lead agency for injury prevention in North Carolina
- New funding for chronic disease targeting cancer, stroke and diabetes totaled \$3 million in 2007.
- Support for infectious disease testing was provided for the public health lab and for outbreak investigation of food-borne and vector-borne diseases.
- The NCGA approved \$5,000,000 for all primary care safety net clinics for FY 2007 including local health departments.
- The Division of Public Health was designated the lead agency in North Carolina for the prevention of child maltreatment.

Preparing for All Hazards

- Approximately \$700,000 in funding to support response for food-borne illness, infectious diseases such as tick-borne illness was appropriated.
- Over \$9.2 million in antiviral medications was appropriated for pandemic flu preparedness.
- The first state law requiring all hospital emergency departments to report specific health data to the State Health Department.

Eliminating Disparities

- There has been an increase of \$1,000,000 in state appropriations for ADAP in FY '06 and \$2,000,000 for HIV prevention. AIDS Drug Assistance eligibility has been significantly raised.

- The NCGA appropriated \$350,000 in recurring funds for new full-time positions for interpreter services at local health departments.
- The Office of Minority Health & Health Disparities received \$2,500,000 for community-focused initiatives targeting the elimination of health disparities.

Task Force 2008 Kicks off October 10, 2007

Focus Areas
Healthy Families
Communicable Disease
Chronic Disease Prevention
Health Disparities/Health Equity
Ten Essential Services



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NORTH CAROLINA PUBLIC HEALTH IMPROVEMENT PLAN

EXECUTIVE SUMMARY Public Health Task Force 2008 Recommendations

Strengthen Core Public Health –
Build Capacity for the 10 Essential
Services in Local Health Departments
Statewide (\$32,010,000)

1. **Build capacity for the 10 Essential Services in Local Health Departments statewide. (\$23,000,000)**

The 10 Essential Services:

1. Monitor the health of North Carolinians
 2. Identify and Investigate Health Problems
 3. Inform and Educate North Carolina citizens about Health Issues
 4. Organize Community Partnerships to Solve Health Problems
 5. Develop Policies and Plans that support Health Programs
 6. Enforce Laws and Regulations that Protect Health and Safety
 7. Connect North Carolina citizens to needed health services – Uncompensated Care
 8. Assure the ability to recruit and retain an adequately trained public health workforce.
 9. Measure the Effectiveness and Quality of Health Services
 10. Identify new solutions to health problems
2. **Expand the capacity for Community Health Assessment at the local level. (\$2,150,000)**

3. **Local Health Department Accreditation – Maintain the highly successful local public health accreditation program through ongoing re-accreditation cycles. (\$200,000)**
4. **Eliminate Health Disparities**
 - Improve the accuracy of reporting of race and ethnicity data by Medicaid providers, State Employees Health Plan, and all hospitals. (\$10,000)
 - Expand the Community Focused Eliminating Health Disparities Initiative (CFEHDI) Grants to local programs. (\$3,000,000)
 - Increase the scarce skill incentive to hire bilingual staff from 5% to 10% potential salary adjustment. Increase local health department interpreter capacity to serve clients as required by Title VI. (\$2,650,000)
5. **Workforce Development**
 - Exempt state and local public health retirees from the requirement to wait six months before they are eligible to return to work full time without negatively impacting their retirement benefits.
 - Establish public health loan repayment programs to attract qualified professionals into the field of Public Health. (\$1,000,000)
6. **Seek to reunite state level Public Health and Environmental Health in the Department of Environment and Natural Resources.**
7. **Sustain the current structure and governance for the local public health system as set out in the North Carolina General Statutes chapter 130A, Article 2.**

**Reduce the Burden of Chronic Diseases
(\$18,958,000)**

- 8. Reduce Obesity – Fund and Support Local Health Departments, local Healthy Carolinians Partnerships, and other community coalitions to implement “Eat Smart and Move More”, NC’s plan to prevent overweight, obesity, and related chronic diseases. (\$10,000,000)**
- 9. Improve Critical Health Surveillance and Accountability - Expand and improve data collection, analysis and dissemination to better measure health threats, establish priorities, and secure additional federal funding at the state and local level. (\$3,721,000)**
 - Seek legislation to create a separate authority to govern critical eHealth initiatives to effectively manage health information exchanges/applications that directly impact the quality of healthcare and improve health. (\$100,000)
- 10. Reduce the Leading Causes of Death – Expand patient self-management of the risk factors associated with cancer, heart disease, stroke, asthma, and injury across the State. (\$5,237,000)**
 - Create more smoke free worksites.
 - Improve passenger safety in pick-up trucks.
 - Support the Tobacco Quit Line.
 - Support the collection of blood samples from patients in hospital emergency departments who are suspected of or confirmed with unintentional drug overdoses.
 - Create a Falls Prevention Coalition

**Support Healthy Children and Families
(\$48,294,000)**

- 11. Improve immunization rates for recommended vaccines and fully fund the NC universal immunization program. (\$27,000,000)**
- 12. Improve birth outcomes – Implement initiatives that will improve birth outcomes and promote the wellbeing of infants, toddlers and preschoolers. (\$2,115,500)**
- 13. Build Healthy Children - Implement and evaluate the effectiveness of evidence-based, community-based family support initiative pilots. (\$5,828,000)**
 - Adjust the fee for newborn screening to include cystic fibrosis.
 - Ban corporal punishment in schools.
 - Enact child endangerment laws.
- 14. Improve School Health – Healthy children in healthy schools are a critical component of academic achievement. (\$12,034,500)**
 - Require schools to provide age-appropriate, fact-based, medically accurate comprehensive sexuality education to all school children.
- 15. Strengthen and expand the statewide dental prevention and education program for high risk children. (\$1,316,000)**

Prevent Communicable Disease and Strengthen Preparedness (\$18,400,000)

- 16. Reinvest in the NC Medical Examiner System – Fully implement the strategic plan to modernize and professionalize the NC Medical Examiner System through regionalization of facilities and personnel (\$12,800,000).**

17. Add Environmental Health Specialists to local Epi Teams (\$5,600,000)

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

19. Seek legislation to improve Public Health Preparedness and Response

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

Finance Recommendations

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

- Increase the current NC tobacco excise tax.
- Seek legislation to enable local authorities to establish fees for food and lodging inspections.
- Legislatively create a permanent sustainable funding source for the Universal Vaccine Program.
- Correct the fee adjustment process for Local Health Departments and Child Development Service Agencies (CDSA).
- Adjust the newborn screening fee to support adding cystic fibrosis screening, currently \$14.00 per child to \$16.20 per child.

21. Increase Medicaid reimbursement to providers to increase access to care.

- Establish the Medicaid reimbursement for vaccine administration for local health departments at the same level as for private providers.
- Increase Medicaid reimbursement rates for dental services to 80% of the national standard to increase access to care. Tag funding to annual inflationary increases.

Strengthen Core Public Health – Build Capacity for the 10 Essential Services in Local Health Departments Statewide (\$32,010,000)

1. BUILD THE CAPACITY FOR PROVIDING THE 10 ESSENTIAL SERVICES STATEWIDE. (\$23,000,000)

Justification / Rationale:

Each local health department is expected (mandated in NC General Statute) to provide the 10 Essential Public Health Services in a consistent high-quality fashion. NC Citizens should expect to receive these services regardless of the geographic area of the state in which they live or visit/vacation. Resource constraints limit the local health department’s ability to meet their individual service needs (based on local community assessment) and provide the essential services at the expected level of consistency and quality.

Impact:

Funding will establish consistent, high-quality delivery of the 10 essential public health services for each North Carolina Citizen regardless of the county in which they live or visit. Full funding would be phased in over a three year period according to the “Strategic Plan for Strengthening Core Public Health” included as Appendix A.

BUDGET	
Year 1 of Strategic Plan (see Appendix A)	\$23,000,000

2. EXPAND THE CAPACITY FOR COMMUNITY HEALTH ASSESSMENT AT THE LOCAL LEVEL. (\$2,150,000)

Justification / Rationale:

Community Health Assessment (CHA) is a public health core function. Six (6) of the ten (10) Essential PH Services involve the Assessment of the Communities Health or the Programs involved in addressing the problems and rely on reliable data collection and the professional ability to assess the data and turn it into meaningful and powerful information for policy makers and the general public. CHA 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 and epidemiologic analysis are the keys in engaging community members in the discussion and planning for community health improvement.

Currently, 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. Investment in the CHA

infrastructure will help support good fiscal management and avoid duplication of services and careful articulation of gaps and emerging issues.

Impact:

Funding will establish a uniform statewide process for community health assessment. Comprehensive Community Health Assessment every four years, Annual State of the County’s Health (SOTCH) Report, and enhanced local capacity to respond to changing public health needs.

BUDGET	
85 LHD (x) 0.05 FTE Health Educator at the LHD (\$25,300)	\$2,150,000

3. LOCAL HEALTH DEPARTMENT ACCREDITATION – FUNDING TO MAINTAIN THE HIGHLY SUCCESSFUL PUBLIC HEALTH ACCREDITATION PROGRAM THROUGH ONGOING RE-ACCREDITATION CYCLES. (\$200,000)

Justification / Rationale:

The accreditation system put into place by the General Assembly has already made a difference for the 30 accredited local health departments. Their “accredited” status allows them to seek or enhance partnerships with other accredited health facilities, as well as offer new services and/or apply for new funding that is available only to accredited agencies. The quality and performance improvement processes put into place during accreditation have led to more efficient services. Boards of Health, County Commissioners and County Managers indicate that they have a better understanding of their role in promoting and protecting the health of their citizens. The legislation provided an eight year timeframe for all local health departments to become initially accredited, but only a four year term of accreditation; therefore, starting in FY08 the first accredited local health departments must seek re-accreditation. Since the legislation and Administrative Code provide for the same process to be used, there are “hard dollar” costs associated with that process that are not covered by the initial appropriation.

Impact:

These new funds will be used to cover the costs of the re-accreditation process for up to 10 local health departments each fiscal year. Those costs include: travel and other expenses for site visitors, additional meetings of the Accreditation Board, and additional staff time in processing the applications and coordinating site visits and Board meetings.

BUDGET	
\$200,000	

4. ELIMINATE HEALTH DISPARITIES

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

Justification / Rationale:

Statewide trends in racial and ethnic health disparities in North Carolina have been recognized due to national surveillance systems; however, reliable race and ethnicity health data is not available for the state at a community level. Health disparities are of ever increasing importance in the state, especially given that North Carolina has the fastest growing Hispanic population in the country and North Carolina's Asian population doubled between 1990 and 2000. Mandating the collection and reporting of ethnic specific race indicators at the time of hospital discharge would allow the state to identify community specific health disparities and effectively and efficiently address those inequities.

North Carolina's Office of Minority Health and Health Disparities and the North Carolina State Center for Health Statistics acknowledged the significance of racial and ethnic health disparities when they published the "Racial and Ethnic Health Disparities Report Card" in 2003, 2005 and 2007.

- Data included in the report are limited to health outcome information obtained from death certificates
- The report can only identify health inequities at the state level and does not offer insight into community-specific issues
- Information is only available via broad racial and ethnic identifiers, such as 'Hispanic' and 'Asian', instead of specific countries of origin.

