EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 6: PREVENTION

Ultimately, the goal of any broad scale health system reform should be to improve population health. The Affordable Care Act (ACA) includes new funding to invest in prevention, wellness, and public health infrastructure. This focus on improving population health is particularly important to North Carolina. North Carolina typically ranks in the bottom third of most health rankings. North Carolina was ranked 32 of the 50 states in the 2011 edition of the America's Health Rankings, a composite of 23 different measures affecting health, including individual behaviors, community and environmental factors, public and health policies, clinical care, and health outcomes.[1]

The ACA appropriated $500 million in FFY 2010, $750 million in FFY 2011, and $1 billion in FFY 2012 to a new Prevention and Public Health fund to support states and communities in their efforts to prevent illness and promote health.[2] The funds have been used to support:

- Community prevention activities such as implementation of the Community Transformation Grant, use of evidence-based interventions to reduce tobacco use and health disparities, and obesity prevention.
- Clinical prevention, including increasing awareness of new preventive care benefits, expanding immunization services, and strengthening employer participation in wellness programs.
- Public health infrastructure to strengthen state and local health department capacity for health promotion, disease prevention, and response to infectious disease outbreaks.
- Research and tracking including surveillance and evaluation of preventive services.

These national priorities closely align with the Healthy North Carolina 2020 (HNC2020) objectives that North Carolina set with the goal of making North Carolina a healthier state by the year 2020.[3] The focus areas for these objectives are tobacco use, physical activity and nutrition, injury, sexually transmitted diseases, unintended pregnancies, maternal and infant health, substance abuse, mental health, infectious disease and food-borne illness, oral health, environmental health, chronic disease, and social determinants of health. The North Carolina Division of Public Health (DPH) is the lead agency for implementation of HNC 2020 objectives over the next decade.

The Prevention Workgroup focused on provisions of the ACA with immediate implementation requirements or funding opportunities. These areas of focus included tobacco use, physical activity and nutrition, maternal and child health, prevention of sexually transmitted disease (STD) and unplanned pregnancies, improved access to preventive services, worksite wellness, and community infrastructure needed to respond to future funding opportunities.

TOBACCO

Tobacco use is the leading cause of preventable death and disease in North Carolina. Smoking harms nearly every organ of the body and causes many diseases, including coronary heart disease, several types of cancer, acute and chronic respiratory illnesses, and adverse pregnancy outcomes[4] North Carolina ranks 36th in prevalence of smoking—with 19.8% of the population reporting smoking in 2011—31st in cardiovascular deaths, and 35th in cancer deaths.[5]

Two provisions of the ACA support efforts to reduce tobacco use. First, the ACA prevents states from excluding coverage for tobacco-cessation drugs from their Medicaid programs.[6] Some FDA-approved tobacco-cessation pharmaceuticals are covered by North Carolina's Medicaid Program (Medicaid). However, there are several barriers to access, including:

- A physician visit, that requires out-of-pocket expense, is required to get a prescription for over-the-counter nicotine replacement therapy.
- Co-pays are required for all tobacco pharmaceuticals.
- Medicaid does not cover nicotine nasal spray and nicotine inhaler.

Under the ACA, the state has an option to provide all United States Preventive Services Task Force (USPSTF) recommended services rated A or B with no cost sharing to Medicaid recipients in return for an increase in reimbursement from the federal government for services to Medicaid clients.[7] If the state takes this option, then cessation therapies, including pharmaceuticals, would be covered. (Medicaid coverage of preventive services is discussed more fully later in the chapter).

Second, the ACA requires states to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use, and prohibits cost-sharing for these services.[8] The North Carolina Division of Medical Assistance (DMA) has determined that the state is in compliance with this provision, as North Carolina currently screens pregnant women receiving Medicaid for tobacco use as part of the pregnancy medical home, and provides coverage for smoking and tobacco cessation counseling visits. The workgroup identified that providers need education on billing options for these services, particularly for providers not enrolled in the pregnancy medical home model.

Funding was made available through the ACA to support tobacco cessation efforts. DPH was awarded two ACA grants, of $98,266 and $139,210, to support tobacco cessation through expanded use of the Quitline, as well as policy and media interventions. North Carolina also received funding through a community transformation grant that will provide funding to communities to, in part, reduce tobacco use.

Community transformation grants (CTG) are competitive grants to state and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.[9] In September 2011, the CDC announced the funding for the CTG to support states or large cities (population of 500,000 or more) with multifaceted interventions to improve population health. North Carolina was one of 35 states and communities that received an implementation grant. The

state received $7.466 million, the fourth largest award announced. DPH is the state agency responsible for administering the CTG grant in North Carolina. DPH is working with 10 multi-county collaboratives across the state to implement strategies in three core areas: tobacco free living, active living and healthy eating, and use of high impact evidence-based clinical and other preventive services. This funding is being disseminated through one lead health department in each collaborative. The strategies for the tobacco free living core area are listed below. The strategies for physical activity and nutrition, and other strategies to promote healthy lifestyles are discussed later in this chapter.

