The Prevention Action Plan for North Carolina: 2015 Update

HISTORY

In 2009, North Carolina's leading health foundations—the Blue Cross and Blue Shield of North Carolina Foundation, The Duke Endowment, the Kate B. Reynolds Charitable Trust, and the former North Carolina Health and Wellness Trust Fund—joined together to ask the North Carolina Institute of Medicine (NCIOM) to convene a Task Force on Prevention. The NCIOM, in collaboration with the North Carolina Division of Public Health (DPH), convened the Task Force in the spring of 2008. The Task Force was chaired by Leah Devlin, DDS, MPH, former State Health Director;[1] Jeffrey Engel, MD, State Health Director, Division of Public Health, North Carolina Department of Health and Human Services; William Roper, MD, MPH, CEO, University of North Carolina (UNC) Health Care System and Dean, UNC School of Medicine; and Robert Seligson, MA, MBA, Executive Vice President and CEO, North Carolina Medical Society. Importantly, representatives of all four foundations were members of the Task Force, so key funders of North Carolina prevention programs helped craft the Prevention Action Plan for North Carolina outlined here. In addition to the co-chairs, the Task Force had 46 other members including legislators; representatives of state and local agencies; key health care leaders; public health experts; foundation leaders; business, community, and faith leaders; and other interested individuals. A Steering Committee of 13 individuals, representing many of the same groups mentioned above, guided the work of the Task Force. (See pages 9-12 of the original report for a complete listing of Task Force and Steering Committee members.)

Specifically, the NCIOM Prevention Task Force was charged with developing a comprehensive, evidence-based, statewide prevention plan to improve population health and thereby reduce health care costs. To accomplish this goal, the Task Force was asked to do the following:

- Comprehensively examine the preventable, underlying causes of the top 10 leading causes of death and disability in the state.
- Examine health disparities.
- Prioritize prevention strategies to improve population health through evidence-based interventions when possible and through best or promising practices when more thoroughly tested evidence-based strategies were not available.
- Develop a comprehensive approach to prevention that includes strategies to address the modifiable factors (i.e. personal behaviors, interpersonal relations, clinical care, communities and the environment, and public and health policies) that affect health outcomes.

2015 UPDATE

The Prevention Action Plan for North Carolina contained 45 recommendations covering the following topics: tobacco use, nutrition and physical inactivity, sexually transmitted diseases, HIV, and unintended pregnancy, substance abuse and mental health prevention and early intervention, environmental risks, injury, preventable infectious disease and foodborne illnesses, racial and ethnic disparities, socioeconomic factors impacting health, data needs, and site-specific strategies to improve population health across multiple risk factors. *The Prevention Action Plan for North Carolina* was developed as a roadmap for improving population health in North Carolina.

Over the past six years, *The Prevention Action Plan for North Carolina* has been instrumental in engaging and empowering North Carolina state and local agencies, health care and public health professionals, health organizations, insurers, community organizations, companies, the faith community, and other groups to prioritize prevention efforts. Working together off a common action plan and making wise use of resources offers the greatest opportunity to improve population health in North Carolina and to lower costs to individuals

[1] Dr. Leah Devlin served as one of the co-chairs for the Task Force from the inception of the work until she retired as State Health Director. At that time, Dr. Jeffrey Engel became one of the co-chairs. Dr. Devlin remained as a member of the Task Force.

and the system. In the last 6 years, this plan has provided guidance for programmatic investments across the state, new legislation, and foundation grant-making.

TOTAL RECOMMENDATIONS: 45

- **FULLY IMPLEMENTED: 17% (8)**
- **PARTIALLY IMPLEMENTED: 62% (28)**
- **NOT IMPLEMENTED: 20% (9)**

Investments by Sponsoring Foundations

Since the 2009 report, the state's major health foundations have made significant investments that support the recommendations. The plan has provided guidance for foundation grant-making and prioritization of prevention efforts and evidence-based practices. While many state funded programs and resources have been cut, such as the Health and Wellness Trust Fund that was abolished by the North Carolina General Assembly in 2011, North Carolina foundations have continued to make substantial investments to improve the health and well-being of residents with the goal of improving population health.

Three of the four original grant-makers of *The Prevention Action Plan for North Carolina*, Blue Cross and Blue Shield of North Carolina Foundation, The Duke Endowment, and the Kate B. Reynolds Charitable Trust, have made substantial investments across all recommendation areas. Together, they have contributed over $38 million to health programs across North Carolina.

BLUE CROSS BLUE SHIELD FOUNDATION

The Blue Cross and Blue Shield of North Carolina (BCBSNC) Foundation has supported preventative health measures through the donation of over $17,333,927 for programs emphasizing community models and evidence-based practices. In *Community Centered Health Homes: Bridging the gap between health services and community prevention,* BCBSNC Prevention Institute outlines an approach that community health centers can take to promote community health even as they deliver high quality medical services to individuals. The basic premise is that safety net health care organizations should engage with community partners to inform and engage in advocacy and policy change to improve community conditions that impact health. BCBSNC Foundation has provided technical assistance and financial support for 12 communities to experiment with aspects of the model and is currently in the process of selecting 2 to 4 communities to do more substantial planning and implementation of the model elements.[2]

Task Force Recommendation	Grantee/Grant Amount	Related BCBSNC Foundation supported activity	Key partners/Other information
4.1 Implement Child Nutrition Standards in All Elementary Schools and Test Strategies to Deliver Healthy Meals in Middle and High Schools	NC Department of Agriculture and Consumer Services 2011-2015 $1,206,000 Center For Environmental Farming Systems- Food Corps 2011-2014 $195,270 2014-2017 $384,000 Contracts with Chef Cyndie Story 2011-2012 $35,600 2013-2014 $55,000 and UNC Center for Health Promotion and Disease Prevention 2012-2015 $100,000	• Purchased five new tractor trailers for the NCDA Farm to School Program to increase the number of schools served and umber of growers participating. Also supported a marketing campaign for NCDA Farm to School. • Piloted and subsequently expanded Food Corps work in North Carolina to use schools gardens as cornerstones for building a local food infrastructure and teaching children about healthy eating • Partnered with the Reidsville Area Foundation to pilot training, equipment, and social marketing for low income elementary schools to increase consumption of fruits and vegetables as part of the school lunch program.	
4.2 Ensure All Foods and Beverages Available in Schools are Healthy	Appalachian Sustainable Agriculture Project 2009-2010 $67,539 2011-2013 $199,600 2014-2017 $300,000	• Two grants focus on pre-service dieticians and teachers to implement farm to school as part of their undergraduate experience and curriculum • One grant focuses on connecting local growers to local markets and expanding farm to school efforts across NC	**Three separate grants with ASAP**
4.4 Expand Physical Activity and	Be Active Kids	• Be Active Kids-Increase developmentally appropriate	**Be Active Kids is a signature program of the BCBSNC**

[2] Eyes, K.

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Nutrition in Child Care Centers and After-school Programs	Natural Learning Initiative 2007-2008 $49,625 2008-2011 $382,818 2012-2015 $808,000 UNC Center for Health Promotion Disease Prevention 2011-2014 $600,000 2014-2017 $950,475 NC Partnership for Children 2010-2013 $3 million 2014-2017 $3 million	active play for young children birth through age 5 • Preventing Obesity by Design-Increase physical activity and access to healthy food in child care by redesigning the outdoor learning environments with natural elements • Go NAPSACC-Nutrition and Physical Activity Self Assessment for Child Care-change policy and practice in child care related to breastfeeding, healthy eating and physical activity • Shape NC-Comprehensive project incorporating Be Active Kids, Preventing Obesity By Design, Go NAPSACC, Community Action Teams and ongoing TA to increase the number of NC children starting kindergarten healthy and ready to learn	**Foundation and we have been supporting the work of BAK annually. We have both separate support of BAK, NLI and UNC HPDP but those organizations are all also part of Shape NC as well.**
4.10 Expand Community Grants to Promote Physical Activity	Annual Physical Activity Equipment Grants	Each fall the BCBSNC Foundation offers physical activity equipment grants for up to $5000 per agency (total of $100K available each cycle) to purchase equipment to increase physical activity. The Foundation partners with statewide organizations and offers the equipment grants to constituent agencies of that organization. To date, the physical activity equipment grants have been in partnership with: • Natural Learning Initiative, NC State University, grants went to child care centers and community colleges to redesign outdoor learning environments with natural elements • NC PTA, grants went to schools to increase physical activity during the school day	
11.3 Expand Opportunities for High Quality Early Childhood Education and Health Programs	NC Partnership for Children 2010-2013 $3 million 2014-2017 $3 million	Shape NC	

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12.1 Enhance North Carolina Healthy Schools	NCPTA East Carolina University Youth Empowered Solutions	• Developed and expanded the NCPTA Just ASK program which engages parents as advocates for school health policy, practice and environmental change • ECU is home to the MATCH program, 7^{th} grade school based wellness intervention that has shown a 68% success rate in reducing BMI z-scores and maintaining that reduction more than 4 years after the intervention • Youth Empowered Solutions has worked on school polices and practice around healthy cafeterias and second chance breakfast to affect the school food environments	

THE DUKE ENDOWMENT

The Duke Endowment has continued its dedication to improving the health and wellness of North Carolinians, with over $4,533,312 of support since 2009. The bulk of their work in public health has been with three key grantees, The North Carolina Hospital Association (NCHA), The Center for Healthy NC (CHNC) and Western NC Health Network (WNCHN). These organizations have worked throughout the state to support the adoption and implementation of the *Prevention Action Plan* and Healthy NC 2020. The work of The Duke Endowment has been heavily influenced by the recommendations. In June 2015, the foundation released a request for applications to community coalitions to assist with implementation of evidence-based strategies and improve the effectiveness of coalitions. The focus areas are physical activity/nutrition and chronic disease.
improve the effectiveness of coalitions. Our focus areas are physical activity/nutrition and chronic disease.

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3.3 Expand Smoke-free policies in NC	NC Hospital Association 2009-2010; $250,000 2012-2015, $630,000	Helped to established the Healthy NC Hospitals project that implemented comprehensive wellness policies in hospitals and helped develop comprehensive tobacco cessation systems for patients in hospitals	Prevention Partners
3.4 Expand Access to cessation services, counseling, and medications for smokers who want to quit	NC Hospital Association 2009-2010; $250,000 2012-2015, $630,000	Helped to established the Healthy NC Hospitals project that implemented comprehensive wellness policies in hospitals and helped develop comprehensive tobacco cessation systems for patients in hospitals	Prevention Partners
4.2 Ensure All Foods and Beverages Available in Schools are Healthy	WNC Health Network 2011-2012, $372,000 2012-2014, $219,000	Project goal is to build and strengthen cross-sector collaboration on healthy living in our community by involving high school students in the planning and implementation of local health initiatives, including improving food options in the high school cafeteria. **Team attended 2014 WNC Healthy Kids Summit and these activities are supported by a mini-grant from WNC Healthy Kids*	**Madison County Cross-Sector Team*:** Madison County Health Department, YES! (Youth Empowered Solutions), Madison High School Health Ambassadors-schools (Youth Leaders), Safe Routes to School Coordinator (Regional), Appalachian Sustainable Agriculture Project (Regional)
4.4 Expand Physical Activity and Nutrition in Child Care Centers and After-school Programs	WNC Health Network 2011-2012, $372,000 2012-2014, $219,000	WIC/Nutrition staff will assist in providing proper sports nutrition education to athletes and their families through the soccer program **Team attended 2014 WNC Healthy Kids Summit and these activities are supported by a mini-grant from WNC Healthy Kids*	**Henderson County Cross-Sector Team***: Henderson County Health Department (Health Education & WIC); Henderson County Schools (School Nursing); Henderson County Parks & Rec.
		Enhance the after school Discovery Program with purchase of physical activity equipment.	**Clay County Cross-Sector Team*:**

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		**Team attended 2014 WNC Healthy Kids Summit and these activities are supported by a mini-grant from WNC Healthy Kids.*	Clay County Health Department (Health Education); Clay County Schools (School Nurse); NC Cooperative Extension—Clay County office; Clay County Communities in Schools
		ShapeNC; Alignment with regional message, 5-2-1-Almost None and dissemination of materials to families in centers that are also making changes to their physical activity, nutrition and outdoor play environment policies and practices. **Team attended 2014 WNC Healthy Kids Summit and these activities are supported by a mini-grant from WNC Healthy Kids* Healthy Kids Director provides leadership on the ShapeNC Steering Committee and is facilitating this group to identify results using the Results Based Accountability (RBA) framework.	Smart Start of Buncombe County houses one of the ShapeNC projects*.
		An afterschool "life skills" program for students at the county's alternative school, to include cooking classes, tasting sessions, meal planning, and shopping for healthy options at the grocery store as well as alternatives such as food pantries. The program will also provide opportunities to incorporate physical activity as part of "make-up" time as required for school attendance (*policy change). **Team attended 2014 WNC Healthy Kids Summit and these activities are supported by a mini-grant from WNC Healthy Kids*	**Transylvania Cross-Sector Team*:** Davidson River School, Transylvania County Schools; Transylvania County DSS; EFNEP, Cooperative Extension; Transylvania County Parks and Recreation; School Nurses, Transylvania County Schools; Transylvania County Department of Public Health
4.5 Implement the Eat Smart, Move More North Carolina Obesity Prevention Plan and Raise Public Awareness	WNC Health Network 2011-2012, $372,000 2012-2014, $219,000	5-2-1 Almost None “Getting Started in Your Sector” Toolkit distributed to stakeholders at WNCHK’s November 2014 Summit and available online, www.521almostnone.com These tools integrate the recommendations from the ESMM NC Obesity Prevention Plan and point to the related tools available on the ESMM website.	WNC Healthy Kids Policy Team: WNC Health Network, NC Center for Health and Wellness, MAHEC, YES!

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		The regional, aligning message and framework, 5-2-1 Almost None, is aligned with four of the 6 priority behaviors identified in the plan.	WNC Healthy Kids Communication Team: WNC Health Network, NC Center for Health and Wellness, Buy Haywood
4.8 Build Active Living Communities	WNC Health Network 2011-2012, $372,000 2012-2014, $219,000	Project goal is to build and strengthen cross-sector collaboration on healthy living in our community by involving high school students in the planning and implementation of local health initiatives, including improving pedestrian options (sidewalk/crosswalk) at the high school. **Team attended 2014 WNC Healthy Kids Summit and these activities are supported by a mini-grant from WNC Healthy Kids*	**Madison County Cross-Sector Team***: Madison County Health Department, YES! (Youth Empowered Solutions), Madison High School Health Ambassadors-schools (Youth Leaders), Safe Routes to School Coordinator (Regional), Appalachian Sustainable Agriculture Project (Regional)
		Including 5-2-1 Almost None and health habits tips on signage in new Creek Wise Park (which includes a KaBoom! build). **Team attended 2014 WNC Healthy Kids Summit and these activities are supported by a mini-grant from WNC Healthy Kids*	**McDowell County** Cross-Sector Team*: Grace Baptist Church Creek Wise Park McDowell Health Coalition North Carolina Public Health Foundation Care South
4.9 Establish Joint-use Agreements to Expand Use of School and Community Recreational Facilities	WNC Health Network 2011-2012, $372,000 2012-2014, $219,000	Project goal is to build and strengthen cross-sector collaboration on healthy living in our community by involving high school students in the planning and implementation of local health initiatives, including shared use of school facilities. **Team attended 2014 WNC Healthy Kids Summit and these activities are supported by a mini-grant from WNC Healthy Kids*	**Madison County Cross-Sector Team:** Madison County Health Department, YES! (Youth Empowered Solutions), Madison High School Health Ambassadors-schools (Youth Leaders), Safe Routes to School Coordinator (Regional), Appalachian Sustainable Agriculture Project (Regional)
4.12 Expand the CCNC Childhood Obesity Prevention Initiative	WNC Health Network 2011-2012, $372,000 2012-2014, $219,000	WNC Pediatric Care Collaborative—group (18+ practices) of area health care providers working to standardize and improve care for children who are obese or at risk of obesity, experiencing asthma and diagnosed with ADHD. The obesity team developed a work flow and related tools/resources to support the implementation of best practices for obesity treatment and	WNC Pediatric Care Collaborative Obesity Prevention Team: CCWNC, Quality Improvement Specialist; MAHEC, Community Health Specialist, Physician Champion—

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		prevention in pediatric primary care practices, which has been widely adopted among the 18+ practices in the collaborative. The CCNC developed patient education tools were included in the materials packet as resources for supporting the workflow. There was additional, specific, family health habits assessment and patient education tools developed for families with children birth to 2 years old to encourage practices to start primary prevention related to physical activity, nutrition, screen-time and parenting skills at birth. http://www.fhconline.com/cms-assets/documents/149707-750859.pediatriccollaborativetargetsobesityas	Medical Director, Henderson County Health Department; WNC Health Network, Director, WNC Healthy Kids
5.1 Increase Awareness, Screening, and Treatment of Sexually Transmitted Diseases and Reduce Unintended Pregnancies	Center for Supportive Schools Jan. 2014—Jan. 2016 $250, 000	Grant to the Center for Supportive Schools to replicate a Teen PEP (a peer-led pregnancy prevention program) in 6 NC schools. 2 year grant term.	The Duke Endowment (Child Care) and the Center for Supportive Schools.
5.1 Increase Awareness, Screening, and Treatment of Sexually Transmitted Diseases and Reduce Unintended Pregnancies	SHIFT NC Dec. 2014—Dec. 2016 $360,000	Grant to SHIFT NC to work with two North Carolina counties to increase the community's ability to implement and sustain teen pregnancy prevention strategies. 2 year grant term.	The Duke Endowment, SHIFT NC, Onslow County public and private agencies, Anson County public and private agencies.
6.1 Develop and implement a Comprehensive Substance Abuse Prevention Plan	Center for Healthy NC 2011-2013, $563,040 2013-2016, $1,389,272	**Haywood County Opioid Overdose Reduction Program** Provided TA and Coaching to: • Form and mobilize a community coalition for opioid overdose reduction and accidental poisoning due to sharing of prescription medication. • Increase participation in CSRS among prescribers and pharmacist in Haywood County • Increase number of medication drop-off boxes in county by 5 for a total of 7 • Provide education and awareness through pharmacy flyers placed with every prescription filled in the county for one month alerting to location of drop-off sites and dangers of sharing medication. • Train and distribute Naloxone kits to first responders resulting in reversing	Mountain Projects of Haywood County; Project Lazarus; Haywood County Commissioners; EMS, Waynesville Police and Fire; Haywood Regional Medical Center; Haywood County Health Department Healthy Harnett (Healthy Carolinians, Harnett Health/Cape Fear Regional Health, Harnett County Health Department); The Sista Project; United Way of Harnett County; Community Health

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		three opioid overdoses in first three months of implementation **Harnett County Opioid Overdose Reduction Initiative.** Provided TA and Coaching to: • Bring EBS to the Healthy Harnett coalition to begin a comprehensive opioid overdose reduction program. • Increase number of medication drop-off boxes in county. • Provide education and awareness through pharmacy flyers placed with every prescription filled in the county for one month alerting to location of drop-off sites and dangers of sharing medication. TA for content of PSA's and two billboards **NENCPPH Substance Abuse Coalition** Provided TA for: • data collection and analysis on scope and depth of substance abuse issues over 13 counties in the north eastern part of NC. • successful completion of two in-service trainings open to prescribers and pharmacists on CSRS with immediate registration into system. **Wilson County Substance Abuse Coalition** Provided TA and coaching to coalition for: • identification of multi-cultural middle and high school substance abuse education program • identifying, writing and submitting grant applications **Sampson County Meth Task Force** Provided TA for: • data collection and analysis for scope of opioid overdoses in county • identification of needed program components and EBS to reduce number of opioid overdoses	Center; Head Start; Central Carolina Community College CCNC; 13 Health Departments who comprise NENCPPH Wilson County School System; WIlson County Health Department; WIlson County Memorial Hospital; Wilson County Commissioners Sampson County Health Department; Sampson County Schools; Sampson County Sheriff; Clinton Police Department
8.2 Enhance Injury Surveillance, Intervention and Evaluation	WNCHN 2012-2014, $500,000	**McDowell County Project**: conducted a one-year pilot with the goal of developing an interdisciplinary comprehensive fall prevention network in a rural, Tier One county to 1) assess current services, opportunities for training/ education and care gaps, and 2) develop a network of services for evaluation and	Triple Aim Project — Falls Prevention Team: McDowell Balance

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		management in the following areas: **Older Adult Screening** –build on the CHAMP program (PT, nursing, and senior center services providing evaluation/management at McDowell County Senior Center), **Primary Care Providers/Prescribers–** include opportunities for education / documentation & utilization of community resource list, **EMS / ED** – focus on: 1) those who fall but do not need transport and 2) those who fall, are transported but do not need to be admitted to hospital. Offer a home safety assessment with report to primary care provider and referrals as needed. **Home Care** – where options include: **OT / PT** – enhancement of programs for screening / evaluation / treatment / referral ; Empowering Direct Care workers to become team members using NCOA/PHI Fall Prevention Awareness Curriculum ; **Community Exercise Providers –** engage in training and adoption of evidence-based fall prevention physical activity programs such as Tai Chi Moving for Better Balance. Now known as McDowell Balance this group continues to convene.	
8.2 Enhance Injury Surveillance, Intervention and Evaluation	Center for Healthy NC 2011-2013, $563,040 2013-2016, $1,389,272	Injury Free Academy Provided TA and coaching to 8 teams participating in Injury Free Academy addressing unintentional poisoning.	
8.3 Enhance Training of State and Local Public Health Professionals, Social Workers and Others (RT injury prevention)	WNCHN 2012-2014, $500,000	29 participants, representing 8 organizations attended Direct Care Worker Training. In addition, seven physicians educated on McDowell Balance and resources available through the network	Triple Aim Project — Falls Prevention Team: McDowell Balance
9.1 Increase Immunization Rates	Center for Healthy NC 2011-2013, $563,040 2013-2016, $1,389,272	Assisting NENCPPH with identifying and EBI to increase immunization of children 0-5.	NENCPPH partners
11.2 Increase the availability of Affordable Housing and Utilities	Center for Healthy NC 2011-2013, $563,040 2013-2016, $1,389,272	Healthy Southern Wake County Provided TA for assessing availability of affordable housing in Southern Wake County	Southern Wake Regional Health and Human Services; Rex Healthcare; WakeMed; Fuquay Varina Chamber of

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			Commerce; Bob Barker Company; Holly Springs Chamber of Commerce; Becky Medlin Realty services
12.5 Improve Provider Training to Promote Evidence-based Practices	WNCHN 2012-2014, $500,000	(see entry for 4.12, above—WNC Pediatric Care Collaborative) (see entry for 8.3, above – Direct Care Worker Training – F**all Prevention**) **Advance Care Planning** team offered Respecting Choices and Beginning the Conversation to over 80 individuals. **Transitions of Care** – focus on providers trained in the region on evidence based practices to reduce readmission. Adoption of INTERACT by Skilled Nursing Facilities including those trained as well as those Implementing. **Mental Health** Team offered Mental Health First Aid courses as well as Commitment Education Programs to hospital staff, magistrates, law enforcement, first responders, outpatient providers, community organizations and government agencies	Triple Aim Project, WNC Healthy Kids, Fall Prevention, Transitions of Care, Advance Care Planning, Mental Health, WNCHN
12.5 Improve Provider Training to Promote Evidence-based Practices	Center for Healthy NC 2011-2013, $563,040 2013-2016, $1,389,272	Evidence-Based Interventions Training twice a year	Multiple EBI partners (UNC, CPHQ, Granville-Vance LHD, AHEC, etc.)
12.5 Improve Provider Training to Promote Evidence-based Practices	Center for Healthy NC 2011-2013, $563,040 2013-2016, $1,389,272	The Community Health Improvement Application (IMAPP) is a comprehensive, user-friendly resource to help cross-sector community partnerships select and implement evidence-based interventions (EBIs) to improve priority population health conditions (Healthy NC 2020).	Center for Healthy NC, Center for Public Health Quality
13.2 Identify and Disseminate Effective Nutrition, Physical Activity, obesity, and Chronic Disease Prevention Practices in North Carolina	WNC Health Network 2011-2012, $372,000 2012-2014, $219,000	Providing Results-Based Accountability trainings to build capacity to better identify what is working to improve health and healthcare in the region. 5-2-1 Almost None "Getting Started in Your Sector" Toolkit distributed to stakeholders at WNCHK's November 2014 Summit and available online, www.521almostnone.com. Each sector-specific document draws from the best sources for best practices/programs/policies	WNC Health Network and WNC Healthy Impact Evaluation & Action Team: Regional partners in addition to hospitals and health departments: Western Carolina University, NC Center for Health and

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		that are related to 4 health habits linked to healthy weigh	Wellness, Care Share Health Alliance WNC Healthy Kids Policy Team: WNC Health Network, NC Center for Health and Wellness, MAHEC, YES!