The value of racial and ethnic health information in North Carolina has been recognized officially by the state since 1999, yet the data has become increasingly difficult to obtain. Since 1996 the rate of missing information on race in hospital discharge data in North Carolina has risen over 33 percent. In 1996 the rate of missing information was 12.2 percent, in 2005 it was 45.3 percent

Impact:

It is critical that patient race and ethnicity data accurately reflect the populations that hospitals and clinics serve. This is important especially because the state, community leaders, research organizations and hospitals use these data to:

- Track illnesses by age, gender, race and ethnicity
- Assess disparities in healthcare services and outcomes
- Develop targeted programs and services that are culturally appropriate and responsive to individual needs of patients and help reduce/eliminate disparities
- Determine the degree to which hospitals are serving minorities in their communities and narrowing the gaps and disparities in service utilization of racial and ethnic groups
- Ensure the quality of hospital services and patient safety for all patients so everyone gets the highest quality care regardless of their racial or ethnic background

- Improve patient satisfaction and compliance for better health outcomes
- Prepare North Carolina to participate in federal quality improvement initiatives to address disparities
- Reflect positively on hospitals attention to quality of care for all of its patients in quality improvement initiatives
- Open dialogue about healthcare disparities between policymakers and the community
- Engage community leaders in efforts to mobilize around health disparity issues and to set health priorities for the communities

BUDGET	
Training of data intake workers	\$10,000

Expand the Community Focused Eliminating Health Disparities Initiative (CFEHDI) Grants to local programs. (\$3,000,000)

Justification / Rationale:

The 2007 General Assembly appropriated two million dollars (\$2,000,000) recurring and five hundred thousand dollars \$500,000 (non recurring to support the Community-Focused Eliminating Health Disparities Initiative (Ratified House Bill 1473, Section 10.22). The areas of focus on health status include infant mortality, HIV-AIDS and sexually transmitted infections, cancer, diabetes, homicides and motor vehicle deaths.

Impact:

The Community-Focused Eliminating Health Disparities Initiative (CFEHDI) provides grants-in-aid to local public health departments, American Indian tribes, and faith-based and community-based organizations to close the gap in the health status of African Americans, Hispanics/Latinos, and American Indians as compared to whites. These funds are also used to support one position to monitor, track, and evaluate grantees’ progress in meeting performance-based standards and outcomes established by the program. Additional funds are needed to expand this effort and support operating costs.

BUDGET	
CFEHDI	\$3,000,000 (recurring)

Increase the “scarce skill” incentive to hire bilingual staff from 5% to 10% potential salary adjustment. Increase local health department interpreter capacity to serve clients as required by Title VI. (\$2,650,000)

Justification / Rationale:

The North Carolina General Assembly appropriated \$250,000.00 to fund a program aimed at creating new full-time positions for interpreter services at the local health departments to enhance

their capacity to serve Limited English Proficient (LEP) clients. With the allocated funding, 11 health departments were awarded \$20,000.00 each year for a 3-year period beginning FY05/06. Local Health Departments (LHD) match this grant to create a full time position. An end-of-year report is requested from all the grantees to show their outcomes, challenges, and/or successes. During the fiscal year 2005/2006, the report showed that the new interpreters reached 7,506 LEP clients in a four-month period. The 2006/2007 end of year report showed that the interpreters reached 35,174 clients, an average of 2,951 clients reached per month.

Although the addition of language interpreters is an important step in addressing the health care needs of those individuals who are LEP clients, it is recognized by the health care system that ideally, the ability to hire bilingual staff and health care providers is preferred. Because of the scarce availability of bilingual workers in the health care industry, most employers, including government, offer a “scarce skill” salary adjustment. In the current North Carolina personnel system, an adjustment of up to 5% of salary offer to recruit workers with bilingual skills is allowed. Due to the high level of competition for workers with bilingual skills, it is recommended that this allowance be increased to 10%.

Impact:

Increasing the potential “scarce skill” salary adjustment for recruiting bilingual workers will create efficiency in service delivery and reduce the need for interpreters.

Expanding the program statewide for interpreters would be beneficial to LEP clients and address federal requirements. In order to expand the program statewide, additional funding is being recommended to include one FTE for the 74 LHDs that are not currently funded and to supplement the 11 positions currently in place. It is a federal mandate to comply with the 1964 Civil Rights Act, Title VI.

BUDGET	
■ Local Health Department Based Interpreters	
74 @ \$33,000 Salary+ Fringe	\$2,442,000
11 @ \$13,000 Salary+ Fringe	\$143,000
(Recurring appropriation of \$220,000 supports 11 current positions \$20,000/position)	
■ LEP Title VI Coordinator 1.0 @ \$65,000 Salary+ Fringe	\$650,000
Total Appropriation Required	\$2,650,000

5. WORKFORCE DEVELOPMENT – ASSURE THE ABILITY TO RECRUIT AND RETAIN AN ADEQUATELY TRAINED AND COMPETENT PUBLIC HEALTH WORKFORCE. (\$1,000,000)

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

Justification / Rationale:

Current North Carolina statutes forbid state and local government retirees from returning to state or local government employment in a “temporary, part-time, substitute, or contractor service at any time during the six months immediately following the effective date of retirement.” Such employment restrictions inhibit the ability to rehire public health workers at the state and local levels during a time in which it nationally recognized that public health occupations are experiencing a workforce shortage crisis. (Public Health Workers Shortage – Trends Alert, The Council of State Governments Pub. 2004) If state and local public health workers could return to government service immediately following retirement without negatively affecting their retirement compensation, many would extend their work career and help during a time of workforce crisis. This lack of flexibility in state personnel policy pose a significant constraint for local and state public health hiring managers, resulting in the loss of many experienced professional, technical and scientific positions to retirement. State and university studies show that approximately 45% of the public health workforce will be eligible to retire over the next three years. Although many of these retired public health workers will continue in the workforce elsewhere, state and local government miss the opportunity to hire them because current statutes prohibit their continuing to work for their former agencies without penalizing their retirement pay. As with public education, when there is a crisis of skilled and highly trained workers available for critical services, public health agencies must be allowed to rehire retired workers without penalizing their retirement pay, and without a six-month prohibition against hiring retired public health workers. Some states, such as South Carolina, may offer a workable model whereby retired state and local government workers, as well as teachers, are allowed to retire and return to government employment at 100% time (while the workers retirement pay goes into an annuity). Such options should be explored for North Carolina to address the crisis in the public health workforce.

Impact:

The positive impact of exempting state and local public health retirees from the requirement to wait six months before they are eligible to return to work full time without negatively impacting their retirement benefits, would be that jobs critical to the safety and protection of the public could be filled during a time of public health worker shortages. This exemption would then allow the public health system time to recruit and rebuild the flow of new workers necessary for future service to state and local public health.

BUDGET
None

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

Justification / Rationale:

Creating a public health loan repayment program would significantly improve the ability of state and local public health agencies to recruit critically needed public health workers. The opportunity for some type of college loan repayment is often cited by new graduates as a prime incentive for job acceptance. Service to state/local agencies for loan repayment for a specified period of time will be required in return.

Impact:

The ability to recruit and retain public health workers will significantly improve the state’s ability to deliver the ten essential services of public health and better ensure our ability to protect and improve the health of our citizens. This recruitment tool is particularly necessary during a period of workforce shortage and high competition for public health workers.

BUDGET
\$1,000,000 Loan Repayment Fund

6. SEEK TO REUNITE STATE LEVEL PUBLIC HEALTH AND ENVIRONMENTAL HEALTH IN THE DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES.

Justification / Rationale:

The Division of Public Health moved from the Department of Environment, Health and Natural Resources (DEHNR) to the Department of Human Resources (DHR) in 1997. Both of these Departments were renamed at that time to the Department of Environment and Natural Resources (DENR) and the Department of Health and Human Services (DHHS). The goal was to create a “mini” health agency within DHHS that would include Medicaid, Mental Health, Public Health, Facility Services and Rural Health. This goal was not achieved for a variety of reasons. The end result of the reorganization after attempting to make this arrangement successful for the past 10 years is that there are tremendous challenges at the local level in having to work with two state agencies to accomplish their work.

Impact:

- Public Access and Understanding - Provides greater clarity for the public in seeking information, alerting state officials of problems or raising issues of accountability about issues related to health and the environment. Provides one point of access for legislators who have oversight of environmental issues and also must answer questions raised by constituents
- Organizational Efficiencies - Creates efficiencies at the local level in that the local health departments, boards of health and county commissioners only have to deal with one state agency for health policy, rulemaking, administration and oversight.

- **Simplifies administration:** Eliminates the amount of coordinating time needed between the Secretaries of DENR and DHHS and the Division Directors for DEH and DPH. Provides clarity for the Attorney General’s Office whose attorneys often find themselves working with dual staffs to resolve an issue. Builds on the accountability and capacity issues that are identified in the accreditation process at both the local and the state levels.
- **State Level Organizational Efficiencies -** Enables a more balanced workload among state agencies as the DHHS is approximately 20,000 FTEs and DENR is approximately 4,000 FTES. (The Division of Public Health is approximately 2200).
- **Program Efficiencies -** Provides a more comprehensive response to human health risks such a childhood lead, lead in the drinking water, other toxins in the environment, asbestos. Aligns drinking water issues—onsite and public water supply—with expertise in the Division of Public Health. Provides increased support by the Public Health Laboratory for a variety of environmental health issues—hazardous waste, water, radiological. Makes the investigation of food borne outbreaks much simpler—this response is already shared between three agencies—Agriculture, DENR and DHHS (DPH) -- so the response to food outbreaks would be simpler. Provides for increased collaboration around injury prevention: example is the swimming pool program which has an enormous impact on drowning deaths particularly of children which is still a leading cause of injury deaths for children in NC.
- **Policy Development -** Allows for more effective development of a common legislative agenda. Examples include the legislation passed on wells, embargo authority, preventing E-coli transmission at the State Fair. Simplifies rulemaking. The Commission for Public Health already makes the health related rules for the Division of Environmental Health. Consolidation would streamline the process. Past experience of DPH in DENR has shown that the important working relationships and collaborations with DHHS are actually strengthened in that two Secretaries are now responsible for assuring that personal health care services for those who need government support are advocated for.
- **Preparedness and Response -** Simplifies the response to a disaster. Examples include most recently the Apex Fire Response. In addition, could capitalize on a variety of expertise shared between the epidemiologists in public health and the skills of environmental health specialists—another recent example was the Castleberry recall of products where the local environmental health specialists in the local health departments pulled more damaged cans from shelves than all other states combined but the coordination at the state level could have been simplified.

BUDGET
No new appropriations.

7. SUSTAIN THE CURRENT STRUCTURE AND GOVERNANCE FOR THE LOCAL PUBLIC HEALTH SYSTEM AS SET OUT IN THE NORTH CAROLINA GENERAL STATUTES, CHAPTER 130A, ARTICLE 2.

Justification / Rationale:

The current statutory language provides several options for the structure of local public health, all of which assure a clearly recognizable entity at the local level with authority and responsibility for public health as well as a Board that is composed of individuals who see promotion and protection of the public’s health as their primary role. Local attempts to find other ways to provide “governance” for local public health could jeopardize the ability of the local health department to act quickly and decisively during times of crisis, such as a pandemic flu or natural or man-made disaster, and are not in the best interests of North Carolina’s citizens.

Impact:

Not allowing other options (i.e., re-affirming the current statutory requirements) is the best way to assure protection of all North Carolinians from public health threats.

BUDGET
No new appropriations.