1. Increase smoke-free regulations in local government buildings and indoor public places.
2. Increase tobacco-free regulations for government grounds, including parks and recreational areas.
3. Increase smoke-free housing policies in affordable multi-unit housing and other private sector market-based housing.
4. Increase the number of 100% tobacco free policies on community college campuses and state and private university/college campuses.
5. Increase the number of health care organizations that support tobacco use screening and referral to cessation services.

North Carolina has taken many steps to reduce tobacco use; however, more could be done to increase tobacco cessation. Therefore, the NCIOM recommended:

RECOMMENDATION 6.1: INCREASE TOBACCO CESSATION AMONG MEDICAID RECIPIENTS

- **a) The North Carolina Division of Medical Assistance (DMA) and the North Carolina State Center for Health Statistics should monitor the utilization of tobacco-cessation drugs and the impact on tobacco-related health outcomes.**
- **b) DMA should provide all FDA-approved over-the-counter nicotine replacement therapy (nicotine patch, gum, lozenge) if accessed through the Quitline or through a physician prescription as part of comprehensive tobacco cessation services.**
- **c) To encourage the provision of counseling and pharmacotherapy to pregnant women for cessation of tobacco use:**
  - **i. The North Carolina Area Health Education Centers Program (AHEC), the North Carolina Medical Society, North Carolina Academy of Family Physicians, North Carolina Obstetrical and Gynecological Society, and other appropriate groups should partner to provide education to providers on billing options for Medicaid preventive services, particularly for those providers who are not enrolled in the medical home model.**
  - **ii. Community Care of North Carolina care managers should educate patients on the availability of these preventive services without copayment.**
- **d) If the state does not take the option to provide all United States Preventive Services Task Force recommended services rated A or B with no cost sharing to Medicaid recipients in return for an increase in reimbursement from the federal government, then the following additional recommendations would provide tobacco cessation support for Medicaid recipients:**

i. **DMA should reduce out-of-pocket costs for clients for effective cessation therapies.**
ii. **DMA should provide access to all FDA-approved tobacco pharmaceuticals without a co-pay for at least two cessation attempts per year.**

PHYSICAL ACTIVITY AND NUTRITION

The percentage of North Carolinians who are obese more than doubled between 1990 (12.9%) and 2011 (28.6%).[10] In 2011, North Carolina ranked 30th in percentage of the population that was obese.[11] As part of the ACA prevention funding, DPH received $3.8 million in Communities Putting Prevention to Work (CPPW) funding. These funds have been used to implement sustainable evidence- and practice-based approaches to changing policies, systems, and environments contributing to the obesity epidemic in the Appalachian District (including Allegany, Ashe, and Watauga counties) and Pitt County. An additional $272,000 was awarded to support BRFSS data collection in these two communities.

As discussed, DPH also has been awarded CTG funding which is being used to promote active living and healthy eating, as well as other strategies to improve clinical care and promote healthy lifestyles. These strategies include:

1. Increase the number of convenience stores that increase the availability of fresh produce and decrease the availability of sugar-sweetened beverages.
2. Increase the number of communities that support farmers' markets, mobile markets, and farm stands.
3. Increase the number of communities that implement comprehensive plans for land use and transportation.
4. Increase the number of community organizations that promote joint use/community use of facilities.
5. Increase the number of health care providers who utilize quality improvement systems for clinical practice management of high blood pressure and high cholesterol.
6. Increase the number of community supports for individuals identified with high blood pressure, high cholesterol and tobacco use (e.g., chronic disease self-management programs, weight management programs, tobacco cessation programs).

MATERNAL AND CHILD HEALTH

Comprehensive, coordinated pre-conception, maternity, and post-partum care is important for improving birth outcomes in North Carolina. The incidence of premature and low-weight births may be reduced through addressing the health of the mother before and during pregnancy. Risk factors associated with poor birth outcomes include diabetes, hypertension, tobacco or other substance use, and unsafe living environments. North Carolina ranks 36th in diabetes incidence, 40th in hypertension, and 36th in smoking.[12] These rankings are not specific to the pregnant population, but are indicators of the overall population's health.

Home Visiting

Support is provided through the ACA for pregnant and parenting teens and home visiting programs, as well as requiring reasonable break times for nursing mothers who are working. The

support to pregnant and parenting teens is provided in the form of grants to states, institutions of higher education, schools, and communities.[13] Funds can be used for programs such as those that help pregnant or parenting teens stay in or complete high school, and for assistance to states in providing intervention services and outreach so that pregnant and parenting teens and women are aware of services available to them. The North Carolina Department of Health and Human Services (NCDHHS) received $1,768,000 to help pregnant and parenting women in high needs communities through *Project Connect*. *Project Connect* supports pregnant and parenting women ages 13- 24 years with health maintenance, parenting skills, and parental self-sufficiency. The goals of *Project Connect* are to: support community strategies to create effective systems of care; incorporate evidence-based practices, strategies, and models; and improve the health of pregnant and parenting women by providing comprehensive support services that are easy to access and meet their needs.