KATE B. REYNOLDS

In accordance with their mission to "improve the quality of life and quality of health for the financially needy of North Carolina", the Kate B. Reynolds Foundation has been a leader in promoting the use of evidence-based programs through their Health Care Division. Since 2009, the organization has donated a total of $16,184,033 since 2009 towards health initiatives. The foundation has supported innovative urban programs to fit the needs of rural communities, including the Nurse-Family Partnership in Rockingham County and Prevention Partners and Healthy Workplace initiatives through Prevention Partners. Other notable programs include a community-centered prevention program with the Halifax County Health Department to implement the Coordinated Approach to Child Health (CATCH) program in fifteen elementary schools in Halifax County serving low-income children.[3]

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Obesity, Nutrition, and Physical Activity Recommendations			
4.3 Implement Quality Physical Education and Healthful Living in Schools	Halifax County Health Department: $664,509 2014 East Carolina University: 2012, $408,693	Operating funds to implement the Coordinated Approach to Child Health (CATCH) program in fifteen elementary schools in Halifax County serving low-income children. operating funds to expand MATCH- a school-based obesity reduction program targeting middle school students in eastern North Carolina	Halifax County Schools Weldon City Schools
4.4 Expand Physical Activity and Nutrition in Child Care Centers and After-school Programs	Beaufort Hyde Partnership for Children, 2013 $183,590	Operating funds and capital dollars for a Beaufort County adaptation of Preventing Obesity by Design, an existing effort that engages child care centers in redesigning the daily routine and physical spaces to encourage physical activity and healthy eating among young children.	The Down East Partnership
4.8 Build Active Living Communities	KaBOOM! 3 grants, total $1,656,807 Halifax County: $24,750 2014	KaBOOM! Community Build Playground Projects in Burke, Nash, Edgecombe, Rockingham, Beaufort, McDowell and Halifax Counties. operating funds to develop a countywide master recreation plan to address obesity and the overall health of residents of Halifax County	
	McDowell County 2 grants 2013-2014 $302,890	capital funds to renovate an indoor gymnasium to increase access to and utilization of public active living spaces for McDowell County residents	
4.9 Establish Joint-use Agreements to Expand Use of School and Community Recreational Facilities	City of Marion $40,000 2013 Halifax, McDowell, Rutherford-Polk-	capital funds to expand the Catawba River Greenway to add a 2,800 linear foot paved extension to increase recreational opportunities for county residents capital funds to construct an interactive fitness areas in rural counties	

[3] Smart, A. Interim President / Vice President, Kate B. Reynolds Charitable Trust. Oral (telephone) communication. July 10, 2015.

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	McDowell District, Rockingham, Forsyth and Beaufort County; 6 grants 2013-2014, total of $2,500,000		
4.10 Expand Community Grants Program to Promote Physical Activity	The North Carolina Public Health Foundation: 2 grants, total 1,935,849 2015	Operating funds to expand community mobilizing and technical assistance efforts to prevent chronic disease in Burke, Edgecombe, Beaufort, Rockingham and Nash counties. The project builds on the Trust's supported North Carolina Department of Public Health's statewide Community Transformation Catalyst program which builds local capacity to advance evidenced based healthy eating and active living strategies. Project staff engage diverse community organizations and facilitate both project development and environmental changes. Catalyst currently are located in five rural counties, four of the Trust's seven Healthy Places NC counties.	
Substance Abuse and Mental Health Recommendations			
6.1 Develop and Implement a Comprehensive Substance Abuse Prevention Plan	University of North Carolina at Greensboro 2 grants 2014-2015 total: $307,525 NC Department of Juvenile Justice and Delinquency 2011 $710,000	Operating funds to deliver coaching, technical assistance and training to Critical Behavioral Health Access Agencies, Court Services and LME-MCO's implementing the Reclaiming Futures model across the State. Operating funds to support the new programmatic infrastructure for the Reclaiming Futures program	
6.2 Expand the Availability of Screening, Brief Intervention, and Treatment for People with Behavioral Health Problems in the Primary Care Setting	Rural Health Group, Inc., $1,300,000 April 2015 North Carolina Foundation for Advanced Health Programs, Inc. 3	operating funds to develop integrated behavioral health School-Based Health Centers in Halifax, Northampton and Warren counties funds to support various behavioral health care initiatives, including NC Center for excellence for integrated care and community care of NC Chronic Pain Initiative	

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	grants from 2011-2013 total of $2,067,682		
6.3 Expand Early Intervention Services in the Faith Community			
Racial and Ethnic Disparity Recommendations			
10.1 Fund Evidence-Based Programs to Meet the Needs of Diverse Populations	El Futuro, Inc. $274,460 2012 Hispanics in Philanthropy: $55,000 2013	operating funds to strengthen the system of behavioral healthcare for Latinos in Alamance, Chatham, Durham, Lee, Orange and Randolph counties Operating funds for support of funders collaborative providing funding and capacity building support for Latino-led non-profit organizations engaged in health issue work.	Group of NC Funders
Socioeconomic Determinants of Health Recommendations			
11.1 Promote Economic Security			
11.2 Increase the Availability of Affordable Housing and Utilities	NC Housing Foundation, Inc. 3 grants 2011-2013 totaling $625,500	providing supportive housing services to financially needy residents of Forsyth County	
11.3 Expand Opportunities for High Quality Early Childhood Education and Health Programs	Smart Start of Forsyth County, $150,000 2015	operating funds to implement the My Teaching Partner Program (MTP) for teachers to improve the quality of behavioral interactions between teachers and students	
11.4 Increase the Graduation Rate			
Cross-Cutting Strategies in Schools, Worksites, and Clinical Settings Recommendations			
12.2 Require the Use of Evidence-based Curricula for Healthful Living Standard Course of Study			Center for Creative Leadership

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12.4 Expand Health Insurance Coverage to More People	Care Share Health Alliance 2 grants, total $459,800 2014-2015 Child Care Services Association: $82,500 2013 Council on Aging in Buncombe County, Inc. $67,100 2014 Enroll America 3 grants,2013-2014 total $625,948 HealthNet Gaston 2 grants 2014-2015 total $252.099 Hispanic Liaison of Chatham County, 2014 $27,000 NC Institute of Medicine $27,500 2013 NC Justice Center, 2013-2014 2 grants, total $484,000 Pisgah Legal Services $63,454 2013	Operating funds to increase understanding, awareness and enrollment for health coverage through the Affordable care Act throughout North Carolina Medicaid Expansion	
12.5 Improve Provider Training to Enhance Knowledge of Evidence-based Practices	Prevention Partners: 3 grants, 2011-2015 total $838,177	operating funds to engage community leaders and employers with low-wage workers to build and value healthy workplaces and reduce chronic disease through evidence-based program and policy work	
Data Recommendations			

Task Force Recommendation	Grantee/Grant Amount	Related Foundation supported activity	Key partners/Other information
13.2 Identify and Disseminate Effective Nutrition, Physical Activity, Obesity, and Chronic Disease Prevention Practices in NC	Third Sector New England $49,200 2014	operating funds for the assessment ,development and dissemination of local and national strategies involving healthy eating and physical activity	Active Living by Design

CHAPTER 3: TOBACCO USE

Recommendation 3.1: Fund and Implement a Comprehensive Tobacco Control Program

NOT IMPLEMENTED

a) The North Carolina General Assembly should support the state's Comprehensive Tobacco Control Program by protecting the North Carolina Health and Wellness Trust Fund's (HWTF) ability to continue to prevent and reduce tobacco use in North Carolina by:
   1) Ensuring that no additional funds are diverted from HWTF's share of the Master Settlement Agreement (MSA).
   2) Releasing HWTF from its obligation to use over 65% of its annual MSA receipts to underwrite debt service for the State Capital Facilities Act, 2004.

b) The North Carolina General Assembly should better enable the North Carolina Division of Public Health (DPH) and HWTF to prevent and reduce tobacco use in North Carolina by appropriating additional funding to DPH so that this new state funding, combined with HWTF's annual allocation for tobacco prevention (based on provision A), reaches $106.8 million in recurring funds by SFY 2020. The total amount of the funds available for Tobacco Control in North Carolina should be increased as follows:
   1) $26.7 million in recurring funds by SFY 2011
   2) $53.4 million in recurring funds by SFY 2015
   3) $90.8 million in recurring funds by SFY 2018
   4) $106.8 million in recurring funds by SFY 2020

c) DPH should work collaboratively with the HWTF and other stakeholders to ensure that the funds are spent in accordance with best practices as recommended by the Centers for Disease Control and Prevention.

Background
The Health and Wellness Trust Fund was one of three grant-making entities created in 1999 by the North Carolina General Assembly (NCGA) to administer the state's Tobacco Master Settlement Agreement (MSA) funds, and the only grant making entity of the three for the benefit of health related programs and initiatives. The Tobacco Master Settlement Agreement is an agreement between tobacco manufacturers and states where tobacco manufacturers agreed to a number of conditions as well as to make annual payments to states, and received immunity from the harms caused by tobacco. North Carolina receives approximately $140 million each year in perpetuity from this MSA.[4]

The Health and Wellness Trust Fund
The Health and Wellness Trust Fund (HWTF) was abolished by the NCGA in 2011. A NCGA Fiscal Research Division Brief dated May 2, 2012 provided details of the changes made that year to how the Tobacco Master Settlement agreement funds are to be used in North Carolina. At the time of this report, funding from the NC MSA was to continue to go to pay the debt service authorized in SL 2004-179 and to the University Cancer Research Fund (GS 116-29.1).[5]

When the HWTF was abolished in 2011-12, the final years' funds for tobacco prevention and cessation - $17,326,423 - came to the Division of Public Health (DPH) to manage and close out. DPH worked with leaders to fully utilize the remaining funds on evidence-based tobacco prevention and cessation programs. Funding was

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[4] Herndon, S. Head, Tobacco Prevention and Control Branch, Chronic Disease and Injury Section, Division of Public Health, NC Department of Health and Human Services. Written (email) communication. August 14, 2015.
[5] Herndon, S.

distributed to a number of programs including: community grants programs focused on teen tobacco prevention, mass media campaigns to educate young people about the harms of tobacco use, and QuitlineNC services to help tobacco users quit.[6]

With QuitlineNC funding in 2011-2012 at $1,898,000, DPH expanded QuitlineNC promotions to promote these services to all adult smokers who wanted to quit, where previously the target population had been primarily teens and young adults. In addition, DPH recommended and received support to provide nicotine replacement therapy through QuitlineNC (as resources allowed) for tobacco users ready to quit, in keeping with evidence-based practices. The one 2013-14 state budget recurring line item for tobacco prevention and cessation is for QuitlineNC at $1,200,000.[7]

The Centers for Disease Control updated "Best Practices for Comprehensive Tobacco Control Programs" in 2014. The overarching components of a Comprehensive Tobacco Control Program include:

- State and Community Interventions
- Mass Reach health communication interventions
- Cessation interventions
- Surveillance and Evaluation
- Infrastructure, administration and management

The report describes an integrated budget structure for implementing interventions proven to be effective, and the minimum and recommended state investment that would be required to reduce tobacco use in each state. North Carolina specific recommendations in the 2014 report are as follows:[8]

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[6] Herndon, S.
[7] Herndon, S.
[8] Herndon, S.

North Carolina

Program Intervention Budgets	2014
Recommended Annual Investment	**$99.3 million**
Deaths in State Caused by Smoking	
Annual average smoking-attributable deaths	14,200
Youth aged 0-17 projected to die from smoking	180,000
Annual Costs Incurred in State from Smoking	
Total medical	$3,810 million
State Revenue from Tobacco Sales and Settlement	
FY 2012 tobacco tax revenue	$294.8 million
FY 2012 tobacco settlement payment	$141.0 million
Total state revenue from tobacco sales and settlement	$435.8 million
Percent Tobacco Revenue to Fund at Recommended Level	**23%**

	Annual Total (Millions)		Annual Per Capita	
	Minimum	**Recommended**	**Minimum**	**Recommended**
I. State and Community Interventions Multiple social resources working together will have the greatest long-term population impact.	$26.4	$33.1	$2.71	$3.39
II. Mass-Reach Health Communication Interventions Media interventions work to prevent smoking initiation, promote cessation, and shape social norms.	$6.8	$9.8	$0.70	$1.00
III. Cessation Interventions Tobacco use treatment is effective and highly cost-effective.	$27.1	$43.5	$2.78	$4.46
IV. Surveillance and Evaluation Publicly funded programs should be accountable and demonstrate effectiveness.	$6.0	$8.6	$0.62	$0.89
V. Infrastructure, Administration, and Management Complex, integrated programs require experienced staff to provide fiscal management, accountability, and coordination.	$3.0	$4.3	$0.31	$0.44
TOTAL	$69.3	$99.3	$7.12	$10.18

Note: A justification for each program element and the rationale for the budget estimates are provided in Section A. The funding estimates presented are based on adjustments for changes in population and cost-of-living increases since *Best Practices — 2007* was published. The actual funding required for implementing programs will vary depending on state characteristics, such as prevalence of tobacco use, sociodemographic factors, and other factors. See Appendix E for data sources on deaths, costs, revenue, and state-specific factors.

Centers for Disease Control and Prevention • Office on Smoking and Health
www.cdc.gov/tobacco • tobaccoinfo@cdc.gov • 1 (800) CDC-INFO or 1 (800) 232-4636

The North Carolina General Assembly funded $1,200,000 for state Tobacco Control Programs in the budget for FY 2014-2015, as compared to the CDC Annual Recommendation of $99.3 million.[9]

[9] National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Centers for Disease Control. http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/comprehensive.pdf. Published 2014. Accessed November 23, 2015.

Recommendation 3.2: Increase North Carolina Tobacco Taxes (PRIORITY RECOMMENDATION)

NOT IMPLEMENTED

a) **The North Carolina General Assembly should increase the tax on a pack of cigarettes to meet the current national average. The cigarette tax should be regularly indexed to the national average whenever there is a difference of at least 10% between the national average cost of a pack of cigarettes (both product and taxes) and the North Carolina average cost of a pack of cigarettes.**
b) **The North Carolina General Assembly should increase the tax on all other tobacco products to be comparable to the current national cigarette tax average, which would be 55% of the product wholesale price.**
c) **These new revenues should be used for a broad range of prevention activities including preventing and reducing dependence on tobacco, alcohol, and other substances.**

No new tobacco taxes have been implemented since the $0.35 cigarette tax increase in 2009. North Carolina cigarette taxes are $.45 per pack compared to the national average of $1.60 per pack as of June 30, 2015. North Carolina ranks 46th in the nation for cigarette taxes. Other tobacco products are taxed at 12.5% of the wholesale price. As of June 1, 2015, e-cigarettes are taxed at 5 cents per milliliter of consumable nicotine liquid solution.[10]

Recommendation 3.3: Expand Smoke-free Policies in North Carolina

PARTIALLY IMPLEMENTED

The North Carolina General Assembly should amend current smoke-free laws to mandate that all worksites are smoke-free.

a) **In the absence of a comprehensive state smoke-free law, local governments, through their Boards of County Commissioners, should adopt and enforce ordinances, board of health rules, and policies that restrict or prohibit smoking in other public places.**

In 2009, North Carolina adopted a Smoke-Free Restaurants and Bars Law (NC SFRBL) that is the most restrictive among southern states. This smoke-free law also partially repealed preemption of local government smoking regulations. The percentage of North Carolina workers being exposed to secondhand smoke in the workplace declined from14.6% in 2008 to 7.9% in 2010 (a reduction of 45%) when the smoke-free restaurants and bars law went into effect. Due to changes in the methodology of the Behavioral Risk Factor Surveillance System (BRFSS), the survey that collects secondhand smoke exposure data, in 2011, the prevalence of adult smokers prior to 2011 is no longer comparable to that collected after 2011. In 2013, 9.9% of North Carolina workers were exposed to secondhand smoke in the workplace.[11]

In 2010, North Carolina saw a 21% decline in average weekly Emergency Department visits for heart attacks; and a 7% decline in the probability of Emergency Department visits for the population with asthma after the law went into effect compared to before the law went into effect. Local smoke-free places are increasing healthy environments and supporting healthy behaviors.[12]

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[10] Herndon, S.

[11] Herndon, S.
[12] Herndon, S.

As of August 2015, 75% of counties have a written smoke-free or tobacco-free regulation for government buildings and 41% of municipalities have adopted written smoke-free or tobacco-free regulations for their buildings. Seventeen percent of counties and 11% of municipalities have adopted a 100% smoke-free or tobacco-free grounds regulation. Furthermore, two counties and eight municipalities have adopted local regulations to prohibit smoking and tobacco use in all enclosed places where the public is invited or permitted.[13]

Recommendation 3.4: Expand Access to Cessation Services, Counseling, and Medications for Smokers Who Want to Quit

PARTIALLY IMPLEMENTED

a) **Insurers, payers, and employers should cover comprehensive, evidence-based tobacco cessation services and benefits including counseling and appropriate medications.**
b) **Providers should deliver comprehensive, evidence-based tobacco cessation services including counseling and appropriate medications.**

The Patient Protection and Affordable Care Act enacted in March 2010 and effective January 2014 requires health plans and health insurance to cover tobacco-use counseling and interventions without cost sharing or prior authorization. Furthermore, all patients are required to be screened for tobacco use; under the Affordable Care Act, full coverage is guaranteed for two specific quit efforts during a member's benefit year. Each quit effort is defined as a 90 day effort. Within each quit effort, a member has coverage of prescription drugs (such as Chantix), Nicotine Replacement Therapy/over the counter drugs (such as the patch), and/or telephonic counseling – 4 telephonic counseling sessions per each 90 day quit effort.[14]

Historically, Blue Cross and Blue Shield of North Carolina (BCBSNC), the largest provider of private insurance in North Carolina, already covered tobacco screening. Since the implementation of the Affordable Care Act, BCBSNC has changed the drug benefit for members with the tobacco cessation benefit to ensure 100% coverage for both prescription drugs and the Nicotine Replacement Therapy/over the counter drugs. In addition, BCBSNC contracted with the North Carolina Quitline to provide telephonic counseling to meet the ACA requirements. QuitlineNC provides free cessation services to any North Carolina resident who needs help quitting tobacco use, 24 hours a day, 7 days a week, in both English and Spanish.[15]

State funds for QuitlineNC are limited. Individuals with Medicaid and the uninsured are the priority recipients for Quitline NC services supported by state funds. The Tobacco Prevention and Control Branch works with the NC Public Health Foundation to provide access to QuitlineNC services for employers and health insurance plans who wish to contract for this evidence-based tobacco cessation service.[16]

The tobacco cessation services described above are available for individuals who have health care coverage under the Affordable Care Act. Individuals who do not have ACA coverage may be able to access tobacco screening and telephonic counseling via the QuitlineNC if resources are available. Individuals without coverage through ACA do not have access to the cessation drugs.[17]

Since 2009, providers have also taken strides to ensure delivery of comprehensive, evidence-based tobacco cessation services. The North Carolina Academy of Family Physicians (NCAFP) is the state's largest specialty medical association, with a membership of over 3,700 family physicians, family medicine residents, and

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[13] Herndon, S.
[14] Allen, C. Healthcare Program Director, Blue Cross Blue Shield North Carolina. Written (email) communication. July 6, 2015.
[15] Allen, C.
[16] Herndon, S.
[17] Allen, C.

medical students. Through their mandated efforts to improve the health of patients, families, and communities in North Carolina, the NCAFP has included education around tobacco cessation counseling at a number of Continuing Medical Education Conferences since 2009. The organization has also promoted the use of evidence-based practice such as SBIRT (Screening, Brief Intervention, and Referral to Treatment) and motivational interviewing techniques for reducing tobacco use.[18]

CHAPTER 4: OBESITY, NUTRITION, AND PHYSICAL ACTIVITY

Recommendation 4.1: Implement Child Nutrition Standards in All Elementary Schools and Test Strategies to Deliver Healthy Meals in Middle and High Schools

PARTIALLY IMPLEMENTED

a) **Elementary schools should fully implement the State Board of Education (SBE)-adopted nutrition standards. Districts should receive support for implementation from the North Carolina General Assembly under the following conditions:**
    a. **The school district is in full compliance with SBE policy on nutrition standards in elementary schools (GS 115C-264.3).**
    b. **The school district is not charging indirect costs to the Child Nutrition Program until such time as the Child Nutrition Program achieves and sustains a three-month operating balance.**

b) **The North Carolina General Assembly should appropriate $20 million in recurring funds beginning in SFY 2011 to the North Carolina Department of Public Instruction (DPI) to support the full and consistent implementation of the SBE-adopted nutrition standards in elementary schools.**

c) **North Carolina funders should develop a competitive request for proposals to fund a collaborative effort between DPI and other partners to test the potential for innovative strategies to deliver healthy meals in middle and high schools while protecting/maintaining revenue for the Child Nutrition Program. Funders should require grant recipients to conduct an independent rigorous evaluation that includes cost.**

The Healthy, Hunger-Free Kids Act (Pub. L. 111-296, HHFKA) became a federal law in 2010, superseding the 2006 North Carolina State Board of Education nutrition standards. A key component of the HHFKA raised school nutrition standards for all schools receiving federal reimbursement. Every public school in North Carolina receives federal reimbursement for meals. USDA rule 7 CFR 210 and 220 established the new national school nutrition standards to be in line with the 2005 Dietary Guidelines for Americans. The standards include mandatory reductions in sodium, saturated fat and trans fat, accompanied by required increases in whole grains, fruits, vegetables and low or non-fat milk. The school nutrition standards were based on a 2009 report from the Institute of Medicine (IOM). In addition to raising nutritional requirements for reimbursable meals, the HHFKA raised the nutritional standards for a la carte and vending machine items, which had previously been exempt from meeting nutritional guidelines.

North Carolina was one of the first states to be fully compliant with the new nutrition standards, achieving 100% compliance in June, 2013.[19] School districts have very little discretion in compliance with the federal law,

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[18] Allen, C.

[19] Harvey L. Director, Child Nutrition Services, North Carolina Department of Public Instruction. Testimony before the Subcommittee on Early Childhood, Elementary, and Secondary Education of the U.S. House of Representatives Committee on Education and the Workforce. Child Nutrition Assistance: Looking at the Cost of Compliance for States and Schools. June 24, 2015.

because they cannot claim federal reimbursement for meals if their nutrition program does not conform to the federal nutritional standards.