Reduce the Burden of Chronic Diseases (\$18,958,000)

8. REDUCE OBESITY – FUND AND SUPPORT LOCAL HEALTH DEPARTMENTS AND LOCAL HEALTHY CAROLINIANS PARTNERSHIPS OR OTHER COALITIONS TO IMPLEMENT “EAT SMART AND MOVE MORE”, NC’S PLAN TO PREVENT OVERWEIGHT, OBESITY, AND RELATED CHRONIC DISEASES. (\$10,000,000)

Justification / Rationale:

Chronic diseases can be prevented and their health care costs can be controlled. Together with tobacco use, physical inactivity and poor diet are the underlying cause of chronic diseases such as heart disease, stroke, diabetes and cancer and they are the leading preventable causes of death in North Carolina and the United States. Child and adult obesity rates have reached epidemic levels across our state and are the direct cause of a parallel epidemic of diabetes. In 2004, obesity cost the state \$2.1 billion dollars in medical costs including \$662 million to the state Medicaid program.

An impressive body of scientific evidence now supports interventions to increase physical activity and reduce obesity. This proposal supports evidence-based local and statewide interventions outlined in the in the Eat Smart Move More NC plan and supports the creation and support of local coalitions like Healthy Carolinians. These broad based interventions target changes at the intra-personal, inter-personal, institutional, community and public policy level.

Community-based Programs

- Improve and increase the number of sidewalks, greenways, trails, pedestrian crossings and bike lanes by working with state and community partners, thereby promoting physical activity to prevent obesity and related chronic disease.
- Provide technical support and training to small businesses implementing worksite wellness programs.
- Expand Farmer’s Markets and community gardens thereby increasing access to fruit and vegetables.

School-based Programs

- Provide technical assistance for the implementation of the federally mandated school district local wellness policies that make healthy food, drinks, and physical activity a priority for school-age children and youth.
- Support DOT safe routes to school campaign

Medical Setting

- Develop Medicaid and state employees health plan coverage for medical nutrition therapy and Eat Smart, Move More, Weigh Less programs (“NC weight watchers”) for at risk children and families

Social Marketing

- Implement a state-wide social marketing and media campaign targeting families with at least one child in the home to change social norms and behavior around healthy eating and physical activity

This proposal also includes resources for three large-scale community demonstration projects designed to pilot specific resource-intensive interventions (BMI reporting in schools, matching funds for capital improvement projects, tax incentives for worksite wellness programs) and establish best practices for other communities in NC.

Impact:

- Increase the number of documented policy and environmental change activities that support healthy eating and physical activity opportunities for all North Carolinians by fostering supportive policies and environments (NC Progress Check database)
- Increase the percentage of North Carolinians who are at a healthy weight (BRFSS, CHAMP)
- Increase the percentage of North Carolinians who consume a healthy diet (BRFSS, CHAMP)
- Increase the percentage of North Carolina adults and children ages 2 and up who participate in the recommended amounts of physical activity (BRFSS, CHAMP)

BUDGET	
■ Funding to communities:	
Local Health Departments	\$5.2 million
Healthy Carolinians	\$1.8 million
■ Funding for 3 community demonstration projects:	
Statewide Social Marketing Campaign	\$1 million
State technical assistance and materials	\$275,000
■ FTEs: Public Health Consultant (3.0 FTE)	
	\$225,000
Total	\$10,000,000

9. IMPROVE CRITICAL HEALTH SURVEILLANCE AND ACCOUNTABILITY - EXPAND AND IMPROVE DATA COLLECTION, ANALYSIS AND DISSEMINATION TO BETTER MEASURE HEALTH THREATS, ESTABLISH PRIORITIES, AND SECURE ADDITIONAL FEDERAL FUNDING AT THE STATE AND LOCAL LEVEL. (\$3,721,000)

Justification / Rationale:

Surveillance and Accountability - A cornerstone of good public health practice is sound health surveillance utilizing the best available data to make the best evidence-based decisions that benefit the most people. The range of data needs to provide a solid scientific basis for public health decision making and a vital resource for competitive federal grant applications. Information technology advances make more and better data available on a much timelier basis, however public health lacks sufficient capacity to collect and analyze even the existing data. Establishing a common set of indicators is necessary to provide a clear statement of public health business, monitor the health of the state, manage state/local resources, implement statewide plans and adequately correlate resources to high priority issues. Given the significant increase in preventable chronic diseases in North Carolina, behavioral health data systems must be expanded and improved to

better target interventions and track progress. Building additional epidemiology capacity at the state level will ensure that consistent quality data is available to all counties.

Public Health Informatics - An unprecedented need exists to enhance the skills of the public health workforce in the area of public health informatics. It is estimated that the immediate job gap of skilled PH informaticians is 1000 positions nation wide. Greater skills are needed to manage public health information systems, to turn complex data into useful information and to develop the business plans and systems needed to assure financial sustainability. New systems such as the applications of the Public Health Information Network will require sophisticated expertise to manage the systems and those who use these systems at the local level will require informatics training to facilitate usage.

Individual medical records are rapidly moving from a paper-based to electronic medical record. An electronic health record (EHR) represents the continuous medical record across the continuum of care for the lifetime of an individual. EHRs contain certain data elements that are essential for public health practice. Examples include notifiable diseases and conditions, chronic disease management, and preventive measures such as immunizations. Health Information Exchange (HIE) between the EHR and Public Health systems (such as cancer registries, immunization registries, and reportable disease surveillance systems) requires proper governance of organizations, and many states have enacted or are considering legislation to establish separate authority for public-private eHealth initiatives. A common thread in many legislative activities is public health's leadership role in HIE initiatives with the private healthcare sector. Public health's vision, leadership and participation are critical to successful HIE implementation. Public health is well suited to be the enabler in the health information network framework for the development of a seamless and interoperable EHR system that lays the groundwork by bringing together public and private stakeholders in a partnership to foster common data standards, cooperative arrangements, and interoperability. Public health provides a neutral party interest and already has a footprint in every community. Public health provides an honest broker that all stakeholders, including hospitals, providers and the public can trust.

- Expand BRFSS (Behavioral Risk Factor Surveillance System) to provide local data by state legislative district, implement statewide CHAMP (Child Health Assessment and Monitoring Program)(\$400,000), and increase user functionality of the website(\$50,000). Improve reporting practices for race and ethnicity data (\$10,000). Increase state capacity to analyze and disseminate chronic disease data. (\$85,000)
- Fund the ongoing operation of CATCH (Comprehensive Assessment and Tracking of Community Health), a new web-based system for compiling and reporting community level health assessment data locally (\$150,000)
- Fund the necessary expansion of the NC Cancer Registry. (\$600,000)
- Develop and implement a surveillance system for child maltreatment. (\$326,000)
- Build undergraduate, graduate, and certificate training programs in the new science of Public Health Informatics at established NC educational institutions. (\$2 million)
- Seek legislation to create a separate authority to govern critical eHealth initiatives including the Public Health Information Network and other health information exchanges/applications that directly impact the quality of healthcare and improve health. (\$100,000)

Impact:

- Assure North Carolina’s State Center for Health Statistics remains at the forefront of state health statistics programs
- Positively influence decision-making and health policy, thereby improving the health of all our citizens, by collecting and disseminating high-quality information on the health of North Carolinians
- Provide accessible, high quality health information through the DPH web site and through special health data reports, published as state government reports and in reputable peer-reviewed journals
- Prepare the NC workforce for the new field of Public Health Informatics
- Provide independent governance for eHealth initiatives to partner with private entities to establish public-private Regional Health Information Organizations
- Allow Health Information Exchange among electronic health records and public health information systems

BUDGET	
■ Funding for state center data systems:	\$355,000 (R)
	\$ 50,000 (NR)
FTEs: Statistician (1.0)	\$ 65,000
PH Epidemiologist (1.0)	\$ 75,000
■ Funding for CATCH (UNC Charlotte)	\$150,000
■ Funding for Cancer Registry	\$150,000
FTEs: 2 Social/Clinical Research Assts	\$125,000
5 Social/Clinical Research Spec.	\$225,000
2 Business/Technology Analysts.	\$100,000
■ Funding for child maltreatment surveillance	\$326,000
FTEs: PH Epidemiologist (2.0)	\$150,000
■ Funding for training programs (UNC SPH)	\$2,000,000
■ Funding for eHealth Authority	\$ 20,000
FTE: Program Coordinator (1.0)	\$ 80,000
Total	\$3,721,000

10. REDUCE THE LEADING CAUSES OF DEATH – EXPAND PATIENT SELF-MANAGEMENT OF THE RISK FACTORS ASSOCIATED WITH INJURY, CANCER, HEART DISEASE, STROKE AND ASTHMA INCLUDING HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, DIABETES AND TOBACCO CESSATION ACROSS THE STATE. (\$5,237,000)

Justification / Rationale:

Heart disease, stroke, diabetes, asthma and cancer are responsible for the deaths of 15,000 North Carolinians each year. The prolonged course of illness from diseases such as heart disease and stroke, cancer, diabetes, and asthma result in extraordinary direct and indirect costs, pain and suffering, poor quality of life, and disability for millions of Americans. More effective treatment of existing chronic diseases is important. Treatment of diabetes, hypertension and high cholesterol can decrease the burden of debilitating conditions like stroke and chronic kidney disease. Low health literacy is a significant barrier to effective treatment. It is associated with poor understanding of written or spoken medical advice, reduced adherence to medical recommendations and adverse health outcomes.

Injuries are a frequently overlooked cause of death and disability in North Carolina. They are the leading cause of death in North Carolina residents ages 1 through 44 and the 4th leading cause of death for all ages. Most injuries are preventable through policy, environment and educational interventions. Fall-related injuries are a particular problem in North Carolina. Unintentional deaths from falls among older adults were 47.6 in comparison with 39.2 for the US as a whole.

We must begin to invest adequate financial and public policy resources to reduce the significant burden of chronic disease in North Carolina. This proposal supports evidence-based local and statewide interventions and supports the creation and support of local coalitions like Healthy Carolinians. It also draws from the recent recommendations of NC Institute of Medicine reports of the Health Literacy Task Force and the Chronic Kidney Disease Task Force.