The ACA also provides funding to states to implement evidence-based maternal, infant, and early childhood evidence-based visitation models targeted at reducing infant and maternal mortality and its related causes. Model goals include improving prenatal, maternal and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.[14] In 2010, the North Carolina infant mortality rate was the lowest in the State's history at 7.0 deaths per 1,000 live births.[15] North Carolina received $5.46 million to implement the North Carolina Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). The MIECHV program offers information, risk assessment, and home-based parenting support using evidence-based models in at-risk communities, including sections of Buncombe, Durham, Gaston, Edgecombe, Halifax, Hertford, Northampton, Mitchell, and Yancey counties.[16] Three evidence-based home visiting models are supported: Nurse Family Partnership, Healthy Families America, and an integrated Healthy Families America and Parents As Teachers program. The Nurse Family Partnership provides nurses to educate and support low-income, first-time mothers through the first two years of motherhood. Healthy Families America is a evidence-based home visiting program for families at risk of child abuse or neglect. The program's goals include development of nurturing relationships, promotion of healthy child development and growth, and building the foundation for a strong family. Parents As Teachers provides family education and support to families with young children. This support includes home visits by parent educators, parent group meetings, developmental and health screenings, and linkages to community resources.

Supporting Nursing Mothers at Work

The ACA requires employers with 50 or more employees to provide reasonable break time and a private place (other than a bathroom) for an employee to express breast milk for nursing children for one year after the birth of a child.[17] Employers with less than 50 employees must apply for and prove undue hardship if they have difficulty complying with the new provisions. This provision became effective when the ACA was signed in to law in March 2010, and affects employees covered by the Fair Labor Standards Act. Employers are not required to compensate the employee for this break time.

The primary gap identified for North Carolina was the need for education of employers and employees on this provision, including on the definition of reasonable break time and appropriate facilities. The workgroup also identified that the ACA provision for workplace

lactation support provides break time and space for hourly employees, which leaves gaps in the law for salaried employees. The break time for hourly employees is unpaid, unless that employer routinely pays for break time. The North Carolina Office of State Personnel policy provides more comprehensive protection for state employees covered by the State Personnel Act, but further action is still required to fill remaining gaps for those state employees not covered by the State Personnel Act, and to provide similar support for non-state employees. Therefore, the NCIOM recommends:

RECOMMENDATION 6.2: SUPPORT NURSING MOTHERS IN THE WORK ENVIRONMENT

a) **The North Carolina Department of Labor and the Office of State Personnel (OSP) should partner to educate employers and employees on the requirement for reasonable break time for working mothers, and, as appropriate, the OSP policy.**
b) **Small businesses should be encouraged to provide similar support to working mothers. The North Carolina Division of Public Health should partner with the North Carolina Small Business Administration to provide information to small businesses on supporting breastfeeding mothers, as well as information on the requirement to apply for and prove undue hardship for an exemption to this requirement. The North Carolina Department of Labor should partner with the North Carolina Breastfeeding Coalition, which already has trained business outreach workers, to provide guidance on the Business Case for Breastfeeding, a national training model for best-practices.**

PREVENTING SEXUALLY TRANSMITTED DISEASES AND UNINTENDED PREGNANCIES

Personal Responsibility and Abstinence Education

Preventing sexually transmitted diseases (STDs) and unintended pregnancies will help improve quality of life, decrease death and disability, and reduce health care costs. North Carolina has been working to reduce cases of STDs and has seen improvements in recent years. In 2010, the reported number of new HIV diagnoses, early syphilis cases, chlamydia cases, and gonorrhea cases declined from the previous year (8.6%, 23.0%, 3.6%, and 4.4% declines respectively).[18] For the past ten years, the percentage of pregnancies reported to be unintended has remained steady at between 40-45%.[19,20] However, North Carolina's teen pregnancy rate has declined significantly since 2000 from 44.4 to 26.4 per 1,000 teens ages 15-17 in 2010.[21]

The ACA provides $75 million per year through FY2014 for Personal Responsibility Education (PREP) grants to states for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS.[22] Funding is also available for innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations, allotments to Indian tribes and tribal organizations, and research and evaluation, training and technical assistance. NCDHHS applied for and received $1.5 million in PREP funds to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections.