In 2010, The North Carolina General Assembly commissioned a report from the Program Evaluation Division (PED) to examine the viability of the Child Nutrition Program. The PED report took note of the "trilemma" of child nutrition, in which a trade-off exists between cost, nutritional value, and student participation. Nutritious food is often costly and unappealing to students, which tends to reduce student participation in meal programs. Traditionally, students wishing to avoid unappealing meals have purchased less healthy a la carte items, which are not reimbursable and have historically provided substantial revenue to Child Nutrition Programs. A la carte sales have thus traditionally offset losses from meal programs, which are typically reimbursed at a lower rate than the costs incurred in meal preparation.

The USDA sets the federal reimbursement rates for school meals. As of FY 2011-2012, free meals for qualifying students were reimbursed at $2.77 per meal, reduced price meals were reimbursed at $2.37 per meal, and paid meals were reimbursed at $0.26 per meal. At the time, the cost of preparation was $3.00 per meal in North Carolina, so on average, each meal incurred a loss.[20] To help offset higher costs of nutritious food, HHFKA raised the reimbursement rates by $0.06 per meal. Testifying before Congress on June 24th, 2015 Dr. Lynn Harvey, Chief of School Nutrition Services at the North Carolina Department of Public Instruction said "6 cents is not sufficient to support the lunch requirements, let alone the cost of serving more whole grains and fruit at breakfast, for which no additional funds have been provided."[21]

Child Nutrition Programs have to pay school districts indirect costs at the discretion of the district. The district assesses how much of its funding went toward indirect costs of the Child Nutrition Program, and the Child Nutrition Program reimburses the district for those expenses. In North Carolina, Child Nutrition Programs are considered insolvent if they have less than one month's operating budget on hand. In 2013, the North Carolina Legislature enacted G.S. § 115C-450 to prevent districts from assessing costs to the Child Nutrition Program, unless the program had more than one month's operating budget available.

No new state appropriations have been made available to support Child Nutrition Programs in North Carolina. North Carolina does not contribute funding to the Child Nutrition Program beyond the federally required state match. Federal reimbursement is tied to student participation, so any reduction in meal program participation reduces revenue. In North Carolina, student participation in meal programs has fallen by 5% since the new rules were implemented.[22] Students have been reluctant to accept the new whole grain and sodium requirements. Food waste has also increased, possibly as the result of a provision of the law that requires students to choose a fruit or vegetable as part of a reimbursable lunch. Compliance with the HHFKA has placed additional financial strain on North Carolina's Child Nutrition Programs. Twenty of North Carolina's 115 school districts currently have negative operating balances, and are drawing on general district funding. Another 21 are insolvent, with less than 1 month's operating budget.[23] Now that districts cannot assess indirect costs to insolvent programs, these districts are experiencing losses in general funds.

Because of the federal regulations, no new pilot programs have been done since 2009 to test cost-effective nutrition programming. However, some districts and schools have taken simple but innovative approaches to help Child Nutrition Programs reduce food waste and increase nutrition. Pitt County has renamed foods to make them sound more appealing. Wake and Stokes counties have altered fruit and vegetable packaging to make

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[20] Program Evaluation Division. Child Nutrition Programs Challenged to Meet Nutrition Standards, Maintain Participation, and Remain Solvent: Final Report to the Joint Legislative Program Evaluation Oversight Committee, Report No. 2011-06. October 12, 2011.
[21] Harvey L.
[22] Harvey L.
[23] Harvey L.

them more convenient. Some schools have restructured their cafeterias to make fruit and vegetables more visible at the front of the food line.[24]

While the Child Nutrition Program was not reauthorized upon expiration on September 30, 2015, the Continuing Resolution provides that the programs will continue to be funded and operate. North Carolina has requested certain changes in the reauthorization to make its program more sustainable. Specifically, the Department of Public Instruction (DPI) has requested: permanent waivers for lower whole-grain content in grain products, the maintenance of the higher of the two target sodium levels specified in the HHFKA, an allowance for reimbursable meal items to be served a la carte, and a relaxation of the rule requiring reimbursable meals to include a fruit or vegetables.[25]

Recommendation 4.2: Ensure All Foods and Beverages Available in Schools are Healthy

PARTIALLY IMPLEMENTED

The North Carolina General Assembly should direct the State Board of Education to establish statewide nutrition standards for foods and beverages available in school-operated vending machines, school stores, and all other operations on the school campus during the instructional day. These standards should meet or exceed national standards.

a) **The North Carolina General Assembly should direct local Boards of Education to require all principals whose schools operate vending machines outside of the Child Nutrition Program to sign a Memorandum of Agreement (MOA) with beverage and snack vendors to ensure vending machines contain only those foods and beverages that are consistent with the new nutrition standards or with current law GS 115C-264.2 until the new standards are developed. The MOA should be submitted to the North Carolina Department of Public Instruction annually to indicate full compliance.**
b) **The North Carolina General Assembly should enact a law to remove advertising and marketing of unhealthy foods and beverages in schools that do not meet standards of GS 115C-264.3.**

Section 208 of the Healthy Hunger-Free Kids Act (HHFKA) required the USDA to establish nutrition standards for competitive foods and beverages sold in schools. Competitive foods include items sold in vending machines, school stores, a la carte, or at fundraising events. In 2013, the USDA released an interim final rule specifying the new nutritional requirements for competitive foods in schools, now known as the Smart Snacks in School rules. The USDA gave states a deadline of July 1, 2014 to comply with the Smart Snacks rules. The Smart Snack rules include limits on calories, fat, sodium and sugar for food as well as certain ingredient requirements. Beverage sales are restricted to bottled water, fat free and low fat milk, and 100% fruit or vegetable juice that may be diluted with water. Certain carbonated beverages are permissible for sale in high schools if they contain fewer than 10 calories per 20 oz.

North Carolina's State Board of Education nutrition policy is being revised for compliance with the Smart Snacks rules, but will not be finalized until the final rule is issued.[26] Prior to the USDA interim final rule, North Carolina had already adopted certain nutrition standards for all foods and beverages sold in schools, some of which are stronger than the current federal guidelines (GSC 115C-264). Notably, vending machines have been banned in North Carolina elementary schools since 2010.

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[24] Harvey L.
[25] Harvey L.
[26] Mendes, M, The Pew Charitable Trusts. Snack Foods and Beverages in North Carolina Schools. http://www.pewtrusts.org/~/media/assets/2015/01/state-fact sheets/kshf_appendix_northcarolina_v4.pdf?la=en. Published January 2015. Accessed October 7, 2015.

However, North Carolina has had to strengthen its policies to meet most other provisions of Smart Snacks, including all of the nutrition guidelines. The effect has been a substantial reduction in revenues from a la carte sales. In school year 2014-2015, Smart Snacks compliance cost North Carolina over $20 million in lost revenues.[27] The North Carolina Department of Public Instruction has requested that in the reauthorization of the Child Nutrition Programs, the Smart Snack standards be modified to allow any part of a reimbursable meal to be sold a la carte.

To date, no action has been taken to ban advertising of food and beverages that do not meet North Carolina's nutritional standards in schools.

Recommendation 4.3: Implement Quality Physical Education and Healthful Living in Schools (PRIORITY RECOMMENDATION)

<u>NOT IMPLEMENTED</u>

a) The North Carolina General Assembly should require the State Board of Education (SBE) to implement a five-year phase-in requirement of the following:
   1) Quality physical education that includes 150 minutes of elementary school physical education weekly.
   2) 225 minutes weekly of Healthful Living curriculum in middle schools, and 2 units of Healthful Living curricula as a graduation requirement for high schools. The new requirement for middle and high school should require equal time for health and physical education.

b) The SBE shall be required to report annually to the Education Oversight Committee regarding the Healthful Living education program, physical education program, and Healthy Active Children policy.

c) The SBE should work with appropriate staff members in the North Carolina Department of Public Instruction, including curriculum and finance representatives, and staff from the North Carolina General Assembly Fiscal Research Division to examine the experiences of other states and develop cost estimates for the five-year phase-in, which should be reported to the research division of the North Carolina General Assembly and the Education Oversight Committee by April 1, 2010.

There have been no changes to the state Physical Education or Healthful Living standards since 2009.[28] The State Board of Education's (SBE) Healthy Active Children Policy encourages, but does not require schools to adhere to 150 minutes of weekly Physical Education in elementary schools and 225 minutes in middle schools. Only one unit of Healthful Living is required for high school graduation. The SBE does not report to the Education Oversight Committee on health programs. There have been no attempts to research other state programs or to estimate costs of phasing in new requirements.

Recommendation 4.4: Expand Physical Activity and Nutrition in Child Care Centers and After-school Programs

<u>PARTIALLY IMPLEMENTED</u>

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[27] Harvey L. Director, Child Nutrition Services, North Carolina Department of Public Instruction. Testimony before the Subcommittee on Early Childhood, Elementary, and Secondary Education of the U.S. House of Representatives Committee on Education and the Workforce. Child Nutrition Assistance: Looking at the Cost of Compliance for States and Schools. June 24, 2015.

[28] Essick E. Section Chief, NC Healthy Schools, North Carolina Department of Public Instruction. Written (email) communication, June 20, 2015.

a) **The North Carolina Division of Public Health (DPH) and the North Carolina Partnership for Children, Inc. (NCPC) should expand dissemination of evidenced-based approaches for improved physical activity and nutrition standards in preschools using Nutrition and Physical Activity Self-Assessment for Child Care (NAP-SACC). Beginning in SFY 2011, the North Carolina General Assembly should appropriate $70,000 in recurring funds to the DPH and $325,000 in recurring funds to NCPC for these activities.**
b) **The North Carolina Child Care Commission should assess the funding needed for child care centers to incorporate healthy eating and physical activity practices and the process to include healthy eating and physical activity as quality indicators in North Carolina's Star Rated License system for licensed childcare centers.**
c) **After-school programs should use the *Move More North Carolina: Recommended Standards for After-School Physical Activity*. Specifically:**
    1) **State agencies should require after-school programs that receive state funding or federal funding administered by the state to use the standards.**
    2) **The North Carolina Department of Public Instruction and the North Carolina Center for Afterschool Programs should encourage other after-school programs that do not receive state or federal funds to use the standards.**

While no state appropriations have been made to support dissemination of Nutrition and Physical Activity Self-Assessment for Child Care (NAP-SACC), NAP-SACC has been incorporated as a component of the Shape NC Partnership between Blue Cross Blue Shield North Carolina Foundation (BCBSNC Foundation) and The North Carolina Partnership for Children, Inc. Shape NC: Healthy Starts for Young Children is a six-year initiative with $6 million in funding that began in 2011.Between 2011 and 2013, nineteen early education centers across the state adopted NAP-SACC practices during the first phase of the Shape NC initiative.[29] At this time, the University of North Carolina at Chapel Hill revised NAP SACC and published it online under the name Go NAP SACC. Go NAP SACC includes additional nutrition and activity guidelines. Phase II of the Shape NC Initiative began in 2014 and so far has expanded Go NAP SACC to another 115 child care centers throughout North Carolina to reach over 7,000 children. Shape NC has also trained forty-five Technical Assistance Specialists to help child care centers use the Go NAP SACC self-assessment tool. During Phase II, which ends in 2016, Shape NC aims to expand Go NAP SACC to a total of 240 new child care centers.

A 2010 rule from The North Carolina Child Care Commission (The Commission) required that USDA Child and Adult Care Food Program (CACFP) nutrition standards apply to all child care centers at a minimum level. Under the 2010 rule, a child care center must implement USDA nutrition standards to meet the minimum standards of accreditation and earn even a single star under the Star Rated License system[30]. The Commission raised the nutrition and physical activity standards in 2012. In addition to USDA nutrition standards, the 2012 standards include provisions to limit screen time, require a minimum amount of outdoor activity, and provide facilities for breastfeeding mothers.[31] In January 2015, the USDA released a proposed rule to update the CACFP standards in accordance with the Healthy Hunger-Free Kids Act of 2010. This rule is not yet final.

North Carolina House Bill 474, filed on April 2nd, 2015, would create a new voluntary certification for after-school programs. This certification, the Healthy Out-of-School Time (HOST) Recognition Program would allow after-school programs meeting sufficiently high activity and nutrition standards to earn a HOST certification to distinguish themselves to parents. The criteria for a program to qualify as a HOST program are similar to the *Move More North Carolina Recommended Standards for After-School Physical Activity*. Both the Move More standards and the HOST standards require a minimum amount of moderate to vigorous physical

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[29] White, Donna. Deputy Director, The North Carolina Partnership for Children, Inc. Written (email) communication, June 19, 2015.
[30] 10 NCAC 09 .0102 Definitions. http://ncchildcare.nc.gov/pdf_forms/rule_changes_july_aug_2010.pdf. Published July/August 2010. Accessed July 15, 2015.
[31] North Carolina Department of Health and Human Services, Division of Child Development and Early Education. 10A NCAC 09. 0901- 1718. http://ncchildcare.nc.gov/pdf_forms/rule_changes_effective_nov1__dec1_2012.pdf. Accessed July 15, 2015.

activity and staff training in healthy eating and physical activity. The HOST standards go beyond the Move More standards through inclusion of nutrition standards and limitations on screen time.[32] HB 474 is currently in the Senate, where it has been referred to the Committee on Rules and Operations of the Senate.

Recommendation 4.5: Implement the *Eat Smart, Move More North Carolina Obesity Prevention Plan* and Raise Public Awareness (PRIORITY RECOMMENDATION)

NOT IMPLEMENTED

a) The North Carolina Division of Public Health (DPH) along with its partner organizations should fully implement the *Eat Smart, Move More North Carolina Obesity Prevention Plan* to combat obesity in selected local communities and identify best practices for improving nutrition and increasing physical activity that will ultimately be adopted across the state. The North Carolina General Assembly should appropriate $6.5 million in recurring funds beginning in SFY 2011 to DPH to support this effort. Funding should be allocated as follows:
   1) $5 million ($50,000 per county) to support local capacity (1 FTE) for the dissemination of evidence-based prevention programs and policies in North Carolina communities.
   2) $1 million to *Eat Smart, Move More North Carolina* to expand community competitive grants. Communities should be limited to grants of up to $40,000 to support evidence-based strategies or best and promising practices that improve nutrition and/or physical activity behavior, thereby promoting healthy weight and reducing chronic disease.
   3) $500,000 to DPH to provide technical assistance for the implementation of the *Eat Smart, Move More North Carolina Obesity Prevention Plan* and/or the competitive grants and to conduct an independent evaluation.

b) The North Carolina General Assembly should appropriate $500,000 annually in non-recurring funds for six years beginning in SFY 2011 to DPH for pilot programs of up to $100,000 per year to reduce overweight and obesity among adolescents.

c) The North Carolina General Assembly should appropriate $3.5 million annually for six years beginning in SFY 2011 to DPH to continue the demonstration projects initially funded by the North Carolina General Assembly in 2008. Funding will be distributed to the five current demonstration counties and to three additional counties (on a competitive basis) for interventions in preschools, schools, local communities, faith organizations, worksites, and health care settings to promote and support physical activity and healthy eating. DPH should work in collaboration with Eat Smart, Move More North Carolina partners, NC Prevention Partners, the UNC Center for Health Promotion and Disease Prevention, and others to provide technical support and disseminate best practices.

d) DPH, the North Carolina Health and Wellness Trust Fund (HWTF), and the North Carolina Department of Public Instruction (DPI) should raise public awareness and implement a statewide social marketing campaign to promote healthy physical activity and nutrition behaviors and environments in schools, homes, and the community. Campaign messages should be based on behaviors identified by the Centers for Disease Control and Prevention to guide state efforts against obesity. DPH should work with the HWTF and DPI on the expansion and evaluation of this social marketing campaign. The North Carolina General Assembly should appropriate recurring funds beginning in SFY 2011 to DPH until the funding level reaches $16 million annually to support this effort. A portion of the funding will be used for evaluation. Funding should be increased as follows:
   1) $5.0 million in recurring funds by SFY 2011
   2) $8.0 million in recurring funds by SFY 2015
   3) $12.0 million in recurring funds by SFY 2018
   4) $16.0 million in recurring funds by SFY 2020

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[32]General Assembly of North Carolina Session 2015, House Bill 474, Healthy Out-of-School Recognition Program. http://www.ncleg.net/Sessions/2015/Bills/House/PDF/H474v2.pdf. Published April 2, 2015. Accessed July 16, 2015.

No appropriations have been made to support *Eat Smart Move More North Carolina*.

Recommendation 4.6: Expand the Availability of Farmers Markets and Farm Stands at Worksites and Faith-based Organizations

FULLY IMPLEMENTED

Employers and faith-based organizations should help facilitate farmers markets/farm stands at the workplace and in the faith community with a focus on serving low-income individuals and neighborhoods.

The WorkHealthy America (WHA) initiative, led by North Carolina based non-profit Prevention Partners, has engaged 345 North Carolina employers in making health-based changes to the worksite. WHA recommends that workplaces establish farmers' markets or Community Supported Agriculture (CSA) programs. At the baseline in 2009, 97 participating employers offered a farmers' market or CSA programs. Between 2009 and 2015, 47% of participating employers reported having improved worksite-based farmers' market or CSA offerings.[33]

In 2011, the North Carolina Division of Public Health received a CDC Community Transformation Grant (CTG) of $7.4 million per year over three years. Part of the CTG grant went toward expanding farmers' markets. Between 2011 and 2014, 64 new farmers' markets were created throughout the state.[34] Twenty-seven of the CTG-funded markets were established in rural counties, and thirty-five accept SNAP/EBT, allowing underserved populations better access to fresh produce.[35]

The Healthy Corner Store Initiative, led by the North Carolina Alliance for Health, also aims to expand healthy food options in low-income communities. The related legislation, HB 250/S296, has passed the House and is currently being considered in the Senate. This legislation will require establishing a state fund designed to help corner store owners retrofit their stores to improve healthy food offerings. Funding would be disbursed to counties and local health departments to cover initial costs, refrigeration, shelving and other necessary infrastructure in corner stores[36].

Recommendation 4.7: Promote Menu Labeling to Make Nutrition Information Available to Consumers

PARTIALLY IMPLEMENTED

a) **The North Carolina Division of Public Health (DPH) in collaboration with NC Prevention Partners should promote and offer technical assistance for menu labeling in restaurants through a collaborative effort with the North Carolina Restaurant and Lodging Association. If menu labeling is not implemented by a substantial proportion of restaurants within three years, the state should seek mandatory labeling laws.**

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[33] Molloy M. Chief Executive Officer, Prevention Partners. Written (email) communication. July 7, 2015.
[34] Boss-Nelson S. Project Manager, North Carolina Department of Health and Human Services. Written (email) communication. July 9, 2015.
[35] Boss-Nelson S.
[36] General Assembly of North Carolina Session 2015, House Bill 250 Healthy Food Small Retailer/Corner Store Act. http://www.ncleg.net/Sessions/2015/Bills/House/PDF/H250v2.pdf. Published June 15, 2015. Accessed July 15, 2015.

b) DPH should work with other organizations around the country to draft model legislation to promote national standards for menu labeling.

A bill introduced in the 2009-2010 session of the North Carolina legislature would have required DPH to partner with other organizations to encourage menu labeling in restaurants. The bill, HB1273, died in Committee at the conclusion of the 2010 session. Since then, no similar bills have been introduced in the state legislature.

The Patient Protection and Affordable Care Act of 2010 (ACA) contained a provision to require menu labeling in restaurant chains and fast-food restaurants. FDA Rule 79 FR 71155 finalized the menu labeling requirements in 2014. The rule applies only to fast-food restaurants and chains with 20 or more locations that operate under the same name and serve substantially the same food. USDA data shows that North Carolina had 6,942 fast food restaurants operating throughout the state in 2011.[37] These restaurants will have to comply with the menu labeling rules by December 1, 2016, following a one-year compliance extension announced on July 9, 2015.

Recommendation 4.8: Build Active Living Communities

<u>NOT IMPLEMENTED</u>

a) The North Carolina General Assembly should authorize counties/municipalities to have the local option to hold a referendum to increase the sales tax by ½ cent for community transportation, parks, and sidewalks.
b) The North Carolina Division of Parks and Recreation should expand the existing Adopt-a-Trail grant program, which provides grants to governmental agencies and nonprofit organizations for trail and greenway planning, construction, and maintenance projects. The North Carolina General Assembly should appropriate an additional $1.5 million in recurring funds beginning in SFY 2011 to the North Carolina Division of Parks and Recreation for this program.

The North Carolina General Assembly has not authorized referenda to increase county or municipal sales taxes for any specific use. In the 2014-2015 state budget, the legislature eliminated all funding for the Adopt-a-Trail grant program. [38]

Recommendation 4.9: Establish Joint-use Agreements to Expand Use of School and Community Recreational Facilities

<u>FULLY IMPLEMENTED</u>

a) The North Carolina School Boards Association should work with state and local organizations including but not limited to the North Carolina Recreation and Park Association, Local Education Agencies, North Carolina Association of Local Health Directors, North Carolina County Commissioners Association, North Carolina League of Municipalities, North Carolina High School Athletic Association, and Parent Teacher Associations to encourage collaboration among local schools, parks and recreation, faith organizations, and/or other community groups to expand the use of school facilities for after-hours community physical activity. These groups should examine successful local initiatives and identify barriers, if any, which prevent other local school districts from

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[37] United States Department of Agriculture, Economic Research Service. Food Environment Atlas: Grocery Stores, 2007. http://ers.usda.gov/data-products/food-environment-atlas/go-to-the-atlas.aspx. Published April 14, 2015. Accessed July 17, 2015.
[38] North Carolina State Parks, N.C. Trails Program: Adopt-a-Trail Grants Program. http://www.ncparks.gov/About/trails_AAT.php. Accessed July 20, 2015.

offering the use of school grounds and facilities for after-hour physical activity and develop strategies to address these barriers. In addition, this collective group should examine possibilities for making community facilities available to schools during school hours, develop model joint-use agreements, and address liability issues.

b) **The State Board of Education should encourage the School Planning Section, Division of School Support, North Carolina Department of Public Instruction to do the following:**
   1) **Provide recommendations for building joint park and school facilities.**
   2) **Include physical activity space in the facility needs survey for 2010 and subsequent years.**

North Carolina's CDC-funded Community Transformation Grant (CTG) program included efforts to establish joint-use agreements to allow public use of school property outside of school hours. The administering agency, North Carolina Division of Public Health (DPH), encountered several obstacles to promoting joint-use agreements. Initially, there was confusion over terminology due to the existence of two types of shared-use agreements: a joint-use agreement involves a contract between two parties using the same space at different times, while an open use agreement simply allows for public access without a contract. DPH sought and received permission from the CDC to pursue open-use agreements rather than joint-use agreements. From there, DPH struggled to find models to base an open-use policy on. Finally, there were concerns about liability. Informally, many schools had previously allowed public use of school property and were apprehensive that publicizing an open-use policy might increase school liability.[39]

Ratified in 2015, N.C.G.S. § 115C-524 clarifies the legal status of open use arrangements.[40] The existing law allowed schools to avoid liability in joint-use agreements. Now schools are also immune from liability in open-use agreements. This amendment will make it easier for schools to open their grounds to public use outside of school hours without fear of repercussions resulting from injuries to the public occurring on school property. Schools can allow the public access to their grounds without a contract or liability.[41]

Recommendation 4.10: Expand Community Grants Program to Promote Physical Activity

PARTIALLY IMPLEMENTED

The North Carolina Division of Public Health (DPH) should expand the existing Community Grants Program to assist 15 local communities in developing and implementing Active Living Plans. Funding should be used to support community efforts that will expand the availability of sidewalks, bicycle lanes, parks, and other opportunities for physical activity and recreation. The North Carolina General Assembly should appropriate $3.3 million annually for five years beginning in SFY 2011 to DPH to expand the existing Community Grants Program. If successful, the North Carolina General Assembly should expand funding to replicate successful efforts in other parts of the state.

a) **Funds should be used to support programs in both rural and urban areas.**
b) **To qualify for Community Grants, local communities must collaborate with a wide consortium of community partners such as local planning departments, local government, public health, schools, parks and recreation, transportation, the faith community, developers, and businesses. Communities must have joint-use agreements in place.**
c) **Grantees must use the funds to support:**
   1) **Planning to identify what active living infrastructure exists and what is needed.**

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[39] Centers for Disease Control and Prevention. Preventing Chronic Disease, Challenges in Promoting Joint Use Agreements: Experiences From Community Transformation Grant Awardees in North Carolina, Illinois, and Wisconsin, 2011-2014. http://www.cdc.gov/pcd/issues/2015/14_0457.htm. Published April 16, 2015. Accessed July 12, 2015.