Expand efforts to address Health Literacy issues across the state based on the 2007 recommendations of the NC IOM Health Literacy Task Force

- Funding and position for a state health literacy consultant to provide technical assistance to local health departments and Healthy Carolinians partnerships on health literacy strategies and skill development. The position will also develop standardized literacy criteria to guide the development of all written, audio and electronic consumer public health information materials used by all DHHS funded programs. (\$100,000)
- Funding for three lay health advisor demonstration projects to promote improved health literacy and prepare patients and their families for provider-patient interactions through individual support, group interactions and community-based advocacy and systems change efforts in each of the CVD regions in the state. (\$900,000)
- Funding for a broad-based social marketing campaign to activate consumers to engage in dialogue with their health care providers to help mitigate the effects of low health literacy. (\$1,500,000)

Expand efforts to prevent Chronic Kidney Disease by targeting the prevention and control of the major risk factors, diabetes and hypertension based on the 2008 recommendations of the NC IOM Chronic Kidney Disease Task Force

- Funding to the Division of Public Health to expand diabetes prevention and control funding to increase outreach in existing counties and to expand to other counties. These programs will include new efforts to educate at-risk populations about CKD and the importance of early screening. (\$500,000)
- The North Carolina General Assembly should provide funding to the Department of Health and Human Services to expand the DPH Diabetes Education Recognition Program. (\$150,000; \$300,000; \$450,000)

Strengthen the NC Asthma program by offering increased coalition building funds for Healthy Carolinians partnerships and local asthma coalitions

- Funding for four additional local awards at \$35,000 per award (\$140,000)
- Offer higher award amounts to existing awardees who demonstrate a high level of interest in building their coalition (\$132,000)

Cancer Prevention

- Funding for adult calls to the Tobacco Quit Line (\$1,500,000)
- Legislation to establish smoke-free worksites

Injury Prevention

- Legislation to improve passenger safety in pick-up trucks.
- Legislation to collect blood samples from patients in hospital emergency departments suspected of or confirmed with unintentional drug overdoses.
- Legislation and funding to establish a falls coalition to a recommend policy, environment and public awareness interventions to reduce falls, particularly in high risk groups like the elderly. (\$25,000)

Impact:

- Improve community capacity to address chronic diseases locally (Progress Check)
- Increase levels of public understanding of related risk factors and signs and symptoms of chronic diseases (BRFSS, CHAMP)
- Increase the percentage of citizens who report that their high blood pressure, cholesterol, diabetes or asthma is adequately controlled. (BRFSS, CHAMP)
- Increase rates of tobacco cessation. (BRFSS, CHAMP, YTS)
- Decrease North Carolinians exposure to second hand smoke (BRFSS, CHAMP)
- Decrease deaths from unintentional injuries (Mortality reports)

BUDGET	
■ State funding	\$1,610,000
FTEs: Health Educator (1.0)	\$65,000
PH Consultant (5.0)	\$ 375,000
■ Local Funding	\$1,672,000
■ Funding for Quit Line	\$1,500,000
Total	\$5,237,000

Support Healthy Children and Families (\$48,294,000)

The goal of every family is to see its children succeed, and every successful society wisely invests its resources to see that this goal is achieved. Implementation of the following recommendations will help our state move closer to our goal of supporting families to achieve success for all children.

11. IMPROVE IMMUNIZATION RATES FOR RECOMMENDED VACCINES – FULLY FUND THE NC UNIVERSAL IMMUNIZATION PROGRAM. (\$27,000,000)

Justification / Rationale:

The General Assembly has determined that providing all vaccines required by the state free of charge to all children, regardless of family income, is sound public policy. Several reasons support this public policy. First, universal provision of required vaccines has been shown to effectively increase immunization rates. Second, universal provision of required vaccines is sound public policy because it helps protect members of the public who would otherwise be vulnerable to morbidity and mortality due to preventable communicable diseases. Third, immunizations are among the most cost-effective activities engaged in by government, saving \$15 for each \$1 spent. Fourth, universal provision of required vaccines is a strategy that helps keep children in their medical home, a key public health and medical goal.

At the present time, there are five childhood vaccines recommended by the CDC which cannot be provided universally in North Carolina because of insufficient funding. They are: influenza vaccine, PCV7 (“pneumococcal”), rotavirus, MCV4 (“meningococcal”), and HPV (human papillomavirus). While federal funding is available to provide these vaccines to children enrolled in Medicaid and selected other groups, there are insufficient state funds to provide these vaccines universally.

While vaccines are among the most cost-effective interventions in health care, the ongoing development of effective but costly new vaccines creates a great challenge to policymakers who strive to sustain a universal vaccine program in North Carolina. All the newly introduced vaccines carry high price tags: the HPV vaccine series costs about \$360 per series. While federal funding is available to the state to provide these vaccines, the substantial costs of these new vaccines have prevented the immunization program from being able to offer them to all North Carolina children.

In the past, DPH has sought additional state appropriations to support the cost of providing the recommended vaccines to all children. Although the General Assembly has been very supportive of vaccine funding, the costs of the new vaccines have outstripped the funds appropriated. DPH estimates that the funding needed to provide these vaccines in was approximately \$27 million.

While the main beneficiaries of the universal program are the people of the state, insurance companies doing business in North Carolina also benefit from the presence of a program that provides critical services to persons enrolled in private insurance plans free of charge to these insurers. Cost of vaccines, especially at the retail level, are significantly higher than those purchased by the state on a federal contract. Therefore, legislation that secured a small percentage of each commercial insurance premium to defray the costs of universal vaccine provision would be equitable and would provide a reliable source of ongoing funding to support the universal provision of vaccines.

Impact:

Increased immunization rates and reduced disease rates.

BUDGET	
Purchase vaccines	\$27,000,000

12. IMPROVE BIRTH OUTCOMES (\$2,115,500)

Overall Justification/Rationale for Improve Birth Outcomes

While infant mortality in North Carolina has decreased to a historical low of 8.1 deaths per 1,000 live births in 2006, the state’s rate remains among the highest in the country. Approximately two-thirds of all child deaths occur in infancy. In addition, many childhood and even adult morbidities arise in or are influenced by prenatal and infant development, so improving birth outcomes is a critically important issue.

Over the past several decades, marked improvements in birth outcomes have been achieved in North Carolina and in the United States as a whole. More recently, however, improvements in birth outcomes have slowed, and, in some respects, have deteriorated. During this entire period, marked disparities in birth outcomes between rich and poor and among racial and ethnic groups have persisted, and even widened in some instances. These poorer birth outcomes and disparities in outcomes have occurred despite substantial improvements in access to prenatal care.

To a substantial degree, improvements in birth outcomes in recent decades have been attributed to improvements in neonatal intensive care, which have improved birthweight-specific mortality and morbidity rates for decades. For many years, these birthweight-specific improvements have overridden static and now deteriorating prematurity and low birthweight prevalence. The evidence of recent years suggests that the capacity of neonatal intensive care interventions to continue to improve birth outcomes appears to be quite limited.

As substantial progress in our ability to “rescue” profoundly ill infants has slowed, it is clear that strategies focused on reducing the prevalence of premature births, low birthweight births, birth defects and other causes of profound illness in infants (eg. maternal chronic disease, smoking, obesity/diet/fitness, use of teratogens) must come to the forefront. By their very nature, these problems must be addressed before the beginning of pregnancy, in many instances years before pregnancy. We need to begin to address many of these issues in childhood and adolescence. It is also clear that addressing these problems will benefit not only women intending to become pregnant, but all women. Our strategies should include population-based initiatives as well as indicated interventions for children, teens and women who have specific needs.

Public Health Task Force 2008 members are firmly convinced that one key to improving birth outcomes is to recognize the critical importance of strategies that promote the wellbeing of women across the lifespan. Without denigrating in any way the importance of timely, evidence-based

prenatal care, committee members firmly believe that effectively promoting the health of girls and women is key to reducing infant mortality and morbidity.

Complete a comprehensive North Carolina plan to improve the health of women of childbearing age based upon the national CDC guidelines and begin implementation. (\$75,000)

Extend disease case management services to women who are at high risk for poor birth outcomes and whose income is at or below 185% FPL. Begin with women previously delivering very low birth weight infants and enrolled in Medicaid or Family Planning Waiver. Increase the percentage of these women receiving a postpartum visit and annual preventive health follow-up visits for two years after delivery. Cover medical services as needed to reduce the risk of a future poor birth outcome (cost to be determined).

Increase health care coverage among low income women of childbearing age by expanding limited Medicaid coverage to low income parents (cost to be determined).

Justification / Rationale:

Many health risks occurring prior to pregnancy have been identified as harmful to women and their infants, including alcohol misuse, obesity, smoking, closely spaced pregnancies and exposure to sexually transmitted infections. Women, who have already had a preterm birth or low birth weight baby, are at significantly higher risk of having another poor pregnancy outcome. Many North Carolina women of childbearing age have risk factors for chronic disease. Almost half of the pregnancies ending in live birth are unintended, and this also increases the risk for poor pregnancy outcomes.

Most pregnant women receive adequate prenatal care in North Carolina. However, this care is not sufficient to overcome many poor health behaviors and conditions existing prior to pregnancy. Racial disparities in maternal health status are associated similar disparities in birth outcomes. For example, obesity and high blood pressure are more twice as prevalent among 35-44 year old African American women as compared to white North Carolina women. Similarly, the infant death rate and low birthweight rate for African American infants is more than twice that of white infants.

Following pregnancy and delivery, concern for good health and health practices often shifts from mother to infant. Low income women in North Carolina often put their own health needs secondary to those of their family. Obtaining preventive health services is difficult for many low income women who lose their Medicaid coverage two months following during delivery and are uninsured. Postpartum problems such as maternal depression can have a devastating effect on both mother and child, but when low income women lose their health insurance, these problems often go undiagnosed and untreated.

The Centers for Disease Control and Prevention published *National Recommendations for Preconception Health and Health Care* in April, 2006. A recent North Carolina report, *Looking Back, Moving Forward*, describes these national recommendations, reviews past efforts within North Carolina to improve the health of women prior to pregnancy, and lists current opportunities for improvement. Based upon these two reports, a North Carolina action plan to improve the health of women prior to pregnancy is under development.

Impact:

The health of low income women will be improved, health disparities will be reduced and birth outcomes will be improved.

BUDGET	
Comprehensive Planning	\$75,000
In addition, the cost of the proposed Medicaid expansions is to be determined.	

Expand utilization of 17-Hydroxy Progesterone for low income women to reduce pre-term births. (\$97,000)

Justification/Rationale:

One out of every eight babies in North Carolina will be born too soon, making preterm birth a leading underlying cause of infant morbidity and mortality in North Carolina. The causes of preterm birth are complex. New research has shown that women who had a previous preterm birth and receive weekly shots of a derivative of the hormone progesterone (17-hydroxyprogesterone, or 17P) reduce their risk of having another preterm baby by over 33%. Other women have the degree of prematurity of their pregnancy reduced, improving birth outcomes and reducing neonatal complications.

As of April 2007, Medicaid is covering 17P as a cost-effective intervention that can save the state over \$6 million each year. Additional funding is needed to help educate community-based health care providers about 17P and to provide 17P for low income women ineligible for Medicaid.

Impact:

Preterm births will be decreased by using an evidence-based clinical intervention.

BUDGET	
Purchase Pharmaceuticals	\$97,000

Expand/strengthen current statewide initiatives addressing SIDS risk reduction, Safe Sleep, and secondhand smoke exposure for women of reproductive age and their families. (\$250,000)

Justification/Rationale:

SIDS remains the third leading cause of infant mortality, after prematurity and birth defects, and accounts for approximately 90-100 deaths each year in North Carolina. Evidence-based infant sleep positioning has clearly been shown to reduce the number of SIDS deaths. However, the rate of deaths due to SIDS continues to be higher in North Carolina than the national average. In addition, in the last three years, infant deaths relating to accidental asphyxiation have more than doubled in our state.

Research shows that mother’s exposure to secondhand smoke during pregnancy and baby’s exposure after birth, increases a baby’s risk of being born at a lower birthweight, dying from SIDS, and experiencing increased acute and chronic respiratory problems.

NC data (PRAMS) show that many women who quit smoking during pregnancy resume smoking after their baby is born. Almost 50% more women were smoking three months after their baby is born than smoked during the last trimester of pregnancy. (25% smoked before pregnancy, 13% during last 3 months of pregnancy, 21% smoked after pregnancy).

Funds will be used to provide: Resources for the expansion and implementation of messages and materials for an ongoing SIDS/Sleep Awareness campaign, which will highlight safe sleep practices and increase public awareness of ways to decrease secondhand smoke exposure in homes and cars. The program will work through existing partnerships. A media campaign will be launched in a later phase.

Impact:

Infant deaths due to SIDS and accidental suffocation will be reduced using an evidence-based intervention.

BUDGET	
SIDS/Sleep Awareness Campaign	\$250,000

Add cystic fibrosis screening to the universal newborn screening panel. This initiative can be supported by State laboratory of Public Health (SLPH) receipts (\$767,000) and appropriations (\$160,000).