In October 2010, the North Carolina Division of Public Instruction (DPI) received $1.5 million in Title V funds for abstinence education as part of implementation of comprehensive sex

education pursuant to the "Healthy Youth Act of 2009." The workgroup recognized that the overlap of the goals and audience for these two programs provided an opportunity for collaboration between DPH and DPI. The Workgroup supported collaboration between DPH and DPI on providing this education.

IMPROVING ACCESS TO PREVENTIVE SERVICES

Private Health Insurance

The ACA requires most employer-sponsored group health plans and private health insurance policies to provide coverage, without cost sharing, for preventive services rated A or B by the USPSTF, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), preventive care and screening for infants, children, and adolescents, and additional preventive services for women that are recommended by Health Resources and Services Administration of the United States Department of Health and Human Services.[23] The only health plans that are not subject to this requirement are "grandfathered plans". Grandfathered plans are those health plans that have been in existence continuously since March 2011 without significant changes in covered benefits or cost sharing.[24] [25]The primary gaps identified by the workgroup were monitoring of health plans to ensure that coverage is provided, education of providers and patients on the covered services, and providing mechanisms in electronic medical record systems to promote the provision of these services.

Medicare

Preventive service coverage is also provided to those covered by Medicare. The ACA eliminates copayments and application of deductible for Medicare preventive services that are rated A or B by the USPSTF, as well as deductibles for colorectal cancer screening tests.[26] The ACA also eliminates copayments for Medicare enrollees who receive an annual wellness exam that includes a health risk assessment and a personalized prevention plan.[27] The annual wellness exam consists of an update of medical and family history and a list of current providers and suppliers of medical care; measurement of height, weight, blood pressure, and other routine measurements; detection of cognitive impairment; establishment of or update to screening schedules and lists of risk factors; and furnishing of personalized health advice and referral. The annual wellness exam is not the same as an annual physical exam, which is not reimbursable by Medicare. The primary gap identified was education of providers and Medicare enrollees on what the annual wellness visit covers, and the elimination of copayments for USPSTF-recommended preventive services. Therefore, the Workgroup recommended educating providers and Medicare recipients on new benefits. (See Recommendation 6.4.)

Medicaid

The ACA provides the option for states to provide similar coverage of preventive services for Medicaid-eligible adults.[28] Beginning in January of 2013, states may provide Medicaid coverage for all preventive clinical services recommended by the USPSTF and all immunizations recommended by ACIP. States that elect to cover these preventive services and vaccines and provide these services without cost sharing, will receive an increase of one percentage point in their Federal Medical Assistance Percentage (FMAP) rate for these services. The FMAP is used to determine the amount of federal matching funds provided to the state for Medicaid medical expenditures.

DMA already covers most of the recommended services and immunizations. However, it does not currently cover BRCA testing (which tests for a gene mutation associated with a high risk of breast cancer), the herpes zoster (shingles) vaccine, aspirin for cardiovascular disease prevention, folic acid supplementation for women of child-bearing years, iron supplementation for at-risk children, or human papilloma virus (HPV) immunizations for people ages 21-26. As discussed above, many of the tobacco cessation drugs are covered by DMA, but copays and prescriptions are required. DMA conducted a cost analysis to determine the costs involved in offering all of the recommended clinical preventive services and immunizations without cost-sharing versus the additional reimbursement it would receive from the enhanced FMAP rate (Table 6.1). The number of Medicaid enrollees was projected based on SFY2010 counts with trending based on historical increases in enrollment. The number of enrollees does not include costs associated with the potential Medicaid expansion. In the table below, the "Total cost impact" is the total cost of adding each benefit. The "State cost impact" is the total cost minus the federal cost. The federal cost is the total cost times the new FMAP. The existing FMAP rate is 64.71%, so the state is responsible for 35.29% of the costs. Assuming a similar match rate, if North Carolina includes coverage for all USPSTF A and B recommended services and ACIP recommended immunizations, the federal government would pay 65.71% and the state would pay 34.29% of the costs.

The analysis indicates that there will be an immediate cost to the state to implement the USPSTF and ACIP recommendations without cost-sharing. However, substantial savings through disease prevention may occur that are not considered in this analysis. The workgroup members recommended that North Carolina provide the same coverage of preventive services through Medicaid as is provided by private coverage plans. Thus, the Workgroup recommends that the state provide coverage of all of the preventive services or immunizations recommended by the USPSTF (rated A or B) and ACIP without cost-sharing. The workgroup recognizes that there is a significant financial impact to the state from this recommendation; however, the financial cost may be offset by potential long-term cost savings through health status changes.