[40] General Assembly of North Carolina Session 2015. Session Law 2015-64 Senate Bill 315. http://www.ncleg.net/Sessions/2015/Bills/Senate/PDF/S315v4.pdf. Published June 11, 2015. Accessed July 17, 2015.

[41] Stein A. Legal Specialist, Department of Health and Human Services, Division of Public Health. Written (email) communication. June 23, 2015.

2) **Development of public policies to guide public and private investment in active living infrastructure.**
3) **Implementation of physical projects such as new sidewalks, bike paths, and parks to provide residents with places to be active and children with the ability to walk to school.**
4) **Promotions and programs to encourage the use of these facilities.**

d) **DPH should allocate 10% of the funds for an independent evaluation of these projects. Evaluation outcomes should include but not be limited to usage, costs, and the impact of these projects on economic development.**

The North Carolina General Assembly has not made new appropriations in support of sidewalks, bicycle lanes, parks or other infrastructure designed to promote physical activity and the Community Grants Program no longer exists. However, certain federal efforts and North Carolina private and non-profit organizations have made progress toward expanding opportunities for physical recreation in North Carolina.

In North Carolina, the 2013 Strategic Transportation Investments bill (Session Law 2013-183) eliminated all state funding for bicycle and pedestrian projects. The new Transportation Investment Strategy formula includes a bicycle and pedestrian limitation that allows only federal and municipal funding for bicycle and pedestrian improvement projects (NCGS § 136-189.11 (d) (3) c).[42] However, new federal funding for bike and pedestrian projects also became available in 2013 as part of the Moving Ahead for Progress in the 21st Century Act (Public Law 112-141, MAP-21). MAP-21, which provides long-term authorization for national highways, established new federal funding for Transportation Alternative Programs (TAP) including bike and pedestrian initiatives.[43] The North Carolina Department of Transportation (NC DOT) administers TAP funding in North Carolina and has decided to allocate half to bike and pedestrian projects.[44]

The NC DOT Division of Bicycle and Pedestrian Transportation oversees a municipal Bicycle and Pedestrian Planning Grant that was established with state and federal allocations in 2003. The remaining $400,000 in grant funding will expire at the end of 2015. To date, the Planning Grant has provided $4.5 million to 164 municipal projects.[45]

NC DOT has also used its federal funding in partnership with North Carolina non-profits to promote bicycle and pedestrian projects. The WalkBikeNC plan uses NC DOT's federal funding in conjunction with funding from Blue Cross Blue Shield North Carolina Foundation, the NC Department of Environment and Natural Resources, the NC Department of Health and Human Services, the NC Department of Commerce, and Davis Wealth Management to assess and improve North Carolina's biking and walking infrastructure. WalkBikeNC has published program and route recommendations as well as a design toolbox for cities looking to improve biking access.

In 2013, the North Carolina Department of Commerce with funding from the Community Transformation Grants projects published a *Guidebook on Local Planning for Healthy Communities.* The guidebook includes a chapter on Physical Activity and Active Living that recommends improvements to the built environment such

[42] General Assembly of North Carolina Session 2013. Session Law 2013-183, House Bill 817. http://www.ncleg.net/sessions/2013/bills/house/pdf/h817v10.pdf. Published June 26, 2013. Accessed July 20, 2015.
[43] US Department of Transportation, Federal Highway Administration. MAP-21: Moving Ahead for Progress in the 21st Century. http://www.fhwa.dot.gov/map21/summaryinfo.cfm. Published August 17, 2012. Accessed July 20, 2015.
[44] Walls R. MAP-21 Transportation Alternatives Program (TAP). https://connect.ncdot.gov/projects/planning/MPORPODocuments/TAP%20memo_1113.pdf. Published November 13, 2013. Accessed July 20, 2015.
[45] North Carolina Department of Transportation, Division of Bicycle and Pedestrian Transportation and Transportation Planning Branch. Bicycle and Pedestrian Planning Grant Initiative Program Overview. https://connect.ncdot.gov/municipalities/PlanningGrant/Documents/Bike%20Ped%20Planning%20Overview%202016.pdf. Accessed August 7, 2015.

as enhancing street connectivity and limiting block size.[46] In 2014, the NC Division of Public Health also published a guide to assist city planners and design teams called *The North Carolina Guide to Incorporating Health Considerations Into Comprehensive Plans*. This guide includes a set of strategies to promote active living that include developing off-road "greenways" and promoting urban "infill" over peripheral development.[47]

Recommendation 4.11: Increase the Availability of Obesity Screening and Counseling

FULLY IMPLEMENTED

c) **Insurers, payers, and employers should cover Body Mass Index (BMI) screening and counseling on nutrition and/or physical activity for adults who are identified as obese.**
d) **Primary care providers should screen adult patients for obesity using a BMI and provide high-intensity counseling either directly or through referral on nutrition, physical activity, and other strategies to achieve and maintain a healthy weight.**

Section 2713 of the Patient Protection and Affordable Care Act (ACA) requires that private insurers cover certain preventive care services without imposing patient cost-sharing measures, such as co-payments, deductibles or coinsurance.[48] To be covered, a preventive service must have received an 'A' or 'B' grade from the US Preventive Services Task Force. Obesity screening and counseling are among these services. [49] Private "grandfathered" plans, which existed prior to the ACA and haven't made substantial changes to their coverage since, are exempt from the requirement. In 2014, 26% of employees on employer-based plans received coverage under a "grandfathered" plan. However, these plans will be phased out over time.[50]

While obesity screening is covered by all other private insurance plans without cost-sharing, the degree to which physicians are proactive about obesity screening varies from practice to practice. In addition, obesity counseling requirements vary by state and insurance plan. North Carolina requires that insurance plans provide bariatric surgery as an Essential Health Benefit, but unlike some other states, nutrition counseling and weight loss programs are not mandatory benefits in qualifying health plans.[51] Public awareness of no-cost preventive services remains low as well. According to a 2014 survey, only 43% of respondents were aware that they could receive free preventive services under the ACA.[52]

Recommendation 4.12: Expand the CCNC Childhood Obesity Prevention Initiative

FULLY IMPLEMENTED

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[46] North Carolina Department of Commerce, Division of Community Assistance. Guidebook on Local Planning for Healthy Communities. http://www.ecu.edu/cs-dhs/chsrd/upload/Guidebook-on-Local-Planning-for-Healthy-Communities.pdf. Published September 2013. Accessed July 20, 2015.
[47] North Carolina Division of Public Health. 2014. The North Carolina Guide to Incorporating Health Considerations Into Comprehensive Plans. North Carolina Department of Health and Human Services, Raleigh, NC http://www.eatsmartmovemorenc.com/HealthConsiderations/Texts/North_Carolina_Guide_to_Incorporating_Health_Considerations.pdf. Accessed July 21, 2015.
[48] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001et seq. (2010). http://www.hhs.gov/healthcare/rights/law/title/i-quality-affordable-health-care.pdf. Accessed July 21, 2015.
[49] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010). http://www.hhs.gov/healthcare/rights/law/title/i-quality-affordable-health-care.pdf. Accessed July 21, 2015.
[50]Kaiser Family Foundation. Health Reform: Preventive Services Covered by Private Health Plans under the Affordable Care Act. http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/. Accessed July 21, 2015.
[51]Robert Wood Johnson Foundation, Leonard Davis Institute of Health Economics. Essential Health Benefits: 50-State Variations on a Theme. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf416179
[52] http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/. Published October 2014. Accessed July 21, 2015.

If shown to be successful through program evaluations, Community Care of North Carolina (CCNC) should continue expansion of the Childhood Obesity Prevention Initiative including the dissemination and use of already developed clinical initiatives aimed at obesity reduction for Medicaid-enrolled and other children and their families. The North Carolina General Assembly should appropriate one-time funding of $174,000 in SFY 2011 to the North Carolina Office of Rural Health and Community Care to support this effort.

The Childhood Obesity Prevention Initiative was a two-year pilot program that ended in 2010 and did not receive further funding. Community Care of North Carolina (CCNC), a Medicaid program linking providers to beneficiaries, has continued childhood obesity prevention efforts with the help of a federal grant.

In 2010, North Carolina became one of ten states to receive a Quality Demonstration grant under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.[53] CCNC administers the CHIPRA grant throughout the state. CCNC is pursuing several initiatives under the grant that focus on childhood obesity prevention including: motivational interviewing, evidence-based clinician training, BMI tracking, and a Maintenance of Certification course on childhood obesity.

Motivational Interviewing is an evidence-based intervention that has proven successful for pediatric and adult weight loss. This strategy involves eliciting patient values and perceived barriers to healthy habits, followed by the gentle introduction of strategies to achieve healthier behaviors. With CHIPRA funding, CCNC convened a state working group to develop a motivational interviewing tool for primary care providers. The working group included dieticians, clinicians, care managers and other experts. They also developed family educational materials, including a handout designed to help families make better choices at their preferred fast food restaurants.

As part of the CHIPRA grant, twenty-six teams of pediatric and family health practitioners received training on evidence-based practices to prevent childhood obesity, including motivational interviewing. The teams also received billing and coding training and information on community resources. CCNC, in partnership with the NC Pediatric Society and the NC Academy of Family Physicians, also developed a Maintenance of Certification course around childhood obesity prevention that physicians can take free of charge to fulfill their MOC Part 4 requirement. Motivational interviewing is a key component in the course, which also includes age-specific recommendations and a guide to billing and coding for childhood obesity prevention.

The final component of CCNC's childhood obesity prevention efforts under the CHIPRA grant involves coding and data collection. CCNC promotes a claims measure in their practices that includes 4 categories (V Codes) of Body Mass Index (BMI). CCNC encourages providers to screen patients and categorize them according to the four V codes. As of 2013, only 13% of CCNC patients ages 3-20 were being screened for obesity, up from 4% in 2012. Widespread adoption of the V Code system will help track population obesity trends throughout the state.[54]

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[53] Agency for Healthcare Research and Policy. Children's Health Insurance Program Reauthorization Act (CHIPRA). http://www.ahrq.gov/policymakers/chipra/index.html#Evaluation. Accessed July 22, 2015.
[54] Dover M. Pediatric Project Manager, Community Care of North Carolina. Written (email) communication. July 1, 2015.

CHAPTER 5: HIV, STDS, AND UNINTENDED PREGNANCY

Recommendation 5.1: Increase Awareness, Screening, and Treatment of Sexually Transmitted Diseases and Reduce Unintended Pregnancies

PARTIALLY IMPLEMENTED

a) **The North Carolina General Assembly should appropriate $6.2 million in recurring funds beginning in SFY 2011 to the North Carolina Division of Public Health (DPH) to support efforts to reduce sexually transmitted diseases (STDs) and HIV infection and transmission and prevent unintended pregnancy. Of these funds, DPH should use:**
   1) **$2.4 million to expand the *Get Real Get Tested* campaign for HIV prevention, create STD prevention messages, and collaborate with local health departments to offer nontraditional testing sites to increase community screenings for STDs such as chlamydia and syphilis and for HIV among adolescents, youth, and high-risk populations.**
   2) **$300,000 to hire bridge counselors in high-prevalence-county local health departments to link individuals who test positive for HIV into medical care in order to prevent transmission.**
   3) **$3.5 million to develop and disseminate an unintended pregnancy prevention campaign and expand community-based, evidence-based pregnancy prevention programs such as the Nurse Family Partnership, Teen Outreach Program, and other evidence-based pregnancy prevention programs to reach more adolescents and young adults.**

b) **DPH should also take the following additional steps to prevent STD and HIV transmission among high-risk populations:**
   1) **Collaborate with academic health centers and other major health systems to promote the new rules that allow for opt-out HIV testing.**
   2) **Expand the training and certification of nontraditional providers to increase the use of rapid testing for HIV in high-risk populations.**
   3) **Work with the North Carolina Medical Board, the North Carolina Board of Pharmacy, and the North Carolina Medical Society to explore how to implement Expedited Partner Therapy for chlamydia and gonorrhea in North Carolina.**

Get Real, Get Tested *Campaign Background*

The *Get Real Get Tested* began as a statewide HIV education and testing campaign conducted by the Communicable Disease Branch (CDB) of the North Carolina Division of Public Health (DPH), in cooperation with community-based organizations and local health departments. The campaign was built on a three pronged strategy: test people for HIV and other sexually transmitted diseases, identify persons living with HIV and STDs who need care, and link persons identified as HIV positive into care.

Campaign Activity from 2009 – July 2015

Beginning in 2009, decreased financial resources led to a change of scope for the *Get Real, Get Tested* to emphasize treatment for the HIV positive population, rather than testing. Since the change, testing events are organized by request and require minimal staffing and resources.[55]

The CDB management team wanted to re-enforce the importance of HIV positive individuals getting linked to HIV care and medical treatment. The decision was made to re-brand the *Get Real, Get Tested* campaign so that treatment was included in all campaign messaging. The new campaign - *Get Real, Get Tested, Get Treatment* - was presented in 2011. In 2012 and 2013, two *Get Real, Get Tested, Get Treatment* commercials were created. These commercials have been well received and generated many phone calls from HIV positive individuals

[55] Clymore, J.

seeking HIV medications and care. The *Get Real, Get Tested, Get Treatment* began airing in July 2015 for a summer campaign.[56]

Get Real, Get Tested *Campaign Results*

Since the campaign began in December 2006, over 4,500 people have been tested during the community testing events: 40 people tested positive for the HIV-1 antibody, 45 people tested positive for syphilis and 71 people tested positive for gonorrhea and/or chlamydia. The campaign has generated many phone calls that have led to HIV positive individuals being linked to HIV care and HIV medications.[57]

HIV Bridge Counselors

The CDB began funding Bridge Counselors in 2009 through the HIV Prevention program and in later years added funding through the HIV Care Program (Ryan White HIV/AIDS Program Part B) and the HIV Care and Prevention in the US (CAPUS) grants. The CDB spends approximately $350,000 in federal funds each year in salary for these positions. Currently there are 9 State Bridge Counselors located around the state in the regional offices responsible for:

- Assuring that people newly diagnosed with HIV attend their first medical appointment, which is scheduled for them when they are officially notified of their infection and that a follow up appointment has been scheduled
- Going into the filed to locate people living with HIV disease that have fallen out of care and are not currently seeing a doctor or receiving medication, in order to re-engage them in care, reduce their HIV viral loads and reduce the possibility of transmitting virus to others.

A number of health departments and regional networks of HIV care and prevention also have their own bridge counselors in order to augment this work on a regional level.[58]

Pregnancy Prevention

In 2008, the Nurse-Family Partnership (NFP) Funders Alliance (The Duke Endowment, Kate B. Reynolds Charitable Trust, Blue Cross and Blue Shield Foundation of NC, NC Partnership for Children, Prevent Child Abuse NC, and NC Division of Public Health, Children and Youth Branch) expanded NFP home visiting in five sites. In 2010, the Division of Public Health, Children and Youth Branch applied for and received the Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant funds to add four more NFP sites. In addition, the Eastern Band of Cherokee's NFP program was funded with Tribal MIECHV grant funding from the Administration of Children and Families. In SFY 13-15, the North Carolina General Assembly appropriated non-recurring funding that supported the expansion of NFP to five additional sites. Today with a combination of funding from the NFP Funders Alliance, 14 NFP sites are funded (23 counties, plus Eastern Band of Cherokee), representing a total of 1,572 first-time, low-income mothers and their newborns served annually. [59]

Through Personal Responsibility Education Program (PREP) and the Adolescent Pregnancy Prevention Program, agencies are implementing the following evidence-based pregnancy prevention programs:

- Becoming a Responsible Teen (1 agency)
- Draw the Line/Respect the Line (1 agency)
- Making Proud Choices (9 agencies and 7 school systems)
- Reducing the Risk (5 agencies)
- Teen Outreach Program® (8 agencies)

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[56] Clymore, J.
[57] Clymore, J.
[58] Clymore, J.
[59] Andersen, P. Operations Manager, Women's and Children's Health Section, Division of Public Health. Written (email) communication. July 22, 2015.

- We have several agencies implementing evidence-informed prevention programs:
- Wise Guys (7 agencies)
- Teen PEP (3 agencies)

Through the implementation of the above programs, over 6000 adolescents are completing an evidence-based adolescent pregnancy prevention program every year. Twenty-three adolescent Parenting Program sites are implementing Parents as Teachers or Partners for a Healthy Baby for home visits. Each site also uses Be Proud! Be Responsible! Be Protective! for group education sessions. The programs reach an estimate of 600 pregnant or parenting teens every year.[60]

Opt-out HIV Testing

In September of 2006 CDC released revised recommendations on HIV counseling and testing in order to increase routine HIV testing, to eliminate barriers to testing and 'normalize' HIV testing by making it a regular part of health checkups. The CDB responded to these recommendations by making a concerted effort to increase routine (opt-out) HIV testing among providers across NC. On November 1st, 2007 NC made substantial changes in the NC administrative codes concerning HIV, however, it took time for the changes to filter down to practice. The CDB made a concerted effort to get information about the changes out to health providers. As a result, all local health departments in NC adopted HIV Opt-out testing as the standard resulting in an additional 7,000 HIV tests each year since. The CBD also worked with the Department of Corrections (DOC) at the time to train staff, revise policies and provide technical assistance on how to adopt routine HIV testing. This led to the DOC conducting routine testing of all DOC detainees resulting in the testing of over 20,000 inmates annually for HIV.[61]

Expansion of Rapid HIV Testing

In 2008 the CD Branch received a $2 million dollar recurring increase in state funds entitled "HIV Prevention – Counseling and Testing"; although this amount has been reduced to $1,610,298 since then, the CDB has greatly increased the size and scope of its HIV rapid testing program. State funds as well as CDC funds were used in this expansion. HIV rapid testing allows agencies to conduct HIV testing among high risk populations in non-traditional settings and provide a result in less than 30 minutes. This greatly increases access to testing to high-risk individuals and decreases the time it takes to link and refer infected individuals to HIV primary care.[62]

Since 2008, the CD Branch has expanded the Rapid HIV Testing Program and currently supports 53 sites with a rapid testing budget of $255,495 used to purchase 26,535 test kits and 257 controls. New quality assurance protocols mandating annual proficiency testing, a new State Laboratory of Public Health HIV Test Request Form and a new CDB Prevention Progress Report have been put in place. In addition, a dual rapid testing protocol has been implemented to ensure that a second rapid test of a different brand is administered at the same time that an initial reactive result is observed. All agencies are required to have and make immediate referrals for clients in need of follow-up care, case management or other HIV related services. Training workshops have increased to two trainings per year. These trainings are conducted in cooperation with the Southeast AIDS Training and Education Center and covers HIV risks and transmission, prevention counseling, rapid testing algorithms, program management, quality assurance, safe work habits, test kit/controls demonstration and practice, and completion of required forms. Product representatives conduct additional trainings on as needed basis to demonstrate the use of their test kits.[63]

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[60] Andersen, P.
[61] Clymore, J.
[62] Clymore, J.
[63] Clymore, J.

Both numbers of persons tested and positivity rates have gone up since 2008 with 15,869 clients tested through the Rapid Testing Program; in 2014, 203 clients (1.3%) were positive. HIV rapid testing has been at this increased level since 2011.[64]

North Carolina Health Board Partnerships

Discussion on this activity has continued but primarily at the local health department level; there has not been a strong effort to address it with larger organizations or membership bodies. As a result of a time-limited award from the CDC, known as Program Collaboration and Service Integration, expedited partner therapy was addressed in four counties: Wake, Mecklenburg, Buncombe and Pitt. Three of these counties have continued the practice past the terms of the grant award, on a limited basis.[65]

Recommendation 5.2: Increase HIV Testing in Prisons, Jails and Juvenile Centers

<u>PARTIALLY IMPLEMENTED</u>

The North Carolina Department of Correction (DOC) should expand its existing HIV-testing policy to include opt-out testing for all prisoners upon release. The North Carolina General Assembly should provide $1 million in recurring funding beginning in SFY 2011 to the DOC to support this effort.

a) **The North Carolina Department of Juvenile Justice and Delinquency Prevention (DJJDP) should offer opt-out HIV screening in their institutional facilities including youth development centers and youth detention centers. The North Carolina General Assembly should appropriate $6,750 in recurring funds beginning in SFY 2011 to the DJJDP to support this effort.**
b) **Counties should include opt-out HIV testing as part of the comprehensive exam given to inmates in county jails.**
c) **The DOC and the North Carolina Division of Public Health should collaborate to ensure prisoners identified as HIV-positive are coordinated for outpatient care prior to release to help them manage their disease and prevent transmission.**

The Division of Adult Correction and Juvenile Justice (formerly separate entities known as the North Carolina Department of Correction and the NC Department of Juvenile Justice & Delinquency Prevention) has expanded its existing HIV-testing policy to include mandatory testing for all adult prisoners upon admission and prior to release. The North Carolina General Assembly did not provide any additional funding to support these efforts. The Division of Adult Correction and Juvenile Justice also continues to assist and coordinate outpatient care upon release.

While juvenile justice facilities do not currently have opt-out testing for HIV, all juveniles in residential settings are offered confidential, free testing, and education regarding HIV and Hepatitis B transmission. If testing is requested, juveniles receive counseling prior to and following testing, regardless of outcome. The Division of Adult Correction and Juvenile Justice provides specific case management for juveniles that test positive for HIV or Hepatitis B.[66]

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[64] Clymore, J.
[65] Clymore, J.
[66] Lassiter, W. Deputy Commissioner for Juvenile Justice, Division of Adult Correction and Juvenile Justice. Written (email) communication. July 31, 2015.

Recommendation 5.3: Ensure Students Receive Comprehensive Sexuality Education in North Carolina Public Schools (PRIORITY RECOMMENDATION)

PARTIALLY IMPLEMENTED

a) **Local school boards should adopt an opt-out consent process to automatically enroll students in the comprehensive reproductive health and safety education program unless a parent or legal guardian specifically requests that their child not receive any or all of this education.**
b) **The State Board of Education should require Local Education Agencies to report their consent procedures, as well as the number of students who receive comprehensive reproductive health and safety education and those who receive more limited sexuality education. Information should be reported by grade level and by school.**

The Healthy Youth Act of 2009 repealed G.S. 115C-81(e1)(3) of the Education Statute which mandated abstinence until marriage education, and replaced it with G.S. 115C-81(e1)(4), which requires sexual health and safety education for students in grades 7-9.[67] The Healthy Youth Act also requires that North Carolina schools provide instruction about sexually transmitted diseases, contraception, and sexual violence.