Justification/Rationale:

Cystic Fibrosis is an inherited disease that causes chronic breathing problems and lung infections as well as digestive problems resulting in impaired growth. Although medical advances have substantially increased the lifespan of persons with CF and although some persons are affected less severely than others, CF is still a significant cause of morbidity and mortality in childhood. Affecting one in 3300 births nationally, CF is the most common lethal genetic disease in the Caucasian population, and affects minority populations as well.

Cystic Fibrosis (CF) newborn screening is strongly recommended by the March of Dimes, the American College of Medical Genetics and the North Carolina medical community as one of the most serious genetic disorders to be screened at the newborn period. Recent clinical studies have indicated that early diagnosis of CF through newborn screening combined with high quality clinical follow-up do reduce the burden of disease in affected individuals. North Carolina has a reputation as a leader in newborn screening, but the absence of CF screening from the state panel of tests is problematic.

The Division of Public Health proposes to add CF to North Carolina’s newborn screening panel. To do this requires an increased testing capacity in the State Laboratory for Public Health (SLPH) and an increased follow-up capacity in the Children and Youth Branch of the Women’s and Children’s Health Section. The increased testing capacity in the SLPH should be supported by legislation allowing an increase in the SLPH newborn screening fee. This fee should be used to offset the cost of the Newborn Screening Program and should be recomputed each time a new test is added to the newborn screening panel.

Impact:

Newborns with cystic fibrosis will be identified at birth, leading to better medical outcomes.

BUDGET	
■ Increase in SLPH fee from \$14 per child to \$16.20 per child	
SLPH Receipts	\$767,000
Appropriations	\$160,000

Make North Carolina a more “breastfeeding-friendly” environment in support of the Child Fatality Task Force recommendation.

Justification/Rationale:

It has long been acknowledged that breastfeeding throughout the infant year is a “best practice” to reduce infant mortality and morbidity, and to enhance growth and development. While 72% of new mothers in North Carolina initiate breastfeeding, only 34% are breastfeeding at 6 months and 18% at 12 months. Action should be taken to make North Carolina a more “breastfeeding-friendly” environment. Several strategies should be considered--involving hospitals, child care facilities, employers, schools, as well as a public awareness campaign--all with the intent of enhancing both the initiation and duration of breastfeeding in North Carolina.

Impact:

Increased rates breastfeeding initiation and continuation will result in improved infant and maternal health.

BUDGET	
None	

13. BUILD HEALTHY CHILDREN – IMPLEMENT AND EVALUATE EVIDENCED-BASED STRATEGIES THAT WILL HELP FAMILIES SUPPORT THE HEALTH AND WELLBEING OF THEIR CHILDREN, TO ACHIEVE THE GOAL “EVERY CHILD SUCCEEDS” (\$5,828,000)

Our future success as a state will be determined by how effectively we help our families raise successful children. Several strategies are critical in this regard, and they are detailed below. The common theme that unites these strategies is that they demonstrate that we value children, as our future, and we understand that families are the critical factor in a child’s success. We want to help parents acquire effective parenting skills. We want children to have access to health insurance. We want all children to be the results of intended pregnancies, born into families emotionally and financially well-prepared to nurture and support them. We want children not to be subject to corporal punishment in schools, and for serious child endangerment to be considered a felony. We want to identify innovative ways to meet the social and emotional needs of children.

Justification/Rationale:

The goal of every family is to see their children grow up healthy and successful, and that needs to be our goal as a society as well. Reports ranging from the landmark work “From Neurons to Neighborhoods” to work done by researchers from the Federal Reserve Bank support the conclusion that society’s investments in evidence-based, community-based family support initiatives pay great dividends. We need to commit to the goal that in North Carolina, “Every Child Succeeds”.

Thinking in the broadest terms, we envision a system in which all children and their families are assessed periodically and then offered services that are appropriate to their needs. To reach that goal, we need a spectrum of evidence-based, community-based family support resources which match the spectrum of needs identified—from little or no support for intact, functional, well-networked families to intensive, targeted support for families at the greatest risk for failure.

In addition to evidence-based, community-based initiatives, to be successful we need to create a state-level infrastructure that can support communities that undertake projects of this sort. Even an evidence-based, well-resourced community initiative is at high risk for failure if it is not adequately supported by an effective infrastructure.

Careful research has identified a number of programs with a strong body of evidence demonstrating effectiveness. This initiative will aim to support a range of these evidence-based, community-based family support initiatives. Evidence-based initiatives that may be supported through this initiative include Nurse Family Partnership, Incredible Years, Strengthening Families, and Triple P.

Appropriated resources would be used to support community-based initiatives using evidence-based models as pilots, as well as appropriate evaluations to demonstrate the impact of these initiatives. Effectiveness data from these pilots will be used to build a case for expansion, in order to achieve the ultimate goal of providing every family in North Carolina the support it needs to achieve the goal “every child succeeds.”

Impact:

Improved outcomes resulting from these programs include reduced social/emotional problems among children, improved parenting skills, improved prenatal health, reduced child maltreatment, fewer childhood injuries and improved school readiness for children born to mothers with low psychological resources.

BUDGET	
Funding for local projects	\$3,790,000
Evaluation	\$ 120,000
DPH Project Manager (1.0 FTE) and Operating	\$ 90,000
Total	\$4,000,000

Exploration of innovative strategies to support the social and emotional wellbeing of children through prevention, earlier identification and early intervention.

Justification/Rationale:

The mental health reform initiative in North Carolina has focused on the most serious forms of mental illness, which require the most intensive interventions. Less attention has been given to primary prevention, early identification, and early intervention, particularly with respect to children and families. For example, opportunities exist today to carry out universal childhood screening for social and emotional problems with validated tools, but this opportunity is oncompletely realized. Next, when this screening is actually carried out and a problem is identified, there are a number of barriers that make it difficult for a child and family to access appropriate services. One approach to this problem, pioneered by Community Care of North Carolina, is to integrate behavioral health services into the child’s medical home. Another promising approach is the Child and Family Support Team Initiative, which locates a nurse and social worker team in 100 high need schools to address, either directly or by linking to community resources, children’s social and emotional needs. In both these instances, the goal is to identify needs early and address them, before they progress to become more serious and more intractable problems. DPH should explore, with other stakeholders, other innovative strategies to both prevent social and emotional problems from occurring and to identify early and intervene early to address the social and emotional needs of children

Impact:

The social and emotional needs of children will be more effectively addressed

BUDGET	
None	

Reduce Unintended Teen Pregnancies using evidence-based strategies

Justification/Rationale:

Unintended pregnancies are pregnancies which are either mistimed (earlier than wanted) or unwanted at the time of conception. According to the CDC, approximately half of all pregnancies in the U.S. are unintended. Women of all ages may have unintended pregnancies, but some groups, such as teens, are at a higher risk. Unintended pregnancies are harmful for a variety of reasons. Unintended pregnancies are associated with an increased risk of morbidity for women and with health behaviors during pregnancy that are associated with adverse effects and poorer birth outcomes. For example, women with an unintended pregnancy may delay prenatal care, which may affect the health of the infant.¹ Beyond specific poorer health outcomes for mother and baby, unintended pregnancies often interrupt life goals and aspirations. They can help perpetuate an intergenerational cycle of poverty.

A comprehensive range of strategies should be implemented in North Carolina that will promote reproductive self-determination and reduce unintended pregnancies.

Preventing pregnancies among adolescents is an important strategy to improve maternal and infant health, increase school graduation rates, and reduce poverty. Research has shown that the most effective programs to prevent adolescent pregnancies are comprehensive ones that include a focus on delaying sexual behavior and providing information on how sexually active adolescents can protect themselves.¹³ North Carolina currently funds 62 TPPI community based projects. These projects use models that have been scientifically evaluated and shown to be effective. One-half of these TPPI projects serve only adolescent parents with the goal of preventing a second pregnancy and assuring graduation from high school. These parenting projects serve only a portion of the high risk population as 70 counties do not have a project. Funding for these 31 projects, frozen at \$47,980/year for many years, should be increased to \$65,000/year (\$528,000). Funding should also be appropriated to establish TPPI projects in 20 additional counties with the highest teen pregnancy rates and highest rates among minority teens (\$1.3 million).

Impact:

The Teen Pregnancy Prevention Initiative (TPPI) will be expanded to serve additional teens, who will experience lower rates of unintended pregnancy and higher rates of high school graduation than control teens.

BUDGET	
Funding to local TPPI Projects	\$1,828,000

Ban corporal punishment in NC schools

Justification/Rationale:

An important component of supporting families is to model in society appropriate methods of behavior management. One of the core goals of the Healthy Families Committee is to move toward a social norm that it is inappropriate to use violence against children. In this context, it is inappropriate to sanction as a state any form of corporal punishment of children in schools. There are many good reasons to ban corporal punishment in schools. Research indicates that paddling can and does result in injuries to children. Data shows that corporal punishment is disproportionately used on poor children, minorities, students with disabilities and boys. According to the American Academy of Pediatrics (AAP), corporal punishment may adversely affect a student’s self-image and school achievement and may contribute to disruptive and violent behavior. According to the AAP, alternative methods of behavioral management have proved more effective than corporal punishment. Finally, corporal punishment sends the wrong message to students—that violence is an acceptable means of resolving conflict.

Impact:

Corporal punishment will no longer be endorsed by the state as an appropriate form of punishment in NC schools.

BUDGET
None

Providing access to affordable health insurance for all children

Justification/Rationale:

It is critically important that every child in North Carolina have access to affordable health insurance. The Kids’ Choice program legislation enacted in the last session of the General Assembly will extend access to health insurance for all families earning less than 300% of the federal poverty level. In addition, increased federal funding of SCHIP is critically important to North Carolina’s efforts to insure low income children.

Impact:

Improved child health outcomes

BUDGET
No additional funding is requested.

Enacting a felony child endangerment law.

Justification/Rationale:

According to research done by the NC Child Fatality Task Force, North Carolina is one of only six states that do not have a felony child endangerment law. As a result, there is a gap in the range of options open to prosecutors when an adult endangers a juvenile. It is recommended that legislation introduced in the last session of the General Assembly be revised based on input from stakeholders and then enacted to create child endangerment legislation that will make it a felony to knowingly or with undue negligence place a child in harm's way.

Impact:

This legislation will give prosecutors more appropriate options in addressing child endangerment.

BUDGET	
	None

14. IMPROVE SCHOOL HEALTH – HEALTHY CHILDREN IN HEALTHY SCHOOLS ARE A CRITICAL COMPONENT OF ACADEMIC ACHIEVEMENT. (\$12,034,500)

Increase the School Nurse to Student Ratio to 1:750 through collaboration with the Department of Public Instruction (DPI) in five years. (Additional \$10.4 million recurring each year for five years)

Justification/Rationale: Increase the School Nurse to Student Ratio to 1:750 Statewide

Improving the ratio of school nurses to students is a critical element of the Healthy Schools Initiative. Children who miss school because of poorly controlled asthma, or who are in pain because of a cavity, or cannot concentrate in school because of domestic violence in the home are not on track to be academically successful. Healthy children in healthy schools are a critical component of academic achievement.

The NCGA has supported increasing the number of school nurses in recent years. Further progress toward the goal of a statewide ratio of 1 nurse per 750 schoolchildren will require substantial additional funding. DPH estimates that to achieve the 1:750 ratio in five years will require an additional appropriation of \$10.4 million in the first year and an additional \$10.4 million for each additional year, ending with a final year total of \$52.2 million (recurring).