Table 6.1
Analysis of Cost to State for Addition of USPSTF and ACIP Recommended Services

	SFY2013*	SFY2014	SFY2015¥
Total cost of all prevention services currently provided to Medicaid recipients	$44,447,991	$48,359,000	$49,287,500
FMAP rate (current)	0.6471	0.6471	0.6471
State match rate (current)	0.3529	0.3529	0.3529
Total cost to state of all prevention services currently provided to Medicaid recipients. total cost x state match rate)	$15,685,696	$17,065,891	$17,393,559
Additional costs for new preventive services	$12,797,921	$24,785,508	$24,673,474
Cost of removing copays	$115,495	$118,152	$120,869
Total additional costs for USPSTF and ACIP services	$12,913,416	$24,903,660	$24,794,343
Total costs of all services (current plus USPSTF/ACIP)	$57,361,407	$73,262,660	$74,081,843
New FMAP rate (current rate plus one percentage point)	0.6571	0.6571	0.6571
New state match (if state receives additional federal match)	0.3429	0.3429	0.3429
Cost to state for all services (current and USPSTF/ACIP).	$19,669,226	$25,121,766	$25,402.664
Cost to state to add preventive services (includes additional costs of services and removal of cost sharing, as well as benefit from additional FMAP applied to all preventive services)	$3,983,530	$8,055,875	$8,009,105

*Costs for SFY 2013 cover only half the fiscal year (January-June) because states could not get the enhanced FMAP for adding preventive services until January 2013.

Many Medicaid enrollees, as well as people enrolled in other insurance programs, do not always receive appropriate clinical preventive services, even when they are covered. Thus, merely extending Medicaid coverage to include new preventive services will not ensure their use. Therefore, the Workgroup recommends that DMA, along with health care professional associations, should engage in provider education to ensure that health professionals are aware of—and actively advise—their patients to obtain appropriate clinical preventive services.

Increasing Child and Adult Immunizations

The ACA authorizes states to purchase adult vaccines under the Centers for Disease Control and Prevention (CDC) contracts and reauthorizes the federal Immunization Program.[29] These contracts for adult vaccines provide savings that range from 23%-69% compared to the private sector cost. This provision also authorizes a demonstration program to improve immunization coverage. Under this program, the CDC will provide grants to states to improve immunization coverage of children, adolescents, and adults through implementation of interventions recommended by the Task Force on Community Preventive Services or other evidence-based interventions, such as reminders or recalls for patients or providers, or home visits.

NCDHHS applied for and received $1,023,484 from the Prevention and Public Health Fund to support immunizations. These funds will support information technology contracts to enhance interoperability between electronic health records (EHR) and the North Carolina Immunization Registry, and develop a vaccine ordering module that interfaces with CDC's Vtrcks Vaccine Ordering and Management System.

Preventive care services can improve the health and well-being of North Carolinians as well as reduce the incidence of death and disease from preventable factors. Therefore, the NCIOM recommends:

RECOMMENDATION 6.3: PROMOTE AND MONITOR UTILIZATION OF PREVENTIVE CARE SERVICES

a) North Carolina should provide the same coverage of preventive services for Medicaid enrollees as is provided to people with private coverage. Thus, North Carolina should provide coverage of all preventive services and immunizations recommended by United States Preventive Services Task Force (USPSTF) (with a rating of A or B) and Advisory Committee on Immunization Practices (ACIP) without cost-sharing.

b) The North Carolina Department of Insurance (NCDOI) should continue to monitor health plans to ensure compliance with the requirement that new employer-sponsored group health plans and private health insurance policies provide coverage, without cost sharing, for preventive services rated A or B by the USPSTF; immunizations recommended by ACIP; preventive care and screening for infants, children, and adolescents; and additional preventive services for women that are recommended by the Health Resources and Services Administration (HRSA). Tracking of compliance should include tracking the insurance plan year in which the coverage is required.

c) The North Carolina Office of Health Information Technology (NC-HIT) should encourage companies that provide electronic medical record (EMR) systems in North Carolina to provide clinical decision support tools to identify and promote USPSTF and ACIP recommended services targeted to the patient needs.

d) NC-HIT, Division of Medical Assistance (DMA), Community Care of North Carolina (CCNC), and the North Carolina Healthcare Quality Alliance should ensure that quality improvement initiatives at the state level include monitoring of utilization of patient-targeted prevention services.

e) **North Carolina Area Health Education Centers (AHEC), DMA, the North Carolina Medical Society (NCMS), Old North State Medical Society, other health care professional associations, and the North Carolina Division of Social Services should partner to educate providers to ensure that health professionals and caseworkers are aware of, and actively advise their patients and clients to obtain, appropriate clinical preventive services. They also should provide education to providers on billing options to obtain reimbursement from public and private payers for clinical preventive services, particularly for those providers who are not enrolled in the medical home model.**
f) **Providers should be encouraged to educate patients on the value of these preventive services, as well as availability, without copayment or application of deductible, and to appropriately encourage utilization of preventive services.**
g) **AHEC, NCMS, the North Carolina Division of Aging and Adult Services (DAAS), CCNC, the North Carolina Academy of Family Physicians, and the AARP should provide education to primary care physicians on the annual wellness visit benefit for Medicare enrollees.**
h) **Senior's Health Insurance Information Program (SHIIP), AARP, and DAAS should provide education to enrollees on the annual wellness visit benefit.**
i) **AARP, DMA, SHIIP, and the DAAS should engage community leaders to do community outreach for education of the public on the availability and importance of preventive services.**