The Education Statute, NCGS § 115C-81, requires that parents be allowed a 60 day period during which they can review all materials relating to sexual health and reproduction that the State Board of Education (SBE) has approved for use in schools. The statute instructs local boards of education to "adopt policies to provide opportunities either for parents and legal guardians to consent or for parents and legal guardians to withhold their consent to the students' participation in any or all of these programs." The NC School Board Association created a model policy for Reproductive Health and Safety that most school districts in North Carolina have adopted. The model policy includes a provision allowing parents to opt-out of sexual health education[68]. Unless a parent makes the effort to opt-out of this instruction, their child will receive sexual health education according to the state standards.

School Boards typically post their consent procedures on their district websites, although they are not required to report to the State Board of Education regarding those procedures.
In 2009, North Carolina became one of seven states to receive a Working to Institutionalize Sex Education (WISE) grant from the Grove, Ford, William and Flora Hewlett, and David and Lucile Packard Foundations. 35% of North Carolina students reside in the 20 school districts receiving WISE funding. The WISE initiative supports SHIFT NC, a North Carolina non-profit focused on adolescent sexual health, in providing technical assistance, training, community outreach, and evaluation to support comprehensive sex education efforts in schools.[69]

The North Carolina Department of Public Instruction (DPI) also has a grant from the CDC to provide sexual health education with the goal of HIV prevention. DPI and SHIFT NC collaborate on the CDC-funded projects. In order to receive CDC funding, schools must demonstrate compliance with the Healthy Youth Act.[70]

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[67] General Assembly of North Carolina Session 2009. House Bill 88, Ratified Bill. http://www.ncleg.net/Sessions/2009/Bills/House/PDF/H88v7.pdf. Published June 25, 2009. Accessed July 22, 2015.
[68] North Carolina School Boards Association. Comprehensive Health Education Program. http://www.ncsba.org/clientuploads/DocumentsPDF/LegalPolicy/3540.pdf. Published December 1, 2009. Accessed July 22, 2015.
[69] The Grove Foundation. WISE Initiative. http://wisetoolkit.org/wise-initiative. Accessed July 17, 2015.
[70] Palmer J

Recommendation 5.4: Expand the Availability of Family Planning for Low-income Families

PARTIALLY IMPLEMENTED

a) **The North Carolina Division of Medical Assistance and North Carolina Division of Public Health should enhance access to and utilization of family planning services by low-income families, including providing access to the full range of contraceptives.**
   1) **Local health departments, in partnership with local social services departments, should have a dedicated intake specialist to take Medicaid applications, including Be Smart Family Planning Waiver applications.**
   2) **The North Carolina Division of Public Health should direct existing federal family planning funds towards increasing the number of low-income families that are provided services who do not qualify for Medicaid or the Be Smart Family Planning Waiver program.**
   3) **The North Carolina Division of Medical Assistance should apply to the Centers for Medicare and Medicaid Services to extend the Medicaid Be Smart Family Planning Waiver program beyond October 2010 and should include best practices from other states.**

b) **The North Carolina Division of Public Health should purchase long-acting, highly effective, reversible contraceptive methods for low-income women who do not qualify for Medicaid or the Medicaid Be Smart Family Planning Waiver. The North Carolina General Assembly should appropriate $931,000 in recurring funds beginning in SFY 2011 to the North Carolina Division of Public Health to support these efforts.**

The North Carolina Division of Public Health has encouraged both local health departments and community health centers to partner with local social services departments to have a dedicated intake specialist to take Medicaid applications. Unfortunately, many local social services do not have the funds to pay the salary of an eligibility worker to be based at a local health department or a community health center. In fact, many local social services departments have experienced significant budget cuts resulting in elimination of staff positions and a shortage of staff to process applications.

The North Carolina Division of Medical Assistance applied to the Centers for Medicare and Medicaid Services (CMS) to convert the Medicaid Be Smart Family Planning Waiver (FPW) program to a State Plan Amendment (SPA). CMS did approve North Carolina's request and on October 1, 2014 the FPW converted to the SPA. No additional state funding has been appropriated for family planning services.[71]

CHAPTER 6: SUBSTANCE ABUSE AND MENTAL HEALTH

Recommendation 6.1: Develop and Implement a Comprehensive Substance Abuse Prevention Plan (PRIORITY RECOMMENDATION)

NOT IMPLEMENTED

a) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a comprehensive substance abuse prevention plan for use at the state and local levels. The plan should increase the capacity at the state level and within local communities to implement a comprehensive substance abuse prevention system, prioritizing efforts to reach children, adolescents, young adults, and their parents. The goal of the prevention plan is to prevent or**

[71] Andersen, P. Operations Manager, Women's and Children's Health Section, Division of Public Health. Written (email) communication. July 22, 2015

delay the onset of use of alcohol, tobacco, or other drugs; reduce the use of addictive substances among users; promote emotional and mental health well-being; identify those who need treatment; and help them obtain services earlier in the disease process.

1) **DMHDDSAS should pilot test this prevention plan in six counties or multi-county areas and evaluate its effectiveness. DMHDDSAS should develop a competitive process and select at least one rural pilot and one urban pilot in the three DMHDDSAS regions across the state. DMHDDSAS should provide technical assistance to the selected communities. If effective, the prevention plans should be implemented statewide.**
2) **The pilot projects should involve multiple community partners, including but not limited to Local Management Entities, primary care providers, health departments, local education agencies, local universities and community colleges, and other appropriate groups.**
3) **The pilots should incorporate evidence-based programs, policies, and practices that include a mix of strategies including universal and selected populations. Priority should be given to evidence-based programs that have been demonstrated to yield positive impacts on multiple outcomes, including but not limited to preventing or reducing substance use, improving emotional well-being, reducing youth violence or delinquency, or reducing teen pregnancy.**
4) **The North Carolina General Assembly should appropriate $1,945,000 in recurring funds in SFY 2011 and $3,722,000 in recurring funds in SFY 2012 to DMHDDSAS to support and evaluate these efforts.**

b) **The excise taxes on malt beverages and wine should be indexed to the consumer price index so they can keep pace with inflation.**
   1) **The increased fees should be used to fund effective prevention and treatment efforts for alcohol, tobacco, and other drugs.**
   2) **The North Carolina General Assembly should appropriate $2.0 million in recurring funds in SFY 2011 to support a comprehensive alcohol awareness education and prevention campaign aimed at changing cultural norms to prevent initiation, reduce underage alcohol consumption, reduce alcohol abuse or dependence, offer early intervention, and support recovery among adolescents and adults.**

The General Assembly did not appropriate funding for strategic planning activities or for the implementation of comprehensive local pilots. However, DMH/DD/SAS applied for and was awarded a Strategic Prevention Framework State Prevention Enhancement Grant from SAMHSA. This one-year grant totaling $598,000 was awarded September 1, 2011. A portion of this grant funded the development of a statewide, five-year strategic plan for substance abuse prevention. Planning focused on substance abuse prevention; enhancing data collection, analysis, and reporting; service coordination; and the provision of technical assistance and training.

The 2009 General Assembly enacted Senate Bill 202 which increased alcohol excise tax rates (beginning September 1, 2009).[72] The increase on malt beverages (62 cents per gallon) equated to an increase of approximately 1-cent on a can/bottle of beer (malt beverage). The small tax increase did not include the recommendation that malt beverages should be indexed to the Consumer Price Index (CPI) to keep pace with inflation or that the funds raised should be used to support evidence-based prevention and treatment efforts. Statewide grassroots efforts continue to make increasing the price of malt beverages a priority although it has yet to receive a favorable response from the General Assembly. No significant increase on the tax rate of malt beverages has occurred since 1969.

Recommendation 6.2: Expand the Availability of Screening, Brief Intervention, and Treatment for People with Behavioral Health Problems in the Primary Care Setting

<u>**PARTIALLY IMPLEMENTED**</u>

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a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a Memorandum of Agreement with the North Carolina Office of Rural Health and Community Care (ORHCC), Governor's Institute on Alcohol and Substance Abuse, North Carolina Area Health Education Centers (AHEC) program, and other appropriate organizations to educate and encourage health care professionals to use evidence-based screening tools and offer counseling, brief intervention, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on alcohol, tobacco, and other drugs as outlined in the screening, brief intervention, and referral to treatment (SBIRT) model. The North Carolina General Assembly should appropriate $1.5 million in SFY 2011 in recurring funds to the DMHDDSAS to support this effort.

b) DMHDDSAS, in collaboration with the ORHCC, should work collaboratively with the Governor's Institute on Alcohol and Substance Abuse, North Carolina Academy of Family Physicians, North Carolina Pediatric Society, North Carolina Psychiatric Association, North Carolina Primary Health Care Association, ICARE, and other appropriate groups to identify and address barriers that prevent the implementation and sustainability of co-location models and to identify other strategies to promote evidence-based screening, counseling, brief intervention, and referral to treatment in primary care and other outpatient settings for substance abuse and mental health.

c) Health professionals should screen adolescents and adults age 12 or older for major depressive disorders and for substance abuse disorders using systems that ensure accurate diagnosis, effective treatment, and follow-up.

d) The North Carolina General Assembly should mandate that insurers offer coverage for the treatment of addiction diseases with the same durational limits, deductibles, coinsurance, annual limits, and lifetime limits as provided for the coverage of physical illnesses.

e) The North Carolina General Assembly should direct public and private insurers to review their reimbursement policies to ensure that primary care and other providers can be reimbursed to:

   1) Screen for tobacco, alcohol, drugs, and mental health disorders.
   2) Provide brief intervention and counseling and refer necessary patients for specialty services.
   3) Support co-location of behavioral health and primary care providers.
   4) Pay for case management services to coordinate services and follow-up between primary care and behavioral health specialists.
   5) Pay for telephone or in-person consults between primary care providers and behavioral health specialists.

f) The Division of Medical Assistance should work with the ORHCC to develop an enhanced Community Care of North Carolina (CCNC) per member per month (PMPM) for co-located practices to support referral and care coordination for mental health, developmental disabilities, and substance abuse services.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) has not any received state appropriations since 2009 to support the promotion of evidence-based screening tools and training, including SBIRT. There have been many continuing education efforts around SBIRT in the state at annual specialty meetings for primary care doctors, Physician Assistants (PAs), Nurse Practitioners (NPs), Psychiatrists, CCNC networks, at hospital grand rounds and other educational sessions for resident physicians, and at the Annual Addiction Medicine Conference in 2010, 2011 and 2012. There have also been SBIRT presentations to the substance abuse work force and to students at UNC School of Public Health. The design and release of SBIRTNC.org in August 2011 with educational resources, referral & billing information, clinical tools, and video demonstrations.

In 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded North Carolina a five year $8.33 million grant for Screening, Brief Intervention and Referral to Treatment (SBIRT). The Department of Health and Human Services (DHHS) administers the SAMHSA grant in partnership with the Governor's Institute of Substance Abuse, Community Care of North Carolina (CCNC), the Division of Medical

Assistance (DMA), the American Indian Health Board, North Carolina Community Health Centers Association, and several primary care practices.[73] The grant funding goes toward hiring case managers and mental health and substance abuse professionals who work with physicians to screen, intervene, and refer patients to resources. While AHEC is not a partner on the SBIRT grant, DMHDDSAS and the American Indian Health Board partnered with AHEC to provide SBIRT training in Robeson county and in the Cherokee area.[74]

The NC Office of Rural Health and Community Care (ORHCC) received a 5-year State Health Access Plan (SHAP) grant starting in FY 2009-10, which later lead to the ORHCC integrated behavioral healthcare initiative. At the beginning of Year 3, North Carolina requested a Change in Scope for its SHAP grant funds to undertake a number of unfunded projects. With support from the Health Resources and Services Administration (HRSA), the ORHCC launched the Behavioral Health Access Plan for the Uninsured (BHAP) pilot program. This project was designed to provide training, technical assistance, and limited reimbursement for three to six rural practices across the state to integrate behavioral health and substance abuse treatment with primary care services using a team-based practice model.[75]

Recommendation 6.3: Expand Early Intervention Services in the Faith Community

FULLY IMPLEMENTED

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should partner with a variety of mental health and substance abuse organizations, faith-based institutions of higher education, and other faith leader training programs to develop and offer a training specifically designed to help leaders of all faiths recognize signs of stress, depression, and substance abuse in those they counsel and to develop linkages with outside referrals when appropriate. Faith communities at the local, regional, and state levels should encourage their faith leaders to attend these trainings.

Since 2009, agencies across North Carolina have significantly expanded efforts to connect faith-based organizations to behavioral health resources, including the efforts outlined below.

The Partners in Health and Wholeness program of the North Carolina Council of Churches provides programming and planning around helping churches, clergy, and congregants live healthier lives. In 2010, the NC Council of Churches held a statewide Faith and Health Summit in downtown Raleigh where John Tote, the director of NC's Mental Health Association at the time, led a breakout session on helping faith leaders identify signs of stress and depression, and how to make proper referrals. Unfortunately, after Tote left his position shortly after the Summit took place, there was no follow-up provided to faith leaders who attended his session.

FaithHealthNC is a partnership organization between faith communities, health systems, and other healthcare providers focused on improving health of individuals, couples, and families battling depression, substance, grief, and much more. Wake Forest Baptist provides Health Care Liaisons to help clergy and their volunteers in providing care to patients and training and resources for pastors in mental health first aid. [76]

Duke Clergy Health Initiative's Spirited Life Program, which is offered to United Methodist pastors in North Carolina, has a core component around mental health and stress management. Spirited Life is a multi-year wellness program and behavioral health study offered by the Duke Clergy Health Initiative. More than 60% of the clergy serving appointments in the North Carolina and Western North Carolina Conferences of the United Methodist Church are enrolled.

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[73] McEwen S. Executive Director, Governor's Institute on Substance Abuse. Written (email) communication. July 7, 2015.
[74] Fernandez M. Project Manager, NC SBIRT. Written (email) communication. July 3, 2015.
[75] Collins, C. Director, Office of Rural Health and Community Care, North Carolina Department of Health and Human Services. Written (email) communication. July 29, 2015.
[76] Stallings, W. Project Specialist, NC Get Covered. Written (email) communication. July 26, 2015.

CHAPTER 7: ENVIRONMENTAL RISKS

Recommendation 7.1: Create an Interagency Leadership Commission to Promote Healthy Communities, Minimize Environmental Risks, and Promote Green Initiatives

NOT IMPLEMENTED

The Governor or the North Carolina General Assembly should create an Interagency Leadership Commission to develop a statewide plan to promote healthy communities, minimize environmental risks, and promote sustainability and "green" initiatives that will support and improve the public's health and safety. The Interagency Leadership Commission should create an implementation plan that includes the roles that each agency will play in implementing the plan, the costs of the plan, and potential funding sources. The plan should emphasize local sustainability, environmental justice, protection of vulnerable populations, and precaution. Contents of the plan should include, but not be limited to, statewide efforts to promote active, walkable, livable communities; reduce environmental exposures and risks that negatively impact population health; promote clean, renewable energy, green technology, and local production of food, energy, goods, and services; and increase opportunities for mass transportation.

a) **The Interagency Leadership Commission should include senior level agency staff from the North Carolina Department of Transportation, Department of Health and Human Services, Department of Public Instruction, Department of Environment and Natural Resources, Department of Commerce, State Board of Education, Board of Transportation, Department of Insurance, North Carolina Community College System, and University of North Carolina System. The Commission should also include representatives from the League of Municipalities, North Carolina Association of County Commissioners, North Carolina Association of Metropolitan Planning Organizations, North Carolina Association of Local Health Directors, North Carolina Recreation and Park Association, North Carolina State Society for Human Resource Management, the North Carolina Chamber, and at-large members of the public.**
b) **The Interagency Leadership Commission should oversee the environmental assessment described in Recommendation 7.2 and should lead the development of a communications campaign to educate and inform North Carolinians of the findings and implications and actions being taken as a result of the assessment.**
c) **The Interagency Leadership Commission should present the plan to the Governor and the Joint Legislative Commission on Governmental Operations no later than January 1, 2011, and should report progress on implementation of the plan at least once annually thereafter.**

An Interagency Leadership Commission around environmental risk was not established.

Recommendation 7.2: Develop an Environmental Assessment for North Carolina that Links Environmental Exposures to Health Outcomes

PARTIALLY IMPLEMENTED

The Department of Environmental Sciences and Engineering in the University of North Carolina (UNC) Gillings School of Global Public Health should collaborate with the North Carolina Division of Public Health, North Carolina Department of Environment and Natural Resources, North Carolina Department of Agriculture and Consumer Services, and North Carolina Agromedicine Institute (East Carolina University, North Carolina State University, and North Carolina Agricultural and Technical State University) to develop an environmental assessment for the state that links environmental exposures/risks

and health outcomes and includes strategies to address the exposures/risks. This environmental assessment should be conducted to address the priorities and needs of the state as identified by the Recommendation regarding an Interagency Leadership Commission. The North Carolina General Assembly should appropriate $3 million in non-recurring funds in SFY 2011 to the Gillings School of Global Public Health, University of North Carolina at Chapel Hill to support this effort.

While the Department of Environmental Sciences and Engineering in the University of North Carolina (UNC) Gillings School of Global Public Health did not complete an environmental assessment in the last five years, there has been some activity with the Research Triangle Environmental Health Collaborative (EHC) regarding environmental exposures/risks and health outcomes. The organization strives to bring together collaborative partners around environmental health in the Research Triangle area. The EHC organizes annual Environmental Health Summits, plans seminars and conferences, and sustains a funding base for environmental research and policy work.

The North Carolina Environmental Health Collaborative through NCDHHS publishes the North Carolina Environmental Public Health Data Inventory which provides a listing of available state government databases that may be used for linking environmental hazards to health outcomes. This will likely be updated later in 2015.[77]

Recommendation 7.3: Ensure Healthy Homes

PARTIALLY IMPLEMENTED

The North Carolina Division of Public Health, the North Carolina Division of Water Quality, the North Carolina Department of Environment and Natural Resources, Office of the State Fire Marshal, and North Carolina Department of Insurance should expand and enhance efforts to create healthy homes. These efforts should address, but not be limited to, the following: indoor air quality, mold and moisture, carbon monoxide, lead-based paint, radon, asbestos, drinking water, hazardous household products, pesticide exposure, pest management, and home safety (includes injury prevention of falls, etc). As part of this initiative:

a) **The Building Code Council should revise the state building code to require all residences with fossil fuel burning appliances or attached garages to have carbon monoxide alarms.**
b) **The North Carolina Home Inspector Licensure Board should require licensed home inspectors to have the National Environmental Health Association's Healthy Homes Specialist Credential and to inspect homes comprehensively for environmental health and safety hazards any time the home is required to be inspected.**
c) **Individuals such as state and local public health and fire marshal staff and building inspectors, who regularly visit homes to provide advice regarding health and safety and to conduct building inspections and environmental inspections, should have the National Environmental Health Association's Healthy Homes Specialist Credential. Agency staff who are so certified should conduct comprehensive health and safety assessments when visiting homes and provide families with information about existing environmental or safety hazards and how identified hazards can be abated. Building inspectors and staff of state and local public health departments and the fire marshal should have their Healthy Homes Specialist Credential certification by the end of 2012.**

[77] Shehee, M. Environmental Program Manager, NC Division of Public Health. Written (email) communication. August 4, 2015.

North Carolina State Building Code has been revised to contain provisions requiring the installation of either battery-operated or electrical carbon monoxide alarms in every dwelling unit having a combustion heater, appliance, or fireplace, and in any dwelling unit having an attached garage.[78]

The North Carolina Home Inspector Licensure Board (NCHILB) does not currently require licensed home inspectors to have the National Environmental Health Association's Healthy Homes Specialist Credential. The NCHILB continues to regulate the issuance of North Carolina Home Inspector licenses to inspect homes comprehensively for environmental health and safety hazards.

The Children's Environmental Health Unit (CEH) through the North Carolina Division of Public Health works to expand and enhance efforts to create healthy homes, with an emphasis on the health of North Carolina children. All field staff have been recognized with the National Environmental Association's Healthy Homes Specialist Credential through comprehensive, nationally accredited training. CEH has conducted healthy homes assessments upon physician referral (almost always asthma related), but does not have specific legislative authority or formal policy mandating the program or protocol.

Another program through the Children's Environmental Health Unit is the North Carolina Childhood Lead Poisoning Prevention Program (CLPPP) that currently coordinates clinical and environmental services aimed at eliminating childhood lead poisoning. CLPPP also provides technical assistance, training and oversight for local environmental health specialists, public health nurses, laboratory technicians and private medical providers to assure healthy and safe conditions. Other activities are early identification, surveillance, abatement enforcement, monitoring inspections and risk assessments.[79]

Recommendation 7.4: Reduce Environmental Risks in Schools and Child Care Settings

<u>PARTIALLY IMPLEMENTED</u>

The North Carolina Division of Public Health (DPH), in conjunction with the North Carolina Department of Public Instruction, North Carolina Department of Environment and Natural Resources (DENR), and North Carolina Cooperative Extension, should train elementary and secondary school staff to conduct inspections and identify potential environmental hazards in accordance with the US Environmental Protection Agency's (EPA) Tools for Schools Program. The North Carolina General Assembly should appropriate $400,000 in recurring funds beginning in SFY 2011 to DPH to support this effort.

a) **DPH and the North Carolina Division of Environmental Health, in conjunction with the North Carolina Division of Child Development, should adapt the Tools for Schools assessment for child care centers and include the assessment in the child care center inspection by local environmental health specialists. The North Carolina General Assembly should appropriate $27,944 annually for four years beginning in SFY 2011 to DPH to support this effort.**

The North Carolina Department of Public Instruction and the North Carolina Division of Child Development, in collaboration with DPH and DENR, should develop an implementation plan to phase in the Tools for Schools assessments in all schools and licensed child care centers over a four-year period. Child care centers would be required to complete the assessment as part of child care center licensure requirements.

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[78] North Carolina General Statue, § 143-138.

[79] Shehee, M. Environmental Program Manager, NC Division of Public Health. Written (email) communication. August 4, 2015.