Impact:

The health care needs of schoolchildren will be more effectively addressed and their capacity to achieve academic success will be enhanced.

BUDGET	
School Nurse Positions at the local level	\$10,400,000 (Additional \$10.4 million per year for five years, then recurring)

Require schools to provide age-appropriate, fact-based, medically accurate comprehensive sexuality education to all school children.

Justification/Rationale:

Each year, U.S. teens experience as many as 850,000 pregnancies, and youth under age 25 experience about 9.1 million sexually transmitted infections. By age 18, 70% of U.S. females and 62% of U.S. males have been sexually active. Comprehensive sex education is effective in assisting young people to make healthy decisions about sex and to adopt healthy sexual behaviors. No abstinence-only-until-marriage has been shown to help teens delay sex or to protect themselves when they do initiate sex, despite extensive research.

The American Medical Association (AMA), the American Nurses Association (ANA), the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), the American Public Health Association (APHA), and the Society of Adolescent Medicine (SAM), support responsible sexuality education that includes information about both abstinence and contraception. In addition, a study conducted by the North Carolina Department of Public Instruction in October 2003 found that the vast majority of North Carolina parents (more than 90.5%) thought sexuality education should be taught in the public schools.

Impact:

Students will receive medically accurate comprehensive sex education in schools to promote responsible reproductive health decision-making.

BUDGET
No new appropriations

Funding for five new school health centers at \$50,000 each for a total of \$250,000 and an additional \$750,000 for existing centers, both state-funded and non-state funded, to expand services and assure quality care. Fund one state position (\$85,000) to expand service, monitoring, credentialing and contract support to the 24 non-state funded centers and five new centers. (\$1,085,000)

Justification/Rationale:

Students perform better when they show up for class, healthy and ready to learn. School-based health centers (SBHCs) bring the physician’s office to the school so students avoid health-related absences and get support to succeed in the classroom.

The National Assembly on School Based Health Care issued a position statement in 2005 that reports on the relationship of SBHCs and Academic Performance. Based on a review of published research that studied the relationship between school-based health centers and academic performance, they conclude that:

- Research to date provides insufficient evidence to make generalizations about *direct links* between SBHCs and academic performance.
- Academic performance is negatively affected by factors such as substance use, emotional problems, poor diet, intentional injuries, physical illness, low self-esteem, risky sexual behavior, and lack of access to health care. High levels of resiliency, developmental assets, and school connectedness positively affect academic performance.
- As SBHCs continue demonstrating their impact on health and wellness outcomes, they have the potential to positively affect academic performance indirectly.

Currently, the Division of Public Health provides partial funding (\$1.56 million) for 28 school based centers across the state. These SBHCs are a collection of large, small, rural, urban, school based, and school linked centers. They are managed by 15 sponsors which include local health departments, local education agencies, hospitals, and not-for-profit medical practices. These SBHCs got their start with seed monies and now operate on a combination of state funds, federal funds, third party reimbursements from public and private insurances, and local funding. Altogether, they served 13,491 school children in SY 2005/2006.

The 28 centers funded by DPH report a total 2005/2006 budget from all sources as \$7,574,487.00. DPH provides approximately 20% of the total budget for the state supported centers. Fifty-four percent comes from receipts and community resources with the remaining 26% obtained through in-kind contributions.

Impact:

Additional students will receive high quality health care services at school-based and school-linked centers.

BUDGET	
Funding to local School Health Centers	\$1,000,000
1.0 FTE PH Program Manager and operating	\$85,000
Total	\$1,085,000

Establish the definition of quality physical education in NC schools.

Justification/Rationale:

Physical Education is an important part of the school curriculum and can provide children with life skills to live more healthy and productive lives. However, there is little consistency in school policies, curricula or staffing for physical education in NC schools. National standards exist and could be adapted for North Carolina. The National Association for Sports and Physical Education recommends a minimum of 150 minutes of physical education for elementary students, and 225 minutes for secondary students and requires two units of Healthful Living for graduation and PE electives available in all four years of high school. They also recommend Physical education

teachers have four-year degree in physical education and or board certification in physical education and recommend ideal student teacher ratios. A formal definition of physical education in North Carolina would provide schools with specific guidelines for curriculum development and qualifications for instructors.

Impact:

Development of high-quality physical education curricula in all schools

BUDGET	
None	

15. STRENGTHEN AND EXPAND THE STATEWIDE DENTAL PREVENTION AND EDUCATION PROGRAM FOR HIGH RISK CHILDREN. (\$1,316,000)

Enhance dental preventive and educational services for preschoolers before they develop expensive dental problems (\$766,500)

Justification/Rationale:

Over the last decade, the Division of Public Health has worked with Pediatricians and Family Physicians, the Division of Medical Assistance, the UNC Schools of Public Health and Dentistry and others to train physicians to provide preventive and educational services to infants and toddlers at high risk for tooth decay. Emerging evidence demonstrates that these early preventive services significantly reduce the need for expensive dental treatment services. Using grant funding, the Oral Health Section is developing new programs aimed at educating childcare providers and parents on ways to prevent tooth decay in very young children. Ten public health dental hygienists are requested to implement the new portions of this program in 10 high risk counties.

Impact:

BUDGET	
10 FTEs PH Dental Hygienist	\$707,500
One Time Expenses	\$85,000
Total	\$766,500
(Reflects draw down of almost \$1 of federal funds (FFP) for every \$3 of state appropriations)	

Improve the ratio of public health dental hygienist to elementary school children to 1:7000 (\$549,500)

Justification/Rationale:

This proposal strengthens and expands the statewide dental prevention and education program for high risk children, following Centers for Disease Control and Prevention (CDC) best practices. Tooth decay affects more children than any other childhood disease, in spite of the fact that it is almost entirely preventable. Almost 40% of North Carolina children have already had tooth decay by the time they start school. Recent studies indicate that periodontal (gum) disease may increase the risk of premature birth, low birth weight babies and cardiovascular disease in adults. Once dental disease occurs, it needs to be treated and this is expensive. No matter how many treatment resources for dental disease are established in the state, treatment alone cannot solve the problem. Difficulties in obtaining dental treatment services, particularly for the low income population, make it even more important to prevent this disease. In addition, North Carolina’s population has increased dramatically in the past few years, particularly in the minority populations that studies show have higher levels of tooth decay and gum disease. At the same time, the number of Oral Health Section staff to serve this population with dental preventive and educational services has decreased.

The Section strives to prevent dental disease and eliminate disparities in oral health, especially in children. Direct services provided by Section staff focus on tooth decay prevention and dental health promotion and education: preventive dental sealants, school-based fluoride mouthrinse, community water fluoridation, dental screening and referral for needed care, and data on dental health status of children. Six additional public health dental hygienists are requested.

Impact:

Current ratio 1 : 14,000

BUDGET	
■ 6 FTEs PH Dental Hygienist	
Operating	\$ 424,500
One Time Expenses	\$ 125,000
Total	\$ 549,500
Reflects draw down of almost \$1 from FFP for every \$3 of state appropriations.	

Prevent Communicable Disease and Strengthen Preparedness (\$18,400,000)

16. REINVESTMENT IN THE NC MEDICAL EXAMINER SYSTEM – FULLY IMPLEMENT THE STRATEGIC PLAN TO MODERNIZE AND PROFESSIONALIZE THE NC MEDICAL EXAMINER SYSTEM THROUGH REGIONALIZATION OF FACILITIES AND PERSONNEL. (\$12,800,000)

Justification / Rationale:

In 2001, a report was prepared by a NC Medical Examiner study group which had been sanctioned by the State Health Director and the Department of Health and Human Services to review the operation of the NC Medical Examiner system and make recommendations for improvements. This strategic plan called for the regionalization of medical examiner autopsy services as the most cost-effective model. The model was to insure that all medico-legal autopsies were performed by full time forensic pathologists sited at 5 strategically located facilities around the state, and that these facilities had capacity to handle decomposed remains and mass fatalities.

The two government entities currently performing autopsies, the Office of the Chief Medical Examiner (OCME) and the Charlotte Mecklenburg Medical Examiner's Office (CMMEO) are both in the process of building new state of the art facilities: Charlotte to open in 2008 and OCME in 2010 in Raleigh. The East Carolina University (ECU) facility is suitably equipped for storing a larger number of bodies and examination of decomposed remains. The Wake Forest University (WFU) and Onslow Memorial Pathology Group (OMH) have small facilities with limited body storage and the nature of their facilities is such that they cannot deliver a full range of services and must refer some cases to OCME.

WFU serving the western region is already staffed by forensic pathologists but needs a new facility on par with CMMEO. OMH is no longer strategically located and a new facility is needed in the southeast region of the state, probably Wilmington, to handle an estimated 500-600 cases per year. Autopsy fees (\$1000 per case) offset operational costs, however ECU, WFU and a new SE regional facility will need additional operational funds.

Impact:

The strategic plan to regionalize ME services will establish 5 centers across the state to perform medico-legal autopsies on a timely and accurate basis. For regional emergencies where mass casualties might occur, the facilities will have the capacity to manage and store larger number of bodies. For more routine operations, great reductions in the time needed to determine the cause of death of ME cases will be achieved. All sites will be able to analyze and conduct autopsies on decomposed remains. In addition, a single data base connecting all 5 facilities will greatly increase capacity to detect and respond to emerging public health threats, whether they are unintentional or intentional.

BUDGET: \$12.8 MILLION	
Non-recurring Construction of WFU and SE facilities	\$11.2 million
Operational funds to ECU, WFU and SE region	\$1.6 million
Receipts from autopsy fees	\$2 million
Total Appropriations	\$12.8 million

17. ADD ENVIRONMENTAL HEALTH SPECIALISTS TO LOCAL EPIDEMIOLOGY TEAMS TO ADDRESS ONGOING WORKLOAD DELAYS AND CRITICAL CAPACITY DURING DISEASE OUTBREAKS AND PUBLIC HEALTH EMERGENCIES. (\$5,600,000)

Justification / Rationale:

The Centers for Disease Control and Prevention estimates that 76 million Americans are sickened, 300,000 are hospitalized and 5,000 die from food related illness each year. An increasing number of our meals are prepared and consumed out of the home and an increasing number of disease outbreaks related to food are being identified across the country. Citizens depend on sanitarians employed by local health departments to help safeguard this food supply by regularly inspecting the restaurants. As North Carolina grows, there have been increasing demands on both the state and local sanitarian services to maintain food safety.

- A tremendous increase in the number of mobile food units that operate throughout the week as well as temporary food establishments that serve thousands on any given weekend.
- Increased demand for State and local environmental health staff to assist in the recall of foods that pose an imminent danger to the public health and to participate in the investigation of food-borne illness outbreaks.
- An explosion (the state’s Hispanic population grew by 400% from 1995 to 2000) of cultural changes in the composition of North Carolina’s population, bringing language barriers and ethnic foods into the mix. Training in cultural sensitivity, ethnic foods and languages have been added to the ongoing task of staying current on emerging food-borne illness pathogens.

The Division of Environmental Health in the Department of Environment and Natural Resources (DENR), with the assistance of the local health departments, administer and enforce the N.C. General Statutes and the sanitation rules of the Commission for Public Health. These mandated programs serve to protect the public health in the areas of: (a) Food Safety & Protection; (b) Dairy Protection; (c) Children’s Environmental Health; (d) Childhood Lead Poisoning Prevention; (e) Wastewater Treatment; (f) Private Wells Program; (g) Institutional Sanitation; and (h) Public Swimming Pools. As North Carolina grows, these mandated programs grow as well, increasing the demands on both the DEH and local health departments. In addition to food recalls, other emergency responses include public health safety and assessment following hazardous material releases (both unintentional and intentional). Building capacity through increasing the number of environmental health specialists on both the State and local levels is critical in order to provide mandated and emergency services that are fundamental to the protection of the public’s health.