WORKSITE WELLNESS

Worksite wellness programs can improve the health of North Carolinians by increasing healthy eating and physical activity, decreasing tobacco use, and decreasing stress. By improving the health status of employees, health care costs can be reduced.[30]

The worksite wellness provisions of the ACA allow employers to include wellness programs as part of their insurance coverage, if the programs promote health or prevent disease.[31] Discrimination based on health status is prohibited. However, employers can include requirements that enrollees satisfy health status factors (i.e., tobacco cessation or healthy weight) if the financial consequences (reward or penalty) do not exceed 30% of the cost of employee-only coverage (or 30% of family coverage if dependents participate).[32] Nationally, small businesses with fewer than 25 employees are far less likely to offer wellness benefits—such as gym membership discounts or on-site exercise facilities, smoking cessation programs, or lifestyle or behavioral coaching—than are other employers.[33]

The ACA also includes provisions that direct the Centers for Disease Control and Prevention to provide technical assistance to employers to implement and evaluate evidence-based worksite wellness programs.[34] Funding for this provision has not yet been made available. However, there are several ongoing efforts in North Carolina to provide technical assistance to employers interested in implementing worksite wellness efforts. For example, the Physical Activity and Nutrition Branch within DPH maintains the Work*Well* NC page on the Eat Smart, Move More NC website.[35] The Work*Well* NC page includes toolkits to help businesses develop wellness programs, turnkey programs to encourage healthy behaviors, worksite wellness success story videos from diverse businesses across the state, sample worksite wellness policies, links to

worksite wellness services, and guides to implementing wellness program components at the worksites. North Carolina Prevention Partners offers a prevention academy and an evaluation tool for worksites to evaluate their wellness policies, benefits, and environment focused on tobacco, nutrition, and physical activity.[36]

Despite these statewide efforts to work with employers that are interested in implementing worksite wellness initiatives, the workgroup also noted gaps. For example, many employers do not know about the resources that are available, or the potential impact of implementing these programs on improved worker productivity, reduced absenteeism, and reduced health care costs. The workgroup recommended further employer education about worksite wellness opportunities and requirements, to encourage businesses to adopt a healthy lifestyle culture, and to provide the assistance required for implementation of evidence-based wellness programs with fidelity. Therefore, the NCIOM recommends:

RECOMMENDATION 6.4: PROMOTE WORKSITE WELLNESS PROGRAMS IN NORTH CAROLINA BUSINESSES

a) The Center for Healthy North Carolina and the North Carolina Division of Public Health should continue to provide information to businesses on evidence-based wellness programs, encourage leaders within businesses and worksites to develop a culture of wellness, and provide education to employers and insurers on the specific requirements of the Affordable Care Act for employer worksite wellness programs.

b) Eat Smart, Move More NC should continue to provide information on evidence-based worksite wellness tools and programs through its website,[37] including CDC's worksite wellness technical assistance program.

INFRASTRUCTURE

State Infrastructure

A portion of the Prevention and Public Health Fund was used to strengthen local and state public health infrastructure. DPH received a grant of $371,894 to improve epidemiology and laboratory capacity for surveillance for and responses to infectious diseases and other conditions of public health importance.[38] Public Health Infrastructure Grants were offered to advance health promotion and disease prevention through improved information technology, workforce training, regulation, and policy development. North Carolina was one of only 14 states to receive both component I (non-competitive) and component II (competitive) awards. In component I, North Carolina received $400,000 to support the Public Health Quality Improvement Center. As part of component II, North Carolina received $1,503,858 for the State Center for Health Statistics to strengthen collection, reporting, and analysis of health statistics, including enhancement of the its web-based data query system, the re-design of death registration in preparation for automation, and increased use of electronic health records for disease surveillance. North Carolina received additional funds ($1,037,779) for the second year of this grant cycle. These National Public Health Improvement Initiative grant funds continue to support work on quality improvement activities and preparation for accreditation, as well as electronic death registration and the web-based data dissemination tool (HealthStats).

Develop Local Infrastructure to Respond to Grant Opportunities

The Prevention Workgroup examined funding opportunities available through the ACA and explored strategies to target funding to communities of greatest need. Often the communities with the greatest health needs are those that lack the personnel or infrastructure to apply for grants or to implement new initiatives. State data suggest that some of the smaller, poorer counties have higher *rates* of certain preventable conditions, but urban counties have greater *numbers* of people with the same health problems. Thus, the workgroup discussed the need to target both large and small communities for new prevention activities. The workgroup created an infrastructure subcommittee to identify mechanisms to assist communities with limited public health and grant proposal writing infrastructure to respond effectively to prevention funding opportunities that may become available through the ACA or other sources. An additional objective was to provide communities assistance needed to develop the infrastructure to address the HNC2020 objectives.