The Environmental Health Section in the Division of Public Health, formerly known as the Environmental Health Division, has been responsible for increasing assessment and remediation of environmental hazards in the child care and school settings. The Children's Environmental Health Unit (CEH) through the North Carolina Division of Public Health has been heavily involved in identifying environmental hazards in early child care centers and schools. The Child Care Sanitation (CCS) Program monitors and oversees sanitation requirements for licensed child care centers and provides consultation to local health departments regarding communicable disease control and sanitation in the child care setting. The CCS Program also implements and enforces the Child Care Sanitation Rules. These standards require periodic inspections where specific environmental hazards for identification and remediation.[80]

CHAPTER 8: INJURY

Recommendation 8.1: Review and Enforce All Traffic Safety Laws and Enhance Surveillance

PARTIALLY IMPLEMENTED

a) **North Carolina law enforcement agencies should actively enforce traffic safety laws, especially those pertaining to seat belt usage, driving while impaired (DWI), speeding, and motorcycles. All North Carolina state and local law enforcement agencies with traffic responsibilities should actively enforce DWI laws throughout the year and should conduct regular checking stations. State and local law enforcement agencies should report to the North Carolina General Assembly at the beginning of each biennium their efforts to increase enforcement of DWI.**

b) **The North Carolina General Assembly should change existing state laws or appropriate new funds to strengthen traffic safety laws and enforcement efforts. The North Carolina General Assembly should:**
   1) **Enact a primary belt use law for rear seat occupants**
   2) **Require alcohol interlocks for all DWI offenders.**
   3) **Appropriate $750,000 in recurring funds beginning in SFY 2011 to the North Carolina Division of Public Health to work with the Governor's Highway Safety Program, the University of North Carolina (UNC) Highway Safety Research Center, and other appropriate groups to expand checking stations and to develop and implement highly-publicized, ongoing strategic communication plans to broadly disseminate the existing Booze It and Lose It campaign.**
   4) **Appropriate $1 million in recurring funds beginning in SFY 2011 to the Governor's Highway Safety Program to provide support to state and local law enforcement agencies with traffic responsibilities to enhance their enforcement of speeding and aggressive driving laws, with special emphasis on dangerous roads and intersections.**
   5) **Institute graduated licensure and training requirements for all people who operate motorcycles and amend the existing motorcycle permit provision so that permits cannot be renewed indefinitely.**
   6) **Create a legislative study commission to examine all motor vehicle fees and fines in NCGS §20 and recommend changes to strengthen motor vehicle safety laws. Priority should be given to an examination of the adequacy of the fines for violations of the seat belt laws and to examine reinstatement fees for DWI offenders. Funds from the increased DWI fees should be used to support DWI programs including training, maintenance of checking station vehicles and equipment, and expanding the operation of DWI checking stations to additional locations and times.**

c) **The North Carolina Division of Motor Vehicles should ensure that all motorcyclists are properly licensed and trained.**

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[80] Shehee, M.

1) **The North Carolina Division of Motor Vehicles should work with the North Carolina Community College System to develop a system of training for new motorcyclists.**
2) **The North Carolina Division of Motor Vehicles should match motorcycle operator licenses and vehicle registration files.**

d) **The Governor's Highway Safety Program, in conjunction with the National Highway Traffic Safety Administration, should work to ensure implementation of the Crash Outcome Data Evaluation System (CODES) in North Carolina. Access to CODES data should be provided to all participants on the North Carolina Traffic Records Coordinating Committee, including, at a minimum, the North Carolina Division of Public Health, UNC Highway Safety Research Center, UNC Injury Prevention Research Center, North Carolina Department of Justice Administrative Office of the Courts, North Carolina Department of Transportation, North Carolina Division of Motor Vehicles, North Carolina Office of Emergency Medical Services, and North Carolina State Highway Patrol.**

The North Carolina General Assembly has not enacted new legislation regarding primary belt use; while it remains a potential area of interest among injury and violence prevention stakeholders as recommended by the National Highway Traffic Safety Administration, it is not a current priority at the state level. For first time DWI offenders of BAC level of 0.15% or higher, North Carolina requires the installation and monitoring of an interlock device for a period of 1 year upon license restoration.[81]

The Governor's Highway Safety Program is the main recipient of federal funding on traffic and highway safety issues. Over the course of 2014, they developed an Occupant Protection Strategic Plan and an Impaired Driving Strategic Plan in partnership with key injury prevention stakeholders across the state. In line with the Community Preventive Services Task Force findings on motor vehicle crashes, NC-DPH, Governor's Highway Safety Program, North Carolina Department of Transportation, and UNC Injury Prevention Research Center have worked to reduce motor vehicle-related injuries and support evidence-based interventions. In July 2015, the North Carolina Department of Transportation released the North Carolina Strategic Highway Safety Plan, in partnership with the Injury and Violence Prevention Branch and Governor's Highway Safety Program.

The Crash Outcome Data Evaluation System (CODES) has been discontinued by National Highway Traffic Safety Administration and North Carolina never implemented this program. The North Carolina Traffic Records Coordinating Committee has implemented most of the CODES-like recommendations, but not through the national evaluation system.[82]

In 2011 the CDC released a report that rated North Carolina's Motorcycle Helmet law to be the most effective in the country in preventing deaths and saving health care costs associated with motorcycle crashes. A broad coalition with representatives from trauma, emergency medicine, brain injury prevention, public health, and highway safety formed to preserve this helmet law from annual campaigns to repeal the universal motorcycle helmet law. Efforts to preserve the law should continue.

A partnership from the Governor's Highway Safety Program, Safe Kids NC and the District Attorneys in North Carolina developed a child passenger diversion program to increase car seat usage. The program offers diversion from fines associated with not using a child passenger seat if the offender attends an educational class and certifies their car seat is properly fitted. The strategy holds promise to increase child passenger protection usage in North Carolina. [83]

[81] NCGS §20-17.8.
[82] Proescholdbell, S. Head, Injury Epidemiology and Surveillance Unit, Injury and Violence Prevention Branch, Chronic Disease and Injury Section. Division of Public Health, North Carolina Division of Health and Human Services. Telephone communication. July 29, 2015.
[83] Proescholdbell, S.

Recommendation 8.2: Enhance Injury Surveillance, Intervention, and Evaluation

<u>**PARTIALLY IMPLEMENTED**</u>

a) **The North Carolina General Assembly should amend the Public Health Act § 130A-1.1 to include injury and violence prevention as an essential public health service.**
b) **The North Carolina General Assembly should appropriate $3,860,938 in recurring funds beginning in SFY 2011 to the North Carolina Division of Public Health (DPH) to identify and implement pilot programs and other community-based activities to prevent unintentional injury and violence. Priority should be given to evidence-based programs or best and promising practices that prevent motor vehicle crashes, falls, unintentional poisonings, and family violence. Funds should be allocated as follows:**
   1) **$167,644 to DPH, to work in collaboration with North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Carolinas Poison Center; and other appropriate groups, to prevent unintentional poisonings.**
   2) **$362,565 to DPH for falls prevention.**
   3) **$162,565 to DPH for family violence prevention. Priority should be given to research and program implementation that integrates multiple types of family violence such as domestic violence and child maltreatment.**
   4) **$2.5 million to DPH for other injury prevention activities.**
   5) **$668,164 to the DPH to support 9 FTEs (8 of which would be regional staff) to support state and local capacity for the dissemination of evidence-based injury and violence prevention programs and policies in North Carolina communities.**
c) **The North Carolina General Assembly should appropriate $175,000 in recurring funds beginning in SFY 2011 to DPH to develop an enhanced intentional and unintentional injury surveillance system with linkages. This work should be led by the State Center for Health Statistics and done in collaboration with the North Carolina Medical Society; North Carolina Hospital Association; North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Governor's Highway Safety Program within the North Carolina Department of Transportation; UNC Injury Prevention Research Center; Carolinas Poison Center (state poison control center) at Carolinas Medical Center; and North Carolina Office of the Chief Medical Examiner. The collaborative should examine the need and feasibility for linkages to electronic health records and enhanced training in medical record coding using E codes (injury) and ICD-9/10 codes (disease).**

While the North Carolina Public Health Law was not amended to include injury and violence prevention as an essential public health service, significant progress has been made in the spirit of the recommendations. The North Carolina General Assembly has not allocated funding towards injury surveillance, intervention, and evaluation since 2009. Instead, funding for programs lead by or supported by the North Carolina Division of Public Health (NC-DPH) has been secured from various national and regional funders for specific topics.[84]

Through the Centers for Disease Control and Prevention (CDC) Injury Center, funding ($428,000 for five years) and technical assistance is provided by the Core Violence and Injury Prevention Program (Core VIPP) to the North Carolina Division of Public Health. The program supports 20 state health departments to strengthen capacity to collect and use data for a better understanding of local injury issues, and to protect their residents by putting science into action to save lives and prevent injuries. North Carolina is one of four states within this funding to focus on Surveillance Quality Improvement (SQI). Working with UNC's Center for Health

[84] Proescholdbell, S. Head, Injury Epidemiology and Surveillance Unit, Injury and Violence Prevention Branch, Chronic Disease and Injury Section. Division of Public Health, North Carolina Division of Health and Human Services. Telephone communication. July 29, 2015.

Informatics using NC DETECT data (statewide emergency department visit data) to identify innovative projects that address injury data quality issues such as falls, childhood injuries and overdoses.[85]

The National Violent Death Reporting System (NVDRS) also supports NC DPH ($322,000 annually for five years) to continue data collection and expand data dissemination for the North Carolina Violent Death Reporting System (NC-VDRS). NVDRS a state-based surveillance system that links data from law enforcement, coroners and medical examiners, vital statistics, and crime laboratories to assist each participating state in designing and implementing tailored prevention and intervention efforts. DPH can access all of these important data elements from one central database and uses this information for policy and programming recommendations.[86]

The CDC's Prescription Drug Overdose Prevention for States Program will fund NC-DPH, as one of 16 states, up to $1,000,000 starting September 1, 2015 for five years to coordinate and implement prevention strategies to promote promising and evidence-based practices and advance comprehensive state-level interventions for preventing prescription and drug overuse, misuse, abuse, and overdose. The Drug Control Unit of North Carolina Department of Health and Human Services' Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) operates the North Carolina Controlled Substance Reporting System (CSRS) for prescription drug data monitoring across the state. Efforts to distribute and promote community use of Naloxone are underway through the NC Harm Reduction Coalition.[87]

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services funded DPH to provide with technical assistance and training for suicide prevention (including programs, interventions, and policies) from 2009 through 2014 through the Suicide Prevention Resource Center grant; DPH will work in collaboration with DMHDDSAS for future funding cycles. Child maltreatment and sexual violence prevention initiatives have also been supported by Injury Prevention funding from the John Rex Foundation and the DPH Rape Prevention and Education Program (RPE) funded by the CDC. The NC RPE program received $882,865 February 1, 2015 to fund ten programs statewide, to include rape crisis centers, community-based organizations and universities, to implement evidence-based or evidence-informed strategies that address the primary prevention of sexual violence.[88]

DPH works closely with the NC Falls Prevention Coalition to coordinate and advance falls prevention cross the state. A falls prevention intervention program, spearheaded by the UNC Injury Prevention Research Center (IPRC) was started in 2014. A pilot program at staffed by UNC Gillings researchers is partnering with beauty salons as a focal point to deliver falls prevention messaging and assessments for older adults. Beauty salons have proved effective for distribution of information regarding cancer prevention, sexual disease prevention and physical activity promotion and hopes similar efforts for fall prevention will follow suit.[89]

While collaborative agreement data sharing has been a long-term priority for injury surveillance, there is currently no single mechanism in place to exchange data across organizations. The Injury and Violence Prevention Branch Surveillance Unit at DPH maintains statewide injury and violence related surveillance by providing emergency department, hospital discharge, and mortality data to monitor the incidence of and risk factors for fatal and nonfatal injury. The branch provides this information to North Carolina's health professionals, citizens, lawmakers and others interested in injury and violence prevention in the state. Injury and violence surveillance data provides the epidemiologic foundation for effective, data-driven injury and violence prevention intervention planning. The unit compiles information from several on-going and regularly collected data systems; however, due to data-sharing limitations, there does not exist a method to follow a person from first responder reports to their final disposition including release or death. In addition,

[85] Proescholdbell, S.
[86] Proescholdbell, S.
[87] Proescholdbell, S.
[88] Proescholdbell, S.
[89] Proescholdbell, S.

in the October 2015, the International Classification of Diseases, Revision 10 (ICD -10) codes will be implemented nationwide, increased code specificity for documenting procedures and diagnoses. These changes will require enhanced training, software/system upgrades/replacements, and investment on the part of hospitals and healthcare systems. The impact specifically on injury and violence are unknown but in the immediate future surveillance is likely to be impacted.[90]

Recommendation 8.3: Enhance Training of State and Local Public Health Professionals, Social Workers, and Others

PARTIALLY IMPLEMENTED

The University of North Carolina (UNC) Injury Prevention Research Center should develop curricula and train state and local public health professionals, physicians, nurses, allied care workers, social workers, and others responsible for injury and violence prevention so they can achieve or exceed competency in injury control consistent with national guidelines developed by the National Training Initiative for Injury and Violence Prevention. The North Carolina General Assembly should appropriate $200,000 in recurring funds beginning in SFY 2011 to the UNC Injury Prevention Research Center to support this effort.

The North Carolina General Assembly did not appropriate funds to support this recommendation.

The Injury-Free NC Academy
The Injury-Free NC Academy is an intensive training program for community-based teams working to prevent injuries. The basis of the curriculum is the core competencies in injury prevention developed by the National Training Initiative. It is based on the successful PREVENT program. Academy cohorts to date have focused on teen driver safety (2012-13), prescription drug overdose prevention (2013-14), and creating communities that are free of sexual abuse and sexual violence (2014-15). The 2015-16 Academy will focus on enhancing community-based suicide prevention. Currently, funding is being sought to continue the Academy.[91]

Multi-disciplinary, multi-organizational teams are competitively recruited for the Academy. The Academy spans between 6 and 8 months. It begins and ends with two-day in-person trainings, and coaching and technical assistance are provided in the interim months. Each team brings a project they have already initiated or plan to initiate to the Academy, and all learning activities are based on moving team projects forward. 20 teams working in more than 25 North Carolina counties have been trained to date. The Academy is funded by the Division of Public Health's (DPH) Injury and Violence Prevention Branch.[92]

NC Injury Summits
IPRC has worked very closely with DPH's Injury and Violence Prevention Branch to sponsor statewide summits on Falls Prevention, Drug Overdose Prevention, Suicide Prevention, and Overall Injury Prevention. These have been consistently highly rated, with requests for continued summit in the evaluations, by the 135-150 professionals attending from throughout NC.[93]

IPRC Seminars and visiting scholars

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[90] Proescholdbell, S.
[91] Knight, E. Associate Director for Education, Training, Outreach & Translation, UNC Injury Prevention Research Center, UNC Chapel Hill.
[92] Knight, E.
[93] Knight, E.

During the Academic year, IPRC sponsors a number of seminars, visiting scholars, and the Waller Fellowship on innovative or recent injury prevention topics. Injury prevention professionals from throughout NC are invited to both the seminars and the related small group meetings with the seminar presenters or visiting scholar/fellow.[94]

Webinars and Invited Presentations

IPRC faculty and staff have presented a number of webinars and invited presentations within North Carolina. Presentations have included presentations on child maltreatment prevention and the latest related research findings, and prescription drug overdose prevention.[95]

Recommendation 8.4: Create a Statewide Task Force or Committee on Injury and Violence (PRIORITY RECOMMENDATION)

<u>FULLY IMPLEMENTED</u>

a) **The North Carolina General Assembly should create an Injury and Violence Prevention Task Force to examine data, make evidence-based policy and program recommendations, monitor implementation, and examine outcomes to prevent and reduce injury and violence. The work of the Task Force should build on the work of the North Carolina 2009-2014 State Strategic Plan for Injury and Violence Prevention and should examine data around motor vehicle crashes, falls, unintentional poisonings, occupational injuries, family violence including child maltreatment and domestic violence, other forms of unintentional injuries such as fires and drowning, and intentional injuries such as homicide and suicide. The Task Force should be charged with identifying strategies to enhance the statewide injury and violence prevention infrastructure, including expanding the numbers of trained personnel at the state and local levels, implementing evidence-based programs and policies, and improving the existing injury surveillance system. The Task Force should provide an annual report back to the North Carolina General Assembly.**

b) **The Task Force should include legislators and representatives from the North Carolina Division of Public Health; North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; North Carolina Division of Aging and Adult Services; North Carolina Department of Juvenile Justice and Delinquency Prevention; Governor's Highway Safety Program within the North Carolina Department of Transportation; North Carolina Department of Insurance; North Carolina Department of Labor; North Carolina Trauma System; North Carolina Office of Emergency Medical Services; North Carolina Department of Agriculture and Consumer Services; North Carolina Department of Public Instruction; North Carolina Cooperative Extension within North Carolina State University; North Carolina Department of Environment and Natural Resources; UNC Injury Prevention Research Center; Carolinas Poison Center; North Carolina Medical Society; North Carolina Hospital Association; and local and state law enforcement.**

In late 2008, the NC Injury and Violence Prevention Branch of Chronic Disease and Injury at the Division of Public Health initiated and led a process to develop the Strategic Plan in collaboration with injury and violence prevention partners from across the state of North Carolina. In April 2009, the strategic plan was finalized and in August 2009, the Injury and Violence Prevention State Advisory Council (IVP-SAC) was formed to monitor and advance the overall plan by promoting collaboration among appropriate partners. IVP-SAC members includes representatives from the North Carolina Division of Public Health, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; North Carolina Division of Aging and

[94] Knight, E.
[95] Knight, E.

Adult Services; North Carolina Department of Juvenile Justice and Delinquency Prevention; Governor's Highway Safety Program within the North Carolina Department of Transportation; UNC Injury Prevention Research Center; Carolinas Poison Center and local and state law enforcement.

In August 2011, the IVPB secured five-year funding from the Centers for Disease Control & Prevention (CDC) to build capacity for IVP in the state of North Carolina. As part of this funding, the IVPB proposed to review the status and progress of the state's injury and violence prevention strategic plan. The overall goal of the Building for Strength Strategic Plan for Preventing Injuries and Violence in North Carolina calls for a 15% reduction in the rate of morbidity and mortality from injury and violence. The plan focuses on the three leading causes of death from unintentional injury (motor vehicle crashes, poisoning, and falls), and the two leading causes of intentional injuries (suicide and homicide).[96]

CHAPTER 9: VACCINE PREVENTABLE DISEASE AND FOODBORNE ILLNESS

Recommendation 9.1: Increase Immunization Rates (PRIORITY RECOMMENDATION)

FULLY IMPLEMENTED

a) **The North Carolina Division of Public Health (DPH) should aggressively seek to increase immunization rates for all vaccines recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), including the pneumococcal (PCV7), rotavirus, meningococcal (MCV4), human papillomavirus (HPV), and influenza vaccines which are not currently covered through the state's universal childhood vaccine distribution program (UCVDP).**
b) **All public and private insurers should provide first dollar coverage (no co-pay or deductible) for all CDC recommended vaccines that the state does not provide through the UCVDP, and should provide adequate reimbursement to providers to cover the cost and administration of the vaccines.**
c) **Health care providers should offer and actively promote the recommended vaccines, including educating parents about the importance of vaccinations.**
    1) **The influenza vaccination should be actively promoted for children ages 5 to 18.**
    2) **The HPV vaccination should be made available to females ages 9 to 26; however, vaccine delivery should be targeted toward adolescents ages 11-12, as recommended by the CDC's Advisory Committee on Immunization Practices (ACIP).**
d) **Parents should ensure that their children receive age appropriate vaccinations.**
e) **DPH should monitor the vaccination rate for the PCV7, MCV4, HPV and influenza vaccines not currently covered through the UCVDP to determine whether the lack of coverage through the UCVDP leads to lower immunization rates. If so, the DPH should seek recurring funds from the North Carolina General Assembly to cover these vaccines through the UCVDP, work with insurers to ensure first dollar coverage and adequate reimbursement for these recommended vaccines, or seek new financial models to cover vaccines for children not adequately covered through the UCVDP.**
f) **DPH should conduct an outreach campaign to promote immunizations of the flu, the new Tdap vaccine and all the recommended childhood vaccines among all North Carolinians. Emergency rooms patients and newborn contacts should be targeted specifically for Tdap immunizations. The North Carolina General Assembly should appropriate $1.5 million in recurring funds in SFY 2011to support this effort.**

[96] Dellapenna, A. Branch Head, Injury and Violence Prevention Branch, Chronic Disease and Injury Section, NC Department of Health and Human Services. Written (email) communication. June 30, 2015.

Under the ACA, federal law now requires that all childhood vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) be provided at no cost.[97] ACIP recommends vaccines that were not covered by UCVDP, including HPV, rotavirus, and PCV7.[98] Since 2009, ACIP no longer recommends MCV4, except for groups at an elevated risk of contracting meningitis.[99] There have been changes to vaccine requirements as of 2015. Children are now required to have 4 doses of PCV by 15 months of age and 2 doses of MCV. Providers are asked to strongly encourage HPV and annual influenza vaccinations, although these vaccines are not mandatory.[100] To encourage providers to adhere to vaccination guidelines, DPH employs the CDC-recommended AFIX strategy, which includes procedures for assessment, feedback, incentives and exchange of information.[101]

In 2010, the North Carolina Immunization Program (NCIP) replaced the Universal Childhood Vaccine Distribution Program (UCVDP).[102] Unlike the UCVDP, NCIP does not provide vaccines universally, does not distribute vaccines, and does not receive any state funding. Children who are eligible for the federal Vaccines for Children (VFC) program can receive vaccinations through NCIP. Children who are uninsured, eligible for Medicaid, or who are of Native American or Alaskan descent are all VFC eligible.[103] The North Carolina General Assembly provided one time funding of $3 million to help families and providers transition from the free vaccine program, UCVDP, to NCIP. Sixty-seven percent of North Carolina children are VFC eligible and can still receive free vaccinations through NCIP. The remaining 33% are privately insured. Between NCIP and the ACA ban on cost-sharing for ACIP recommended vaccines, all North Carolina children are able to receive the full set of recommended vaccines at no cost whether or not they are privately insured.

North Carolina has one of the highest rates of childhood vaccinations in the country. In 2013, the latest year with available CDC vaccination data, North Carolina exceeded the national average vaccinate rate for two-year-olds for all routine vaccinations except one—the second dose of Hepatitis A vaccine.[104] In 2013-14, the Pew Charitable Trust found that North Carolina ranked second nationally for the rate of vaccinated kindergartners, with coverage above 90%.[105]

Recommendation 9.2: Strengthen Laws to Prevent Food-borne Illnesses

PARTIALLY IMPLEMENTED

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[97] US Department of Health and Human Services. The Affordable Care Act and Immunization. http://www.hhs.gov/healthcare/facts/factsheets/2010/09/The-Affordable-Care-Act-and-Immunization.html. Published September 14, 2010. Accessed July 17, 2015.

[98] Centers for Disease Control and Prevention. Vaccine Recommendations of the ACIP. http://www.cdc.gov/vaccines/hcp/acip-recs/. Accessed July 17, 2015.

[99] Centers for Disease Control and Prevention. Report from the Advisory Committee on Immunization Practices (ACIP): Decision Not to Recommend Routine Vaccination of All Children Aged 2-10 Years with Quadrivalent Meningococcal Conjugate Vaccine (MCV4). http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5717a4.htm. Published May 1, 2008. Accessed July 17, 2015.

[100] Andersen P. Operations Manager, North Carolina Department of Health and Human Services, Division of Public Health, Women and Children's Health Section. Written (email) communication. July 22, 2015.

[101] Centers for Disease Control and Prevention. AFIX (Assessment, Feedback, Incentives, and eXchange). http://www.cdc.gov/vaccines/programs/afix/about/overview.html. Published December 10, 2014. Accessed July 22, 2015.

[102] North Carolina Immunization Program (NCIP) Overview. http://www.immunize.nc.gov/Training%20Modules/Regional%20Workshops/NCIP%20Overview%20-%20Final%209-3-2010.ppt. Accessed July 17, 2015.

[103] Mecklenburg County. State Funded Vaccines. http://charmeck.org/mecklenburg/county/HealthDepartment/ClinicServices/Pages/StateFundedImmunizations.aspx. Accessed July 17, 2015.

[104] Centers for Disease Control and Prevention. Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series by 24 Months of Age by State and Selected Area-- National Immunization Survey, United States, 2013. http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/13/tab09_24mo_iap_2013.pdf. Accessed July 17, 2015.

[105] Vestal C, The Pew Charitable Trusts. Stateline: In States with Looser Immunization Laws, Lower Rates. http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/2/09/in-states-with-looser-immunization-laws-lower-rates. Published February 9, 2015. Accessed July 17, 2015.