Impact:

New funds will allow hiring of one new sanitarian (environmental health specialist) per county and 7 new FTEs in the State’s Food Protection Program to provide additional training and assistance to the local health departments. This number is to include a Food Safety Health Educator to coordinate training efforts and provide other education focused services.

BUDGET	
100 (x) 1.0 FTE Environmental Health Specialist (\$50,000)	\$5,000,000
7.0 FTEs Environmental Health Staff and operational costs for the State’s Food Protection Program (DENR) to provide additional training and assistance to the local health departments	\$600,000
Total	\$5,600,000

18. HIV PREVENTION – ESTABLISH LEGISLATIVE AUTHORITY TO RAISE ELIGIBILITY FOR THE AIDS DRUG ASSISTANCE PROGRAM (ADAP) UP TO 300% OF THE FEDERAL POVERTY LEVEL (FPL) (NATIONAL AVERAGE) BASED ON AVAILABILITY OF FUNDS.

Justification / Rationale:

HIV/AIDS is a major health burden in NC with an estimated 32,000 individuals living with the disease. Antiretroviral therapy has allowed infected persons to live normal lives and decreases the likelihood of spread to others by lowering infectivity. Unfortunately, the majority of HIV-infected persons are either under- or uninsured facing drug costs between \$10,000 and \$20,000 per year. Even HIV-infected individuals with Medicare covered with the part D supplement face unaffordable premiums, deductibles and co-pays.

Increasing federal and state funds have enabled ADAP to expand services to those living up to 250% of the FPL (as of October 2007) and to provide a special fund for underinsured Medicare part D recipients. Future funding needs will depend on number of enrollees, inflation, operational reserve, and formulary expansion to include additional Tier 2 (non-antiretroviral) drugs.

Impact:

At 300% FPL, the NC ADAP will be at the national average for eligibility and equivalent to our neighbor states of South Carolina and Virginia. This will allow an estimated additional 200 recipients into the program. Tier 2 drugs will allow for management of common co-morbidities including diabetes, hypertension, and depression.

BUDGET	
No new funds	

19. SEEK LEGISLATION TO IMPROVE PUBLIC HEALTH PREPAREDNESS AND RESPONSE

Justification / Rationale:

New legislation is needed in NC that will provide protection to individuals and entities volunteering in an emergency response. Following the Hurricane Katrina disaster in 2005, the National Conference of Commissioners on Uniform State Laws promulgated the Uniform Emergency Volunteer Health Practitioners Act to address serious delays in healthcare delivery from out-of-state volunteer responders. This Act allows trained health practitioners to volunteer in the organized emergency response to provide desperately needed services to disaster victims. The objective of the Act is to open the door for volunteers, with appropriate skills and expertise, to volunteer services in the state with an emergency as if they are licensed in the state with the emergency. The Act addresses licensing issues, liability issues, and to provide a system for care to volunteers who are injured or become ill or die while delivering emergency services.

Related legislation is needed to provide liability protection for private associations, corporations and non-profit entities and organizations who volunteer to aid in the response to in-state incidents. Volunteer examples include trucking and distribution, sheltering, and food services.

Impact:

These Acts will greatly enhance the state's capacity to respond and recover from disasters that overwhelm local, regional and state resources when federal resources may not be available during declared states of emergency. Out-of-state medical teams can be deployed more rapidly which will result in more lives saved. Basic infrastructure can be delivered and supplied more easily to individuals and communities recovering from a disaster.

BUDGET
No new funds

Finance Recommendations

20. SEEK OPPORTUNITIES FOR ADDITIONAL RESOURCES TO IMPROVE ESSENTIAL PUBLIC HEALTH PROGRAMS AND SERVICES.

- Increase the current tobacco excise tax (\$.35 per pack, 45th in the US) to the national average of \$1.09 per pack. Potential tax revenue of \$403 million each year. Increased tobacco tax has the dual benefit of increasing revenues AND improving health by reducing youth smoking.
- Seek legislation to enable local authorities to establish fees for food and lodging inspections.
- Legislatively create a permanent sustainable funding source for the Universal Vaccine Program.
- Correct the fee adjustment process for Local Health Departments and Child Development Service Agencies (CDSA).
- Adjust the newborn screening fee to support adding cystic fibrosis screening, currently \$14.00 per child, recommend \$16.20 per child.

21. INCREASE MEDICAID REIMBURSEMENT TO PROVIDERS TO INCREASE ACCESS TO CARE.

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

Increase Medicaid reimbursement rates for dental services to 80% of the national standard to increase access to care. Funds must be tagged to inflationary increases. (\$40 million State share recurring)

Justification / Rationale:

Experiences from other states show that increasing state dental Medicaid rates to 80% of the National Dental Advisory Service reimbursement level significantly increases the number of practitioners willing to provide treatment services for the low income population. Experience both in North Carolina and other states show that rates must be tagged to inflation and adjusted annually to maintain the desired level of dentist participation.

Strategic Plan to Strengthen Core Public Health

Build Capacity for the 10 Essential Services in Local Health Departments Statewide

December 2008

This section addresses the state resources needed to enable Local Health Departments (LHDs) to build the capacity to provide the 10 essential public health services statewide at a consistent level assuring high-quality. The 10 essential services that each state and local health department is expected to be able to provide for their citizens are listed below in detail with a project activity as an example of a measurable service with an associated budgetary figure. If the state provided the funding to enable every LHD to provide all 10 essential public health services at the appropriate level in one year, the resource commitment would be \$63,780,000.

Because each LHD varies in their ability to provide these services depending on the resources and specific service demands in their community, the implementation activities accomplished within the funding granted by year will be based on local choice and priority; however, each LHD shall provide an increased capacity for service delivery within one of the 10 Essential PH Service categories while retaining the local resource commitment of their political jurisdiction served. Additionally, the Division of Public Health will assure appropriate accountability for quality and consistency of services provided through the consolidated agreement mechanism.

Realizing the need for an incremental approach to expand the local public health system capacity a 3 year plan is proposed as follows:

Year 1 - \$23,000,000
 Year 2 - \$21,000,000
 Year 3 - \$19,780,000

Below we have provided the detail of the resources needed for each essential service upon which the 3-year funding plan is based.

1. MONITOR THE HEALTH OF NORTH CAROLINA CITIZENS (\$4,875,000)

Establish and fund the statewide public health Community Health Assessment system. (\$4,675,000)

Justification / Rationale:

Six (6) of the ten (10) Essential PH Services involve the assessment of the community's health and rely on data collection, assessment and interpretation to turn it into meaningful and powerful information for policy makers and the general public. Local Health Departments are mandated to conduct a collaborative, comprehensive Community Health Assessment (CHA) every four years that must include a review and analysis of secondary data, collection of primary data, and the development of community action plans. Primary data collection and epidemiologic analysis are the keys to engaging community members in the discussion and planning for community health improvement.

Currently, there are no state funds to support this critical function at either the state or local level. Without funding, public health is compromised in its ability to conduct 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 is a requirement for accreditation. Investment in the CHA

infrastructure will help support good fiscal management and avoid duplication of services and careful articulation of gaps and emerging issues.

Impact:

Funding will establish a uniform statewide process for CHA including a comprehensive CHA every four years and an annual State of the County’s Health Report. Funding will also ensure local capacity to respond to changing public health needs and emerging public health threats, prioritized response to community health needs and appropriately targeted, effective interventions.

BUDGET

85 LHD (x) 1 FTE Health Educator at the LHD (\$55,000)
 \$4,675,000

Total \$4,675,000

(NOTE: See Recommendation #2 Community Health Assessment partial funding.)

Maintain the Local Health Department Accreditation Program

Needs Assessment / Rationale:

The highly successful accreditation system put into place by the General Assembly has already made a difference for the 30 accredited local health departments. Their “accredited” status allows them to seek or enhance partnerships with other accredited health facilities, as well as offer new services and/or apply for new funding that is available only to accredited agencies. The quality and performance improvement processes put into place during accreditation have led to more efficient services. Boards of Health, County Commissioners and County Managers indicate that they have a better understanding of their role in promoting and protecting the health of their citizens. The legislation provided an eight year timeframe for all local health departments to become initially accredited, but only a four year term of accreditation; therefore, starting in FY08 the first

accredited local health departments must seek re-accreditation. Since the legislation and Administrative Code provide for the same process to be used, there are “hard dollar” costs associated with that process that are not covered by the initial appropriation.

Impact:

These new funds will be used to cover the costs of the re-accreditation process for up to 10 local health departments each fiscal year. Those costs include: travel and other expenses for site visitors, additional meetings of the Accreditation Board, and additional staff time in processing the applications and coordinating site visits and Board meetings.

BUDGET

NC Institute for Public Health Accreditation Administration \$175,000

NC Division of Public Health Operating Costs \$ 25,000

Total \$200,000

(NOTE: See Recommendation #3 LHD Accreditation)

2. IDENTIFY AND INVESTIGATE HEALTH PROBLEMS IN THE COMMUNITY (\$5,525,000)

Justification / Rationale:

Community-based emerging/unexplained illnesses are occurring more frequently and local public health has become the de-facto first responder and incident commander during these events. This response requires specially trained teams of public health staff who can drop everything and initiate an all out response. These funds would allow each local public health agency to hire a nurse epidemiologist to more quickly identify these events, coordinate the training and staff development at the local level and lead the response. Additionally, these funds would improve the local capacity to assess

environmental hazards and develop appropriate interventions.

Impact:

Improved capacity to respond to a request for an unexplained outbreak, environmental or community investigation within 24 hours of the report.

BUDGET

85 (x) 0.75 FTE of Nurse Epidemiologist (\$65,000) \$5,525,000

3. INFORM AND EDUCATE NORTH CAROLINA CITIZENS ABOUT HEALTH ISSUES (\$6,435,000)

Justification / Rationale:

In this era of information overload, public health competes with dangerous media messages on a daily basis. As was proven during the very successful tobacco prevention media/social marketing campaign, when public health is funded to compete head to head against the unhealthy media messages, it has a tremendous impact on the public's behavior. These funds would allow a coordinated campaign in all 100 counties to address a priority public health message aimed at reducing a potentially hazardous health behavior.

Impact:

Resources and capacity to implement a timely media blitz.

BUDGET

85 (x) 0.5 FTE Health Educator(\$65,000) and local media buy (\$10,000)	\$6,375,000
1 FTE State Coordinator (\$60,000)	\$ 60,000
Total:	\$6,435,000

4. ORGANIZE COMMUNITY PARTNERSHIPS TO SOLVE PROBLEMS (\$10,000,000)

(NOTE: See Recommendation #8 Obesity Initiative under Chronic Disease)

5. DEVELOP POLICIES AND PLANS THAT SUPPORT HEALTH PROGRAMS (\$10,000,000)

Justification / Rationale:

The impact of the built environment on the health status of a community is emerging as the single greatest area remaining for substantial, sustained public health improvement. These funds would provide support for walking trails, bike lanes, walk to school programs and other opportunities to engage in physical activity and design health-friendly neighborhoods.