DPH's mission is to improve the health of North Carolinians. Two of the DPH organizations—the Center for Healthy North Carolina and the Office of Minority Health and Health Disparities (OMHDD)—support this effort by working with communities build capacity. For example, the Center for Healthy North Carolina has been tasked with working with communities to help them develop the infrastructure to reach the HNC2020 objectives. OMHHD works with non-profits in communities on infrastructure development (including capacity building and leadership development) with the goals of improving minority health and reducing health disparities. The subcommittee recognized the importance of community engagement to the success of interventions to improve community health.

To effectively work with communities to build capacity, these two state organizations need to form partnerships with other organizations already working in these communities or those able to assist communities. Such partnerships should help develop infrastructure in these communities that could support participation in funding opportunities. These partnerships also are crucial to maximize results given limited resources, by improving coordination and reducing duplication of effort. Thus, the NCIOM recommended:

RECOMMENDATION 6.5: BUILD CAPACITY OF COMMUNITIES TO RESPOND TO FUNDING OPPORTUNITIES

The Center for Healthy North Carolina and the Office of Minority Health and Health Disparities should:

a) Encourage partnerships between local health departments and community organizations in responses to funding opportunities.
b) Provide information to these organizations on available resources to assist with identifying funding opportunities, grant writing, evaluation design and implementation, development of leadership capacity, and evidence-based interventions.
c) Cultivate partnerships between communities, community organizations, and academic institutions to provide mutual opportunities for research and service.
d) Provide training to local providers to improve cultural competence, and work to increase cultural diversity in community partnerships and funding opportunity participants.

e) Work with communities to develop communication mechanisms to help communities identify potential collaborators, develop the capacity to produce competitive grant applications, and avoid competition within the same community. Use multiple mechanisms of communicating with community members, recognizing that the availability, ability to utilize, and interest in technology varies widely.

Monitoring Additional Funding Opportunities

The ACA includes many other provisions aimed at promoting healthy lifestyles and preventing chronic diseases. For example, the ACA includes provisions to promote healthy aging, promote oral health, and conduct a broad-based education and outreach campaign to support healthy lifestyles and use of clinical preventive services. The ACA includes funding for some of these provisions; others could be funded in the future through the Prevention and Public Health Trust Fund. Therefore, the NCIOM recommended that the state continue to monitor new funding opportunities made available through the Prevention and Public Health Trust Fund or other funding sources.

RECOMMENDATION 6.6: MONITOR FUNDING OPPORTUNITIES FOR PREVENTION PROVISIONS

The state should monitor the federal appropriations process, as well as funding made available as part of the Prevention and Public Health Trust Fund, to identify additional funding of prevention provisions.

REFERENCES AND NOTES

1 United Health Foundation. America's Health Rankings 2011: North Carolina. http://www.americashealthrankings.org/SiteFiles/Statesummary/NC.pdf. Accessed February 14, 2012.

2 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4002, 42 USC 300u-11.

3 North Carolina Institute of Medicine. Healthy North Carolina 2020: A Better State of Health. http://www.nciom.org/wp-content/uploads/2011/01/HNC2020_FINAL-March-revised.pdf. Accessed November 21, 2012.

4 United Health Foundation. America's Health Rankings 2011: North Carolina. http://www.americashealthrankings.org/SiteFiles/Statesummary/NC.pdf. Accessed February 14, 2012.

5 United Health Foundation. America's Health Rankings 2011: North Carolina. http://www.americashealthrankings.org/SiteFiles/Statesummary/NC.pdf. Accessed February 14, 2012.

6 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2502(a), amending §1927(d) of the Social Security Act, 42 USC 1397r-8(d).

7 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4106.

8 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4107, amending section 1905 of the Social Security Act, 42 USC 1396d.

9 Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 4201, 10403.

10 United Health Foundation. America's Health Rankings 2011: North Carolina. http://www.americashealthrankings.org/SiteFiles/Statesummary/NC.pdf. Accessed February 14, 2012.

11 United Health Foundation. America's Health Rankings 2011: North Carolina. http://www.americashealthrankings.org/SiteFiles/Statesummary/NC.pdf. Accessed February 14, 2012.

12 United Health Foundation. America's Health Rankings 2011: North Carolina. http://www.americashealthrankings.org/SiteFiles/Statesummary/NC.pdf. Accessed February 14, 2012.

13 Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 10211-10214.

[14] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2951, enacting Sec. 511 of the Social Security Act, 42 USC 711.