The North Carolina General Assembly should enact laws to strengthen North Carolina's ability to prevent and respond to foodborne illnesses by

a) **Directing the North Carolina Department of Agriculture and Consumer Services, the North Carolina Department of Environment and Natural Resources, and the North Carolina Department of Health and Human Services to create a committee to develop a "single-agency" approach for addressing foodborne illness in North Carolina. The committee should work to**
   1) **Develop a unified proactive, scientifically-based strategy to prevent, detect, and respond to food-borne illness.**
   2) **Identify ways to maintain adequate funding for a holistic food safety and defense program at the state and local level.**
   3) **Strengthen industry ties.**
   4) **Educate policy makers.**

b) **Appropriating $1.6 million in non-recurring funds in SFY 2011 and $300,00 in recurring funds beginning in SFY 2012 to the North Carolina Division of Public Health to develop and maintain an enhanced surveillance system that facilitates sharing of data from the North Carolina Department of Environment and Natural Resources and North Carolina Department of Agriculture and Consumer Services complaint lines, public health surveillance systems, US Department of Agriculture, Centers for Disease Control and Prevention, and Food and Drug Administration (FDA) when needed to detect or prevent the spread of foodborne illnesses.**

c) **Requiring all industries to develop Hazard Analysis Critical Control Point (HACCP) plans or use government risk-based inspections. HACCP plans should be made available to government agencies with jurisdiction.**

d) **Ensuring that the Governor can use the state's rainy day funds to pay for the additional personnel or other costs needed to address public health emergencies. Funds should be made available, when needed, to help pay for the additional costs involved in large outbreak investigations, food protection efforts, or other natural or man-made public health emergencies that require a coordinated and unified national, statewide, or regional response.**

The North Carolina Department of Agriculture and Consumer Services and Department of Environment and Natural Resources should adopt, through regulations, the current FDA Food Code and maintain it in such a manner as to continually address updates to the Code.

The Food Safety Modernization Act (Public Law 111-353, FSMA) was signed into law in 2011 with the goal of preventing food contamination and foodborne illnesses. The FMSA mandates that the FDA require all food facilities to adopt contamination-prevention measures by creating prevention plans. The FSMA also enables the FDA to: establish safety guidelines for produce, issue regulations against intentional contamination, increase frequency of facility inspection, issue mandatory recalls and raise safety standards for imported products among other capabilities. The FSMA also aims to strengthen partnerships between the FDA and state and local regulatory agencies to create an integrated food safety system. [106]

There have been no state appropriations to support foodborne illness surveillance or prevention. However, North Carolina has received four federal food safety grants to support implementation of the FMSA. Three of these grants are currently funded and one received funding in 2011. The 2011 grant under the FDA Innovative Food Defense Project helped the North Carolina Department of Environmental and Natural Resources modernize their Best Environmental Technology System (BETS) database that monitors retail food service facilities. The Innovative Food Defense grant allowed NCDENR to add a grading system to BETS, as well as a

[106] US Food and Drug Administration. Background on the FDA Food Safety Modernization Act (FMSA). http://www.fda.gov/Food/GuidanceRegulation/FSMA/ucm239907.htm. Published July 13, 2015. Accessed July 20, 2015.

searchable clearing house for consumer complaints lodged against food service facilities.[107] The three ongoing FDA grants include a Food Defense Task Force Conference grant, an animal feed safety grant, and a food emergency response laboratory grant.[108]

There is no single agency that handles foodborne illnesses in North Carolina. An outbreak of foodborne illness must be reported to the local public health department. According to the CDC, most foodborne illness incidents are local events that only require the oversight of local agencies. If an outbreak occurs at multiple locations within a state, the state health department investigates the outbreak with the assistance of the state department of agriculture and federal food agencies. The CDC leads investigations of multistate outbreaks.[109]

CHAPTER 10: RACIAL & ETHNIC DISPARITIES

Recommendation 10.1: Fund Evidence-Based Programs that Meet the Needs of the Diversity of the Population Being Served.

PARTIALLY IMPLEMENTED

a) **Public and private funders supporting prevention initiatives in North Carolina should place priority on funding evidence-based programs and practices. Intervention selection should take into account the racial, ethnic, cultural, geographic, and economic diversity of the population being served. When evidence-based programs are not available for a specific population, public and private funders should give funding priority to best and promising practices/programs and to those that are theory-based and incorporate elements identified in the research literature as critical elements of effective programs.**
b) **The North Carolina Division of Public Health (DPH) should examine racial and ethnic disparities in all of its health promotion and disease prevention activities. To increase the effectiveness of prevention initiatives targeting racial and ethnic disparities, DPH should involve community members, including faith-based health ministries, beauty salons/barber shops, civic and senior citizen groups, and other community leaders or lay health advisors.**
c) **North Carolina Foundations should provide funding to support and expand evidence-based initiatives targeting racial and ethnic disparities, and expand funding for community-based participatory research.**

The Community Focused Eliminating Health Disparities Initiative (CFEHDI) of the North Carolina Office of Minority Health and Health Disparities is designed to work collaboratively to ensure implementation of an evidence based medical home model to close the gap in the health status of minority groups as compared to the white population. The CFEHDI was created by the 2005 North Carolina General Assembly to build the capacity of faith based, community based, American Indian Tribal organizations and local health departments to reduce disparities and improve the health of African American, Hispanic/Latino and American Indian populations in

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[107] US Food and Drug Administration. FDA Innovative Food Defense Program Grant Project Summaries. http://www.fda.gov/downloads/ForFederalStateandLocalOfficials/CooperativeAgreementsCRADAsGrants/UCM281368.pdf. Accessed July 20, 2015.
[108] US Food and Drug Administration. For Federal, State, Local, Tribal, and Territorial Officials: Existing Grant & Cooperative Agreement Programs. http://www.fda.gov/ForFederalStateandLocalOfficials/CooperativeAgreementsCRADAsGrants/ucm234305.htm. Published April 22, 2014. Accessed July 20, 2015.
[109] Centers for Disease Control and Prevention. Foodborne Outbreaks: Key Players in Foodborne Outbreak Response. http://www.cdc.gov/foodsafety/outbreaks/investigating-outbreaks/key-players.html. Published March 24, 2015.

the state. Eligible applicants include faith-based organizations, community-based organizations, hospitals, local Community Care of North Carolina (CCNC) networks, hospitals and local health departments (LHD).[110]

In accordance with their mission to "improve the quality of life and quality of health for the financially needy of North Carolina", the Kate B. Reynolds Foundation has been a leader in promoting the use of evidence-based programs through their Health Care Division. Several urban models have been piloted and modified to fit the needs of rural communities, including the Nurse-Family Partnership in Rockingham County and Prevention Partners and Healthy Workplace initiatives through Prevention Partners. Other notable programs include a community-centered prevention program with the Halifax County Health Department to implement the Coordinated Approach to Child Health (CATCH) program in fifteen elementary schools in Halifax County serving low-income children.[111]

The Z. Smith Reynolds Foundation has consistently demonstrated a commitment to protect and expand civil and human rights and provide fair access to opportunities for all North Carolinians. From 2010-2015, Z. Smith allocated $16,462,920 through 239 grants in the Social Justice and Equity focus area.[112] These projects emphasized the Foundation's goals to lessen and eliminate discriminatory rules, policies, and practices which perpetuate the disadvantageous treatment of individuals in some communities and disproportionally advantage individuals in other communities, particularly impacting people of color, women, immigrants, lesbian/gay/bisexual/transgendered people, and the economically disadvantaged.[113]

The Blue Cross and Blue Shield of North Carolina (BCBSNC) Foundation has developed a priority focus on supporting the implementation of Community-Centered Health Home model components focusing heavily on engaging community members to ensure that interventions take the diversity of the population into account. The passage of Affordable Care Act has brought about the opportunity to integrate clinical service delivery with community prevention to reduce demand for resources and services; improve health, safety, and equity outcomes; and provide medical providers with skills and strategies to change the social circumstances that shape the health of their patients.[114]

In *Community Centered Health Homes: Bridging the gap between health services and community prevention,* BCBSNC Prevention Institute outlines an approach that community health centers can take to promote community health even as they deliver high quality medical services to individuals. The basic premise is that safety net health care organizations should engage with community partners to inform and engage in advocacy and policy change to improve community conditions that impact health. BCBSNC Foundation has provided technical assistance and financial support for 12 communities to experiment with aspects of the model and is currently in the process of selecting 2 to 4 communities to do more substantial planning and implementation of the model elements.[115]

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[110] Wright, C. Executive Director, Office of Minority Health and Health Disparities, Division of Public Health, NC Department of Health and Human Services. Personal communication. July 2, 2015.
[111] Smart, A. Interim President / Vice President, Kate B. Reynolds Charitable Trust. Oral (telephone) communication. July 10, 2015.
[112] Puckett, G. Grants Administrator, Z. Smith Reynolds Foundation. Written (email) communication. June 30, 2015.
[113] Winner, L. Executive Director, Z. Smith Reynolds Foundation. Written (email) communication. June 30, 2015
[114] Eyes, K. Senior Program Officer, Health Care, BlueCross BlueShield of North Carolina Foundation. Written (email) communication. July 21, 2015.
[115] Eyes, K.

CHAPTER 11: SOCIOECONOMIC DETERMINANTS OF HEALTH

Recommendation 11.1: Promote Economic Security (PRIORITY RECOMMENDATION)

PARTIALLY IMPLEMENTED

a) **The North Carolina General Assembly should increase the state Earned Income Tax Credit (EITC) to 6.5% of the federal EITC.**
b) **The North Carolina Division of Social Services and local Departments of Social Services should conduct outreach to encourage uptake of the Supplemental Nutrition Assistance Program (SNAP) by low-income individuals and families.**

In 2013 the North Carolina General Assembly adopted several tax policy reforms, including eliminating the state earned income tax credit (EITC) for North Carolina's families.

The State Division of Social Services currently has a SNAP Outreach Plan with USDA that has been in operation for seven years. The SNAP Outreach Plan is funded by USDA with a 50/50 match of federal funds and agency provider funds. There are six agencies under the grant providing services across the state. Outreach consists of dispelling myths about SNAP, providing low-income individuals with eligibility information, assisting potential clients with applications if needed, assisting with recertification, and handing out materials (flyers, brochures, etc) in reference to SNAP and their organization. A focus of the State and agency providers is to increase participation among the senior population because of low participation.[116]

Recommendation 11.2: Increase the Availability of Affordable Housing and Utilities

NOT IMPLEMENTED

To help economically disadvantaged North Carolinians better afford housing and utilities, the North Carolina General Assembly should:
a) **Appropriate $10 million in additional recurring funding beginning in SFY 2011 to the North Carolina Housing Finance Agency to increase funding to the North Carolina Housing Trust Fund.**
b) **Enact legislation to help all North Carolinians and especially low-income North Carolinians lower their energy expenses.**

Since 2009, the North Carolina Housing Finance Agency has faced significant reductions to housing resources such as the Housing Trust Fund (HTF). The highest level of funding was in 2007 in which the Housing Trust Fund was appropriated $18.9 million dollars. From 2009-2014 funding for the HTF has ranged from approximately $7-$10 million. In 2015 funding was at less than half of the 2007 budget at just under $7 million. Additionally, the state's Low Income Housing Tax Credit, an important tool for the financing of affordable rental development, was allowed to sunset on December 31, 2014.The Tax Credit program was replaced with a non-recurring appropriation of $10M for the Workforce Housing Loan Fund.[117] Further depleting funding since 2010, the state has opted not to use any Community Development Block Grant funds for housing programs, instead diverting all of the state's block grant to sewer and infrastructure, further straining the Housing Trust Fund. Meanwhile, federal resources for affordable housing are facing cuts; the US Senate budget proposes a

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[116] Locklear, D. Chief, Economic and Family Services, Division of Social Services, Department of Health and Human Services. Written (email) communication. July 15, 2015.
[117] Parry-Hill, W. Government and Community Liaison, North Carolina Housing Finance Agency. Written (email) communication. July 7, 2015.

stunning 93% cut to the federal HOME grant, which is used in North Carolina for activities such as financing Habitat for Humanity homes.[118]

While no state legislation has been enacted directly addressing energy costs, North Carolina received $132 million dollars for weatherization through the "American Recovery and Reinvestment Act of 2009." The NC Weatherization Assistance Program (WAP) helps low-income North Carolinians save energy and reduce their utility bills. The program is administered through the Division of Energy, Mineral & Land Resources in the N.C. Department of Environment and Natural Resources. NC WAP spent $126,062,648.67 of the 131,954,536 budgeted for the ARRA grant in 2009. 16,738 homes were completed in order to improve energy efficiency and household safety.[119]

Energy efficiency has been an area of focus for NCHFA long before 2009. NCHFA was the recipient of an Energy Star Award in 2011 for its leadership in promoting high energy standards in affordable housing. Virtually all new construction that the Agency finances and all comprehensive single-family rehabilitations are built to high energy standards and are rated by an independent third-party energy rater. New single-family homes that the Agency finances through partners such as Habitat for Humanity, local governments, and other non-profit builders are built to SystemVision standards. Over 4,000 homes for low to moderate income buyers have been built to SystemVision standards. All new multi-family rental housing is constructed to meet or exceed Energy Star standards. Since 2009 HFA has financed over 13,500 energy efficient rental units.[120]

Recommendation 11.3: Expand Opportunities for High Quality Early Childhood Education and Health Programs

PARTIALLY IMPLEMENTED

North Carolina Smart Start should further disseminate the Incredible Years program, the Assuring Better Child Health and Development program, and high-quality education programs to promote healthy social and emotional development among children in need in all North Carolina counties. The North Carolina General Assembly should appropriate $1.2 million in recurring funds to the North Carolina Partnership for Children, Inc. to support this effort.

The North Carolina General Assembly has not provided additional funds, and has actually decreased funding for Smart Start by approximately 22% since 2008-2009.[121]

Incredible Years

Currently 12 Smart Start local partnerships, serving 16 counties, are funding Incredible Years (IY) with state Smart Start funds. Nine partnerships were funding IY in 2008/09. While Smart Start only collects information on the number of local Smart Start partnerships who use Smart Start funds to support Incredible Years, some partnerships use other funding sources to support this evidence based parenting education program. Funding has been provided by the Department of Health and Human Services, North Carolina Partnership for Children, Smart Start Partnerships, and other health agencies. The Incredible Years Program has been largely implemented by local non-profit agencies and family resource centers. Prevent Child Abuse NC supports IY model coaching and evaluation for an average of 25 agencies annually, though many more exist that do not participate in these services.[122]

[118] Parry-Hill, W.
[119] Rowe, B. General Counsel & Director of Advocacy, NC Justice Center. Written (email) communication. August 5, 2015.
[120] Parry-Hill, W.
[121] White, D.
[122] Ingram, K. Director of Implementation Support, Prevent Child Abuse North Carolina. Written (email) communication. November 11, 2015.

Assuring Better Child Health and Development
The North Carolina Partnership for Children (NCPC), the umbrella organization that coordinates the work of the 77 local partnerships that distribute Smart Start funds across the state, used federal Race to the Top – Early Learning Challenge (RTT-ELC) grant funds to partner with Community Care of NC (CCNC) to link local partnerships and the CCNC regional offices so that the Assuring Better Child Health and Development program (ABCD) is currently being implemented in all 14 CCNC regions. However, the program is not being carried out in every county of each region. The partnership with CCNC has helped to infuse a deeper focus on early identification of developmental delays in the quality assurance and quality improvement work the CCNC offices perform, and has also promoted local partnership access to additional medical practices. Each region has developed a regional ABCD advisory committee to inform the planning and implementation. These regional committees are currently discussing options for sustaining the work when the grant period ends. ABCD training has been expanded for local coordinators and will soon begin work to develop an on-line version of the training in partnership with CCNC and North Carolina Pediatrics Society. One important focus of efforts has been on improving the communication between the medical provider and the children's developmental services agencies (CDSAs) and school districts. Standard referral and feedback forms have been developed to simplify and systematize referrals for further assessments and services, and feedback to the doctor on the status of the referrals.[123]

High-Quality Education Programs
Smart Start continues to support the maintenance and enhancement of high quality early care and education programs. Race to the Top – Early Learning Challenge (RTT-ELC) grant funds were used to strengthen the model for child care health consultation in North Carolina by developing a coaching component, a performance assessment, and an app for reporting classroom assessment information. Smart Start also partnered with Blue Cross Blue Shield Foundation of North Carolina to develop Shape NC, an early childhood obesity prevention program that has already reached over 7,000 children in early care and education centers. As with the Incredible Years program, many local partnerships use non-Smart Start funds to offer programs. For instance, some local partnerships were awarded federal grants in the recent Early Head Start – Child Care Partnerships expansion. Local partnerships also administer NC Pre K in many communities.[124]

Parents as Teachers, funded by Smart Start in 57 counties, as well as the Nurse Family Partnership and Healthy Families home visiting programs that local partnerships support are effective programs for fostering parent-child attachment and positive parenting practices.[125]

Recommendation 11.4: Increase the High School Graduation Rate (PRIORITY RECOMMENDATION)

<u>PARTIALLY IMPLEMENTED</u>

a) The North Carolina State Board of Education (SBE) and the North Carolina Department of Public Instruction (DPI) should expand efforts to support and further the academic achievement of middle and high school students with the goal of increasing the high school graduation rate. The SBE should implement evidence-based or best and promising policies, practices, and programs that will strengthen interagency collaboration (community partnerships), improve student attendance rates/decrease truancy, foster a student-supportive school culture and climate that promotes school connectedness, explore and implement customized learning options for students, and more fully engage students in learning. Potential evidence-based or promising policies, practices, and programs might include, but are not limited to:
    1) Learn and Earn partnerships between community colleges and high schools.

[123] White, D.
[124] White, D.
[125] White, D.

2) District and school improvement interventions to help low-wealth or underachieving districts meet state proficiency standards.
3) Alternative learning programs, for students who have been suspended from school, which will support continuous student learning, behavior modifications, appropriate youth development, and increased school success.
4) Expansion of the NC Positive Behavior Support Initiative to include all schools in order to reduce short- and long-term suspensions and expulsions.
5) Establishment of a committee to study the potential impact of raising the compulsory school attendance age from 16 to 17 and 17 to 18 in successive years.

b) The SBE should work with appropriate staff members in DPI, including curriculum and finance representatives, and staff from the North Carolina General Assembly Fiscal Research Division, to examine the experiences of other states and develop cost estimates for the implementation of the initiatives to increase the high school graduation rate. These cost estimates should be reported to the research division of the North Carolina General Assembly and the Education Oversight Committee by April 1, 2010 so that they can appropriate recurring funds.

North Carolina has made tremendous strides in public school performance over the last decade. The state graduation rate has continued to increase for ten consecutive years, reaching an all-time high of over 85% in 2015.[126] North Carolina has made substantial progress but more work still needs to be done to improve student performance across distinct demographics in the state. According to State Superintendent Atkinson, schools with high percentages of students from economically disadvantaged backgrounds continue to lag behind schools in affluent communities.[127] The overall improved state graduation rate is the result of both continued funding from the North Carolina General Assembly and innovative project development from the North Carolina State Board of Education and Department of Public Instruction.

From 2007-2010, the North Carolina General Assembly appropriated $13 million in recurring funds towards dropout prevention grants. The grants were awarded to 83 organizations in 63 counties across North Carolina in 2009.[128] In 2010, $10.8 million was awarded to 77 groups to improve high school graduation rates.[129] The grantees were also required to evaluate their program models.

During the 2009 Session, NCGA Session Law 2009-330 "encouraged local businesses to adopt policies to permit parents to attend student conferences; encourage local boards of education to adopt programs to help students transition from middle school to high school, increase parental involvement, reduce suspension and expulsion, encourage academic progress during suspension, change policies to encourage pregnant and parenting students to graduate." No funding was appropriated or authorized for these recommendations.[130] In the 2015-2016 budget, the General Assembly cut $2.5 million in funding for the North Carolina Department of Public Instruction – over 5% of their total budget. The only increase in state funding for K-12 education was a two-year total $20.8 million allocation to private school vouchers for low-income families, for $17.6 million available in 2015-16 and $24.8 million in 2016-17.[131]

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126 High School Graduation Rate Highest in State History; More than 70 Percent of Public Schools Receive Grades of C or Higher. Public Schools of North Carolina website. http://www.ncpublicschools.org/newsroom/news/2015-16/20150902-01. Accessed October 9, 2015.
127 Hildebrand, P., Chief Health and Community Relations Officer, North Carolina Department of Public Instruction. Written (email) communication. Oct 17, 2012.
128 $13 Million in Dropout Prevention Grants Awarded. Public Schools of North Carolina website. http://www.ncpublicschools.org/newsroom/news/2009-10/20091222-01. Accessed October 9, 2015.
129 General Assembly Awards Dropout Prevention Grants. Public Schools of North Carolina website. http://www.ncpublicschools.org/newsroom/news/2010-11/20101102-01. Accessed October 9, 2015.
130 Section 1 of Session Law 2009-330.
131 Section 8.37 of Session Law 2015-241.

One initiative that the Department of Public Instruction has implemented to improve student behavior and outcomes is the North Carolina Positive Behavior Intervention and Support Initiative (PBIS). PBIS works with schools to integrate their Safe Schools Plans, Character Education efforts and strategies, and discipline efforts to make schools safe environments. The initiative has combined efforts with Response to Intervention (RtI) initiatives to develop a tiered support system in all schools to improve graduation rates. The tiered program consists of (1) universal primary prevention targeting school-/classroom-wide systems utilizing universal and proactive prevention methods; (2) secondary prevention targeting students with at-risk behaviors uses group interventions; and (3) tertiary prevention targeting students with high-risk behavior using individual-level with assessment-based, high intensity and long duration interventions.