Impact:

Built Environment that encourages healthy behaviors

BUDGET

Funds for local projects	\$10,000,000
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6. ENFORCE LAWS AND REGULATIONS THAT PROTECT HEALTH AND SAFETY (\$5,600,000)

Justification / Rationale:

The Centers for Disease Control and Prevention estimates that 76 million Americans are sickened, 300,000 are hospitalized and 5,000 die from food related illness each year. An increasing number of our meals are prepared and consumed out of the home and an increasing number of disease outbreaks related to food are being identified across the country. Citizens depend on sanitarians employed by local health departments to help safeguard this food supply by regularly inspecting the restaurants. As North Carolina grows, there have been increasing demands on both the state and local sanitarian services to maintain food safety.

- A tremendous increase in the number of mobile food units that operate throughout the week as well as temporary food establishments that serve thousands on any given weekend.
- Increased demand for State and local environmental health staff to assist in the recall of foods that pose an imminent danger to the public health and to participate in the investigation of food-borne illness outbreaks.
- An explosion (the state’s Hispanic population grew by 400% from 1995 to 2000) of cultural changes in the composition of North Carolina’s population, bringing language barriers and ethnic foods into the mix. Training in cultural sensitivity, ethnic foods and languages have been added to the ongoing task of staying current on emerging food-borne illness pathogens.

The Division of Environmental Health in the Department of Environment and Natural Resources (DENR), with the assistance of the local health departments, administer and enforce the N.C. General Statutes and the sanitation rules of the Commission for Public Health. These mandated programs serve to protect the public health in the areas of: (a) Food Safety & Protection; (b) Dairy Protection; (c) Children’s Environmental Health; (d) Childhood Lead Poisoning Prevention; (e) Wastewater Treatment; (f) Private Wells Program; (g) Institutional Sanitation; and (h) Public Swimming Pools. As North Carolina grows, these mandated programs grow as well, increasing the demands on both the DEH and local health departments. In addition to food recalls, other emergency responses include public health safety and assessment following hazardous material releases (both unintentional and intentional). Building capacity through increasing the number of environmental health specialists on both the State and local levels is critical in order to provide mandated and emergency services that are fundamental to the protection of the public’s health.

Impact:

New funds will allow hiring of one new sanitarian (environmental health specialist) per county and 7 new FTEs in the State’s Food Protection Program to provide additional training and assistance to the local health departments. This number is to include a Food Safety Health Educator to coordinate training efforts and provide other education focused services.

BUDGET

100 (x) 1.0 FTE Environmental Health Specialist (\$50,000)	\$5,000,000
7.0 FTEs Environmental Health Staff and operational costs for the State’s Food Protection Program (DENR) to provide additional training and assistance to the local health departments	\$ 600,000
Total	\$5,600,000

(NOTE: See Recommendation #17 Environmental Health Specialists)

7. CONNECT NORTH CAROLINA CITIZENS TO NEEDED HEALTH SERVICES (\$15,300,000)

Support for uncompensated care to low income residents in local health departments and other safety net providers.

Justification / Rationale:

Provide medical and/or dental services to low income citizens within their communities who are underinsured or uninsured.

Impact:

Medical and/or dental services directly available at the local health department or via contractual arrangements with other providers to support the care needed by this uncovered population.

<p>BUDGET</p> <p>\$180,000 (x) 85 LHDs based on 127,500 visits for 21,250 eligible citizens statewide requiring 6 visits per year with labs with an average cost per encounter of \$120.00 \$15,300,000</p>	<p>BUDGET</p> <p>CFEHDI Grants to local communities \$3,000,000</p> <p>(NOTE: See Recommendation #4 Eliminating Health Disparities)</p>
<p>Visits are estimates for medical and dental visits combined which would vary based on the treatment required. Smaller LHDs may see fewer based on population and larger LHDs may see more. Additionally, the above estimate does not factor in the overhead for capacity development and staff maintenance.</p> <p>Expand the Community Focused Eliminating Health Disparities Initiative (CFEHDI) Grants to local programs. (\$3,000,000)</p> <p>Needs Assessment / Rationale: Expand this successful program to additional communities with a focus on health status include infant mortality, HIV-AIDS and sexually transmitted infections, cancer, diabetes, homicides and motor vehicle deaths. The 2007 General Assembly appropriated \$2,000,000 recurring and \$500,000 (non recurring) to support the Community-Focused Eliminating Health Disparities Initiative.</p> <p>Impact: The Community-Focused Eliminating Health Disparities Initiative (CFEHDI) provides grants-in-aid to local public health departments, American Indian tribes, and faith-based and community-based organizations to close the gap in the health status of African Americans, Hispanics/Latinos, and American Indians as compared to whites. These funds are also used to support one position to monitor, track, and evaluate grantees' progress in meeting performance-based standards and outcomes established by the program. Additional funds are needed to expand this effort and support operating costs.</p>	<p>8. WORKFORCE DEVELOPMENT – ASSURES THE ABILITY TO RECRUIT AND RETAIN AN ADEQUATELY TRAINED AND COMPETENT PUBLIC HEALTH WORKFORCE. (\$1,000,000)</p> <p>Exempt state and local public health retirees from the requirement to wait six months before they are eligible to return to work full time without negatively impacting their retirement benefits.</p> <p>Needs Assessment / Rationale: Current North Carolina statutes forbid state and local government retirees from returning to state or local government employment in a “temporary, part-time, substitute, or contractor service at any time during the six months immediately following the effective date of retirement.” Such employment restrictions inhibit the ability to rehire public health workers at the state and local levels during a time in which it nationally recognized that public health occupations are experiences a workforce shortage crisis. (Public Health Workers Shortage – Trends Alert, The Council of State Governments Pub. 2004) If state and local public health workers could return to government service immediately following retirement without negatively affecting their retirement compensation, many would extend their work career and help during a time of workforce crisis. (Some states have resolved this dilemma for state and local government workers, including public school teachers, by diverting retirement funds to an annuity held for the retired worker, and limiting this extended period of employment service to not more than five consecutive years)</p> <p>Impact: The positive impact of exempting state and local public health retirees from the requirement to wait six months before they are eligible to return to</p>

work full time without negatively impacting their retirement benefits, would be that jobs critical to the safety and protection of the public could be filled during a time of public health worker shortages. This exemption would then allow the public health system time to recruit and rebuild the flow of new workers necessary for future service to state and local public health.

BUDGET

None

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

Needs Assessment / Rationale:

The most frequently cited reason for staff turnover given by state and local public health managers is their inability to retain qualified, seasoned staff. It is the noncompetitive, inflexible salary structure of most state and local public health personnel systems that leads to the loss of highly qualified and experienced staff. Critical public health staff often leave because an adjacent county, an adjacent state or the private sector heavily competes for well-trained and experienced public health staff. Federal labor data estimate that by 2010, the U.S. will have a ten-million worker shortfall. The heaviest demand for workers will be in the technical and scientific fields. Human resource offices report that voluntary turnover rates are already expressing this turnover shortfall estimate; for FY 06-07 these Public Health classifications are experiencing high rates of turnover: Speech & Language Pathologist I (38%); Physical Therapist I (36%); and Occupational Therapist I (36%).

Another significant constraint for local and state public health hiring managers is the fact that we are losing many experienced professional, technical and scientific positions to retirement. State and university studies show that approximately 45%

of the public health workforce will be eligible to retire over the next three years. Although many of these retired public health workers will continue in the workforce elsewhere, state and local government lose them because current statutes prohibit their continuing to work for their former agencies without penalizing their retirement pay. As with education, when there is a crisis of skilled and highly trained workers available for critical services, public health agencies must be allowed to rehire retired workers without penalizing their retirement pay, and without a six-month prohibition against hiring retired public health workers. Some states, such as South Carolina may offer a workable model whereby retired state and local government workers, as well as teachers, are allowed to retire and return to government employment at 100% time. Such options should be explored for North Carolina to address the crisis in the public health workforce.

Impact:

The ability to recruit, retain and rehire retired public health workers will significantly improve the state's ability to deliver the ten essential services of public health and better ensure our ability to protect and improve the health of our citizens.

Creating public loan repayment programs. The opportunity for some college loan forgiveness is often cited by new graduates as a prime incentive for job acceptance. Service to state/local agencies for both scholarships and loan repayment for a specified period of time is required in return.

BUDGET

\$1,000,000 Loan Repayment Fund

(NOTE: See Recommendation #5 Workforce Development)

Increase local health department interpreter capacity to serve clients as required by Title VI, and increase the ability of hiring managers to offer bilingual skilled workers a “scarce skill” salary adjustment of up to 10% of salary offer. (\$2,650,000)

Needs Assessment / Rationale:

The North Carolina General Assembly appropriated \$250,000.00 to fund a program aimed at creating new full-time positions for interpreter services at the local health departments to enhance their capacity to serve Limited English Proficient (LEP) clients. With the allocated funding, 11 health departments were awarded \$20,000.00 each year for a 3-year period beginning FY05/06. Local Health Departments (LHD) match this grant to create a full time position. An end-of-year report is requested from all the grantees to show their outcomes, challenges, and/or successes. During the fiscal year 2005/2006, the report showed that the new interpreters reached 7,506 LEP clients in a four-month period. The 2006/2007 end of year report showed that the interpreters reached 35,174 clients, an average of 2,951 clients reached per month.

Although the addition of language interpreters is an important step in addressing the health care needs of those individuals who are LEP clients, it is recognized by the health care system that ideally, the ability to hire bilingual staff and health care providers is preferred. Because of the scarce availability of bilingual workers in the health care industry, most employers, including government, offer a “scarce skill” salary adjustment. In the current North Carolina personnel system, an adjustment of up to 5% of salary offer to recruit workers with bilingual skills is allowed. Due to the high level of competition for workers with bilingual skills, it is recommended that this allowance be increased to 10%.

Impact:

Expand the LEP program statewide to serve more clients in the 74 LHDs that are not currently funded and to supplement the 11 positions currently in place. It is a federal mandate to comply with the 1964 Civil Rights Act, Title VI.

BUDGET

Local Health Department Based Interpreters		
74 @ \$33,000 Salary+ Fringe		\$ 2,442,000
11 @ \$13,000 Salary+ Fringe		\$ 143,000
LEP Title VI Coordinator 1.0		
@ \$65,000 Salary+ Fringe		\$ 65,000
Total		\$ 2,650,000

(NOTE: See Recommendation #4 Eliminate Health Disparities)

9. MEASURE THE EFFECTIVENESS AND QUALITY OF HEALTH SERVICES (\$8,850,000)

Justification / Rationale:

Develop a system of accountability and continuous quality improvement health report cards that tie various public health services provided by the LHD to the health outcomes within the geographic service area of the health department.

Impact:

LHD services appropriately measured to assure that desired health improvement is occurring given the existing program.

BUDGET

85 LHDs (x) 1.0 FTE Quality Improvement Coordinator (\$100,000)		\$8,500,000
5.0 FTEs state level positions (3 PH Program Evaluators/Consultants, 2 Statisticians in SCHS) @ \$70,000		\$ 350,000
Total		\$8,850,000

10. IDENTIFY NEW SOLUTIONS TO HEALTH PROBLEMS (\$255,000)

Justification /Rationale:

Develop capacity to implement into daily activity at LHDs best practices based on public health research.

Impact:

Establishment of the Office of Public Health Best Practice and applied Research

BUDGET

3.0 FTEs (Public Health Program Director,
Program Coordinator, and Management Support)
\$ 255,000

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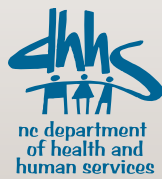
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