[15] State Center for Health Statistics. Division of Public Health. North Carolina Department of Health and Human Services. Selected vital statistics for 2010 and 2006-2010: North Carolina: infant deaths (under 1 year). http://www.schs.state.nc.us/SCHS/vitalstats/volume1/2010/nc.html. Accessed February 15, 2012.

[16] North Carolina Home Visiting Program. North Carolina Department of Health and Human Services. North Carolina Infant and Early Childhood Home Visiting Program State Plan. http://www.ncdhhs.gov/dph/wch/doc/aboutus/2011-NC-HomeVisitingStatePlanNarrative.pdf. Published September 20, 2010. Accessed December 12, 2011.

[17] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4207, enacting Sec. 7 of the Fair Labor Standards Act, 29 USC 207.

[18] Communicable Disease Branch. Division of Public Health. North Carolina Department of Health and Human Services. 2010 HIV/STD Surveillance Report. Raleigh, NC: North Carolina Department of Health and Human Services; 2011. http://epi.publichealth.nc.gov/hiv/pdf/std10rpt.pdf. Accessed November 2011.

[19] CPONDER. Centers for Disease Control and Prevention. North Carolina–All Available Years Pregnancy Intention. http://apps.nccd.cdc.gov/cPONDER/default.aspx?page=DisplayAllYears&state=16&year=0&category=17&variable=16. Accessed February 12, 2012.

[20] State Center for Health Statistics. 2009 North Carolina Pregnancy Risk Assessment Monitoring System Survey Results. http://www.schs.state.nc.us/SCHS/prams/2009/intend.html. Published November 16, 2011. Accessed February 12, 2012.

[21] North Carolina Department of Health and Human Services. 2010 North Carolina Resident Pregnancy Rates: Females Ages 15-19 by Race/Ethnicity, Perinatal Care Regions, and County of Residence. http://www.schs.state.nc.us/SCHS/data/pregnancies/2010/preg1519.pdf. Accessed February 15, 2012.

[22] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2953, enacting Sec.513 of the Social Security Act, 42 USC 713.

[23] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1001, enacting § 2713 of the Public Health Service Act, 42 USC 300gg; Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302.

[24] Department of the Treasury, Department of Labor, Department of Health and Human Services. Group Health Plans and Health Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protectiion and Affordable Care Act; Interim Final Rule and Proposed Rule. 75(116):34538-34570. http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf. Published June 17, 2010. Accessed November 21, 2012.

[25] Department of the Treasury, Department of Labor, Department of Health and Human Services. Amendment to the Interim Final Rules for Group Health Plans and Health Insurance coverage Relating to Status as a Grandfathered health Plan under the Patient Protection and Affordable Care Act. *Federal Register* 75(221):70114-70122. http://www.gpo.gov/fdsys/pkg/FR-2010-11-17/pdf/2010-28861.pdf. Published November 17, 2010. Accessed November 21, 2012.

[26] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4104, amending Section 1833(a)(1) of the Social Security Act, 42 USC 1395l(a)(1).

[27] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4103, amending Section 1861(s)(2) of the Social Security Act, 42 USC 1395x(s)(2).

[28] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4106, amending Section 1905(a)(13) of the Social Security Act, 42 USC 1396d(a)(13).

[29] Patient Protection and Affordable Care Act, Pub L No. 111-148, §4204, amending Section 317 of the Public Health Service Act, 42 USC 247b.

[30] Fries JF, Koop CE, Beadle CE, et al. Reducing health care costs by reducing the need and demand for medical services. the health project consortium. *N Engl J Med.* 1993;329(5):321-325.

[31] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 2705, 10408.

[32] United States Department of Health and Human Services. The Affordable Care Act and Wellness Programs. Fact Sheet. http://www.healthcare.gov/news/factsheets/2012/11/wellness11202012a.html. Posted on November 20, 2012. Accessed November 21, 2012.

[33] The Kaiser Family Foundation and Health Research & Educational Trust. Employer Health Benefits. Annual Survey. 2012. http://ehbs.kff.org/pdf/2012/8345.pdf. Accessed November 21, 2012.

[34] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4303, amending Title III of the Public Health Service Act, 42 USC 2801.

[35] Eat Smart, Move More NC. WorkWell NC. http://www.eatsmartmovemorenc.com/Worksites/Worksites.htm. Accessed May 2, 2012.

[36] North Carolina Prevention Partners. WorkHealthy America. http://www.ncpreventionpartners.org/dnn/WhatWeDo/Programs/WorkHealthyAmerica/tabid/75/Default.aspx. Accessed February 29, 2011.

[37] Eat Smart, Move More NC. WorkWell NC. http://www.eatsmartmovemorenc.com/Worksites/Worksites.htm. Accessed May 2, 2012.

[38] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4304, enacting Sec. 2821 of the Public Health Service Act, 42 USC 300hh-31.