More recent initiatives from the North Carolina Department of Public Instruction include the *Standard Course of Study* content adopted in 2010 and implemented in 2012 to improve curriculum development by teachers according to students' needs and past educational experiences. For the 2015-2016 school year, a 10-point grading system was implemented for all high school students to ensure equity within classrooms and athletic eligibility.[132] Compared to other states across the nation, North Carolina's proficiency standards on end-of-grade tests continue to rank among the highest in 2015, according to the National Assessment of Education Progress.[133]

North Carolina has also received federal funding to improve school outcomes. Forty North Carolina schools are receiving federal school improvement grants; the lowest performing schools in NC received the grants. Schools are to implement programs within the turnaround, transform, or restart models to improve school performance.[134] In 2010, North Carolina was awarded one of 12 Race to the Top United States Department of Education (USED) grants in the amount of $400 million over four years to be used to improve outcomes across all 114 local school districts.[135]

Chapter 12: CROSS-CUTTING STRATEGIES IN SCHOOLS, WORKSITES, AND CLINICAL SETTINGS

Recommendation 12.1: Enhance North Carolina Healthy Schools (PRIORITY RECOMMENDATION)

NOT IMPLEMENTED

a) **The North Carolina School Health Forum should be reconvened and expanded to ensure implementation and expansion of the North Carolina Healthy Schools Initiative. The North Carolina School Health Forum should be expanded to include the Department of Juvenile Justice and Delinquency Prevention, Department of Environment and Natural Resources, and other partners as needed to implement the eight components of the Coordinated School Health program.**
b) **The North Carolina School Health Forum should develop model policies in each of the eight components of a Coordinated School Health System. This would include reviewing and modifying existing policies as well as identifying additional school-level policies that could be adopted by schools to make them healthier environments for students. When available, evidence-based policies should be adopted. The North Carolina School Health Forum and the North Carolina Healthy Schools Initiative**

[132] Back to School in NC: By the Numbers. Public Schools of North Carolina website. http://www.ncpublicschools.org/newsroom/news/2015-16/20150824-01. Accessed October 9, 2015.
[133] NC Proficiency Standards Among Highest in the Nation. Public Schools of North Carolina website. http://www.ncpublicschools.org/newsroom/news/2015-16/20150709-02. Accessed October 9, 2015.
[134] School Improvement Grants. Public Schools of North Carolina website. http://www.ncpublicschools.org/program-monitoring/grants/. Accessed October 9, 2015.
[135] Race to the Top Funds on the Way to Local Districts, Charters. Public Schools of North Carolina website. http://www.ncpublicschools.org/newsroom/news/2010-11/20110211-01. Accessed October 9, 2015.

should develop a system to recognize schools that adopt model policies in each of the eight components.

c) **The North Carolina Department of Public Instruction (DPI) should expand the North Carolina Healthy Schools Initiative to include a local Healthy Schools coordinator in each Local Education Agency (LEA). The North Carolina General Assembly should appropriate $1.5 million in recurring funds beginning in SFY 2011 increased by an additional $1.5 in recurring funds in each of the following five years (SFY 2012-2017) for a total of $12 million recurring funds to support these positions.**
    1) **The North Carolina School Health Forum should identify criteria to prioritize funding to LEAs during the first five years. The criteria should include measures to identify LEAs with the greatest adolescent health and educational needs.**
    2) **In order to qualify for state funding, the LEA must show that new funds will supplement existing funds through the addition of a local Healthy Schools Coordinator and will not supplant existing funds or positions. To maintain funding, the LEA must show progress towards implementing evidence-based programs, practices, and policies in the eight components of the Coordinated School Health system.**
    3) **Local Healthy Schools Coordinators will work with the School Health Advisory Council, schools, local health departments, primary care and mental health providers, and community groups in their LEAs to increase the use of evidence-based practices, programs, and policies to provide a coordinated school health system and will work towards eliminating health disparities.**

d) **The North Carolina Healthy Schools Section of DPI should provide monitoring, evaluation, and technical assistance to the LEAs through the local Healthy Schools Coordinators. The North Carolina General Assembly should appropriate $225,000 in recurring funds in SFY 2011 to DPI to support the addition of 3 FTEs to do this work. Staff would be responsible for:**
    1) **Implementing the monitoring system (including gathering data, measuring compliance, and reporting to the North Carolina State Board of Education (SBE)) for the Healthy Active Children Policy).**
    2) **Implementing the monitoring system (including gathering data, measuring compliance, and reporting to the SBE) for the School Health Profiles survey.**
    3) **Providing technical assistance and professional development to LEAs for coordinated school health system activities and implementing evidence-based programs and policies with fidelity.**
    4) **Implementing, analyzing, and disseminating the Profiles survey, including reporting on school-level impact measures (SLIMs).**
    5) **Working with the PTA and other partners as appropriate to develop additional resources and education materials for parents of middle and high school students for the Parent Resources section of the North Carolina Healthy Schools website. Materials should include information for parents on how to discuss material covered in the Healthful Living Standard Course of Study with their children as well as evidence-based family intervention strategies when available. Information on how to access the materials should be included in the Student Handbook.**

With the 2012 expiration of CDC funding for North Carolina's Coordinated School Health Program, the School Health Forum ceased to exist. The North Carolina Department of Public Instruction (DPI) was not eligible to apply for the most recent round of CDC funding for this program after the CDC made changes to how its divisions were organized. School-level Impact Measures (SLIMs) were a component of the former CDC funding, and no longer exist.

Local Education Agencies (LEAs) do not have healthy schools coordinators, as no funding has been allocated for these positions. Due to a lack of funding, many district-level coordinator positions have been eliminated or combined with other positions.[136]

DPI does collect data from LEAs on the Healthy Active Children initiative, but has not received additional funding to do so. However, DPI does receive $65,000 of CDC funding per year to collect and report data from the School Health Profiles Survey and the Youth Risk Behavior Survey.[137]

DPI provides professional development and technical assistance to support the sexual health component of the Healthful Living Standard Course of Study. The NC Healthy Schools website is being reviewed and updated and will include additional resources.[138]

Recommendation 12.2: Require the Use of Evidence-based Curricula for Healthful Living Standard Course of Study

NOT IMPLEMENTED

The North Carolina General Assembly should require schools to use evidence-based curricula when available to teach the objectives of the Healthful Living Standard Course of Study.

a) **The North Carolina General Assembly should appropriate $1.2 million in recurring funds in SFY 2011 to the North Carolina Department of Public Instruction (DPI) to provide grants to Local Education Agencies (LEAs) to implement evidence-based curricula. To implement this provision, the DPI Healthy Schools Section should identify three to five evidence-based curricula that demonstrate positive change in behavior across multiple health risk behaviors (i.e. substance use, violence, sexual activity) and provide grants (of up to $10,000 per LEA) for implementation and technical assistance to ensure curricula are implemented with fidelity.**
b) **The North Carolina State Board of Education (SBE) and DPI should work together to ensure that middle and high schools are effectively teaching the Healthful Living Standard Course of Study objectives.**
    1) **The DPI Healthy Schools Section should coordinate trainings[139] for local school health professionals on the Centers for Disease Control and Prevention's Health Education Curriculum Assessment Tool (HECAT) and the Physical Education Curriculum Assessment Tool (PECAT) so that they are able to assess and evaluate health and physical education programs and curricula.**
    2) **The SBE should require every LEA to complete the HECAT and PECAT for middle and high schools every three years beginning in 2013 and submit them to the DPI Healthy Schools Section. The Superintendent should ensure the involvement of the Healthful Living Coordinator and the School Health Advisory Council.**
    3) **Tools to assess the implementation of health education should be developed as part of DPI's Accountability and Curriculum Reform Effort (ACRE).**
c) **The SBE should encourage DPI to develop additional health education and physical education courses at the high school level including:**
    1) **Academically rigorous honors-level courses.**
    2) **Healthful living electives beyond the required courses. Courses should provide more in-depth coverage of Healthful Living Course of Study Objectives. DPI and health partners should**

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136 Essick E. Section Chief, NC Healthy Schools, North Carolina Department of Public Instruction. Written (email) communication, July 7, 2015.

137 Minutes of the North Carolina State Board of Education, August 6, 2014. http://stateboard.ncpublicschools.gov/minutes-actions/sbe-minutes/2014-minutes/08minutes.pdf. Accessed July 22, 2015.

138 Essick E.

139 The CDC provides trainings on using these tools free of charge. Would need funding to cover substitutes, food and facilities for trainings- would be a one-time cost.

identify potential courses and help schools identify evidence-based curricula to teach Healthful Living electives.

The General Assembly has not provided funding to LEAs to support the adoption of evidence-based health curricula. Most LEAs use the "Successfully Teaching Middle School Health" and "Successfully Teaching High School Health" curricula, published by the North Carolina School Health Training Center at Appalachian State University. These curricula have been designed to align with the Healthful Living Course of Study Essential Standards.

Very few districts or schools perform HECAT or PECAT evaluations. DPI currently employs a single consultant to oversee all Health and Physical Education programs throughout the state, and does not have the capacity to monitor assessments done at the district level.[140]

Recommendation 12.3: Create the North Carolina Worksite Wellness Collaborative and Tax Incentives for Small Businesses

PARTIALLY IMPLEMENTED

a) The North Carolina Worksite Wellness Collaborative should include, but not be limited to, representatives of state and local government, organizations with expertise in worksite wellness, insurers, small and large employers, Chambers of Commerce, and other natural groupings of employers. Initially, the Collaborative should focus on providing assistance to state and local governments, small businesses with 50 or fewer employees, and nonprofit organizations.
b) The Collaborative should lead efforts to implement the following four components of a statewide worksite wellness effort using evidence-based strategies (and best and promising practices when necessary):
  1) Assessment of organizational-level worksite indicators such as policies, benefits, and workplace environments that influence employee health, and development of an organizational-level worksite action plan for workplaces to make improvements.
  2) Individual employee assessments via Health Risk Appraisals (HRAs) tied to personal feedback and an actionable and specific plan for employees.
  3) Technical assistance to worksites to help them implement evidenced-based strategies to address needs identified in both organizational and individual employee-level assessments and to assist worksites in meeting criteria for comprehensive employee wellness programs.
  4) A data collection system that includes both organizational and individual employee indicators, tracks progress, and evaluates outcomes at the organizational and employee level.
c) The North Carolina General Assembly should appropriate annual funding for five years as shown below to support this effort as the Collaborative develops a sustainable business plan that will eliminate the need for funding after five years.
  1) $800,000 in SFY 2011
  2) $700,000 in SFY 2012
  3) $500,000 in SFY 2013
  4) $500,000 in SFY 2014
  5) $250,000 in SFY 2015
d) The North Carolina General Assembly should provide a tax credit to small businesses with employees of 50 or fewer that offer and promote comprehensive wellness programs for their employees. Eligible businesses should be provided a tax credit of up to $200 per employee for establishing or maintaining a wellness program that is certified under a process established by the Collaborative.
e) The Collaborative should develop a process and set of criteria to certify businesses as eligible to receive state or federal tax credits.

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[140] Essick E.

The state legislature has not made appropriations to support a North Carolina Worksite Wellness Collaborative and there has not been any legislation to establish tax incentives for worksite wellness programs. However, Prevention Partners, a North Carolina-based nonprofit organization leads a worksite wellness initiative called WorkHealthy America (WHA) to advance similar goals. Three hundred forty-five North Carolina worksites with over 470,000 employees participate in WHA. The worksites include hospitals, government agencies, schools, large private employers and small businesses.

Prevention Partners is partnering with the CDC to disseminate the WHA model nationally. There are four broad components to the WHA model: tobacco reduction, healthy food, physical activity, and creating a culture of wellness. Within these categories, WHA promotes 125 best practices for participating worksites. When a worksite purchases a WHA license, it gains access to Health Risk Appraisals (HRAs) as well as technical assistance, recommended best practices, assessments of evidence-based tools, report cards comparing baseline worksite health to target levels, action plans, sample policies, and a variety of other tools. Prevention Partners also maintains a database of WHA sites that tracks organizational progress and publishes aggregate worksite data on health standards.

Since 2010, Prevention Partners has received over $1 million annually in grants, contracts, and donations to support WHA. WHA has launched a new initiative, Power of 10, which aims to extend WHA to ten major employers in each of North Carolina's 100 counties by 2025. To this point, eleven counties have more than ten worksites that employ the WHA model.[141]

Recommendation 12.4: Expand Health Insurance Coverage to More North Carolinians (PRIORITY RECOMMENDATION)

<u>PARTIALLY IMPLEMENTED</u>

a) **The Task Force believes that everyone should have health insurance coverage. In the absence of such, the North Carolina General Assembly should begin expanding coverage to groups that have the largest risk of being uninsured. Such efforts could include, but not be limited to:**
   1) **Provide funding to the North Carolina Division of Medical Assistance to do the following:**
      i) **Expand outreach efforts and simplify the eligibility determination and recertification process to identify and enroll people who are already eligible for Medicaid or NC Health Choice.**
      ii) **Expand coverage to children with incomes up to 300% of the federal poverty guidelines (FPG) on a sliding scale basis.**
      iii) **Develop a limited benefits package to provide coverage to adults with incomes up to 100% FPG, with a phase in of coverage of adults up to 200% FPG.**
   2) **Change state laws to require insurance companies to offer parents the option to continue dependent coverage until the child reaches age 25, regardless of student status.**
   3) **Encourage the University of North Carolina System to require students who are enrolled full-time in one of its universities to obtain health insurance coverage.**
   4) **Develop a subsidized health insurance product targeted to small businesses that employ a low-wage work force.**

The North Carolina Division of Public Health (DPH) should collaborate with NC Prevention Partners to include the coverage of all the US Preventive Services Task Force's (USPSTF) recommended screening and treatment, including but not limited to screenings, counseling, and treatment for STD/HIV, obesity, alcohol and substance use, and depression in the existing annual Preventive Benefits Profile survey of

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[141] Molloy M. Chief Executive Officer, Prevention Partners. Written (email) communication. July 7, 2015.

public and private health insurers in the state. If coverage is found to be inadequate or lacking, then public and private health insurers should expand coverage to include all the USPSTF recommended screenings, counseling, and treatment. The North Carolina General Assembly should appropriate $75,000 in recurring funds to DPH to support these efforts.

Passed in 2010, the Affordable Care Act required most Americans to purchase health insurance beginning in 2014 or pay a penalty. To help families obtain health insurance, the ACA provides either state or federal health insurance subsidies to families with incomes between 133% and 400% of the Federal Poverty Level (FPL).[142] The original ACA provision that would have required states to expand Medicaid eligibility to 133% of the FPL was struck down by the Supreme Court in 2012 (*National Federation of Independent Business v. Sebelius*).[143] The Supreme Court has upheld the legality of both the federal health insurance subsidies (*King v. Burwell, 2014*) and the individual mandate to buy health insurance or pay a fine (*National Federation of Independent Business v. Sebelius*).[144]

Almost 20% of North Carolinians under the age of 65 lacked health insurance in 2013, before the penalties for being uninsured took effect. By the end of 2014, the number of uninsured had fallen to about 16%.[145] North Carolina is one of twenty-two states that have not expanded Medicaid. States that expanded Medicaid experienced more dramatic declines in the rate of uninsured adults, with an average decrease of approximately ten percentage points, compared to an average of three percentage points in states that did not expand Medicaid.[146] If North Carolina chooses to expand Medicaid in the future, an additional half a million North Carolinians will become eligible to gain health insurance coverage.[147]

The ACA addresses several other provisions of Recommendation 12.4. Under the ACA, children are allowed to remain covered by their parents' health insurance policies until age 26.
The University of North Carolina system does require all students to have health insurance. Students may join UNC's student health plan or they may obtain a waiver if they wish to retain their current health insurance.[148] The ACA does provide a tax credit to small employers with fewer than 25 employees earning average annual wages of less than $50,000 that choose to provide health insurance coverage to employees.[149] The ACA also requires that all screenings and treatments recommended by the US Preventive Services Task Force be covered by almost all health insurance plans at no cost to the patient.[150]

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[142]Kaiser Family Foundation. Health Reform: Summary of the Affordable Care Act. http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/. Published April 25, 2013. Accessed July 23, 2015.
[143] Kaiser Family Foundation. Focus on Health Reform: A Guide to the Supreme Court's Affordable Care Act Decision. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8332.pdf. Published July 2012. Accessed July 23, 2015.
[144] Liptak A. Supreme Court Allows Nationwide Health Care Subsidies. *The New York Times*. http://www.nytimes.com/2015/06/26/us/obamacare-supreme-court.html. Published June 25, 2015. Accessed July 23, 2015.
[145] Murawski J. Report: NC uninsured rate fell 13% in ACA's first year. *The News & Observer*. http://www.newsobserver.com/news/business/article25434172.html. Published June 24, 2015. Accessed July 23, 2015.
[146] Hoban R. Fewer Uninsured in N.C., But Fewer Still in Medicaid-Expansion States. *North Carolina Health News*. http://www.northcarolinahealthnews.org/2015/05/21/fewer-uninsured-in-n-c-but-fewer-still-in-medicaid-expansion-states/. Published May 21, 2015. Accessed July 23, 2015.
[147]Binker M. Supreme Court ruling brings Medicaid expansion for NC into focus. *WRAL*. http://www.wral.com/supreme-court-ruling-brings-medicaid-expansion-for-nc-into-focus/14737591/. Published June 25, 2015. Accessed July 23, 2015.
[148] The University of North Carolina at Chapel Hill. Mandatory Student Health Insurance/ Hard Waiver Process. https://campushealth.unc.edu/charges-insurance/mandatory-student-health-insurance. Accessed July 23, 2015.
[149]Kaiser Family Foundation. Health Reform: Summary of the Affordable Care Act. http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/. Published April 25, 2013. Accessed July 23, 2015.
[150] US Department of Health and Human Services. Preventive Services Covered Under the Affordable Care Act. http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html. Published September 23, 2010. Accessed July 23, 2015.

Recommendation 12.5: Improve Provider Training To Promote Evidence-based Practices

PARTIALLY IMPLEMENTED

a) **The Area Health Education Centers (AHEC) Program should offer training courses to enhance the training of health professionals, including physicians, nurses, allied health, and other health care practitioners; increase the use of evidence-based prevention, screening, early intervention, and treatment services to reduce certain high-risk behaviors; and address other factors that contribute to the state's leading causes of death and disability. Training courses should be expanded into academic and clinical settings, residency programs, and other continuing education programs. AHEC should:**
   1) **Partner with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Governor's Institute on Alcohol and Drug Abuse, and other appropriate organizations and professional associations to offer trainings to do the following:**
      i. **Educate and encourage health care professionals to use evidence-based screening tools and to offer screening, brief intervention, and referral to treatment (i.e. SBIRT) to help patients prevent, reduce, or eliminate the use of or dependency on alcohol, tobacco, or other drugs.**
      ii. **Educate health care providers to ensure accurate diagnosis, effective treatment, and follow up for major depressive disorder in youth ages 12-18 and adults.**
   2) **Partner with the North Carolina Division of Public Health (DPH) and other appropriate organizations and health professional associations to offer training on screening, assessing, and counseling to all sexually active youth and adults, especially high-risk individuals, and to promote STDs, HIV, and unintended pregnancy risk reduction, including the use of appropriate and effective contraception.**
   3) **Partner with the UNC Center for Injury Prevention Research Center (IPRC), DPH, and other appropriate organizations and health professional associations to offer trainings in evidence-based strategies to prevent motor vehicle crash injuries, unintentional poisoning (including the appropriate use of pain medications), falls, family violence, and other injuries to state and local public health professionals, physicians, nurses, allied care workers, social workers, and others responsible for injury and violence prevention as well as proper use of e-codes to document injuries.**
   4) **Partner with other appropriate organizations and health professional organizations to offer training to primary care providers and other providers about the screenings, counseling, and treatment recommended by the US Preventive Services Task Force.**
   5) **Help providers better understand how social issues such as housing, poverty, and education impact health so that this knowledge can be integrated into medical practice**

b) **The North Carolina General Assembly should appropriate $250,000 in recurring funds beginning in SFY 2011 to AHEC to support these efforts.**

In 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded North Carolina a five year $8.33 million grant for Screening, Brief Intervention and Referral to Treatment (SBIRT). The Department of Health and Human Services (DHHS) administers the SAMHSA grant in partnership with the Governor's Institute of Substance Abuse, Community Care of North Carolina (CCNC), the Division of Medical Assistance (DMA), the American Indian Health Board, North Carolina Community Health Centers Association, and several primary care practices.[151] The grant funding goes toward hiring case managers and mental health and substance abuse professionals who work with physicians to screen, intervene, and refer patients to resources.[152] The North Carolina Academy of Family Physicians has also provided SBIRT training and motivational interviewing techniques as part of its Continuing Medical Education Conferences.[153]

[151] McEwen S. Executive Director, Governor's Institute on Substance Abuse. Written (email) communication. July 7, 2015.
[152] NC SBIRT. About Us. http://ncsbirt.org/about-us/. Accessed July 27, 2015.
[153] Griggs G. Executive Vice President, North Carolina Academy of Family Physicians. Written (email) communication. July 7, 2015.

While AHEC is not a partner on the SBIRT grant, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MHDDSAS) and the American Indian Health Board partnered with AHEC to provide SBIRT training in Robeson county and in the Cherokee area.[154] AHEC offers related training through online continuing education courses that cover various aspects of adolescent mental and sexual health, including courses with the following titles:

- "Helping students to Cope with pregnancy and HIV/AIDS"
- "Depression and Suicide in Children and Youth"
- "Risk and Resiliency Factors, Crisis Intervention and Follow-up Support"
- "Helping Students Cope with Substance Abuse"
- "Sexually Transmitted Infections in Prepubertal Children & Adolescents"[155]

AHEC does offer four different courses on falls prevention for the elderly but does not currently offer preventive courses on motor vehicle accidents, poisoning, or family violence. However, other injury prevention resources are available to North Carolinians and North Carolina health care providers. The Governor's Institute provides training to physicians on evidence-based practices for preventing addiction and holds an annual conference on Addiction Medicine for providers. They have also collaborated with the UNC Injury Prevention Research Center, DPH and CNNC on Project Lazarus, a community and clinical education program design to reduce the over-prescription and abuse of opioid painkillers. Currently, the Governor's Institute is working with the Mountain and Greensboro AHECs to create an online continuing education module on overdose prevention and prescription drug abuse.[156]

AHEC does not currently offer training on US Preventive Services Task Force recommended practices or on social issues related to health. No appropriations have been made to support specific AHEC programming.

Chapter 13: DATA

Recommendation 13.1: Enhance Existing Data Systems

<u>**PARTIALLY IMPLEMENTED**</u>

a) North Carolina agencies should enhance specific existing data collection systems to ensure that the state has adequate data for health and risk assessment including:
   1) The North Carolina State Board of Education (SBE) should support and promote the participation of Local Education Agencies (LEAs) in the Youth Risk Behavior Survey (YRBS) and the School Health Profiles Survey (Profiles). As part of this effort, the SBE should:
      i) Identify strategies to improve participation in the YRBS and the Profiles survey. Options should include, but not be limited to, training for superintendents and local school boards, changing the time of year the survey is administered, financial incentives, giving priority to grant funds to schools that participate, a legislative mandate, convening a clearinghouse to reduce duplicative surveys of youth risk behaviors and other school health surveys.
      ii) Expect any LEA selected by the Centers for Disease Control and Prevention to participate in the YRBS and/or the Profiles survey to implement both surveys in their entirety unless a waiver to not participate is requested by the LEA and granted by the SBE.

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154 Fernandez M. Project Manager, NC SBIRT. Written (email) communication. July 3, 2015.
155 North Carolina AHEConnect. Course Catalog. http://www.aheconnect.com/newahec/courses.asp. Accessed July 27, 2015.
156 McEwen S.

iii) Develop policies addressing the ability of schools, parents, and students to opt out of the YRBS and Profiles surveys, over-sampling for district-level data, and any additional data that needs to be added to the surveys.

2) The North Carolina Department of Health and Human Services and the North Carolina Department of Public Instruction should periodically collect environmental risk data using the Behavioral Risk Factor Surveillance System and Profiles survey, respectively.

b) The North Carolina General Assembly should appropriate $165,080 in recurring funds beginning in SFY 2011 to the North Carolina Cancer Registry to improve data collection and compliance with required reporting.

North Carolina receives $65,000 annually from the CDC to administer the YRBS and School Health Profiles Survey each year.[157] The YRBS is administered in odd years and the School Health Profiles Survey is administered in even years.[158] CDC's contract evaluator, Westat, selects a random sample of representative LEAs throughout North Carolina. The sample usually includes approximately 70 middle and high schools throughout the selected districts.

Dr. June Atkinson, State Superintendent of Public Schools, sends out a letter to each superintendent of the selected districts requesting their participation in the YRBS process. LEAs may opt out of participation. LEAS that are willing to participate will appoint a local level coordinator to oversee the distribution and completion of the survey. The Department of Public Instruction (DPI) provides training to the appointed individual on data collection.

Participating schools typically use a passive permission process, whereby all students participate in the survey unless they present a parental permission slip that specifically prohibits their participation.[159]

The State Center for Health Statistics under the Department of Health and Human Services conducts the Behavioral Risk Factor and Surveillance Survey (BRFSS) on a monthly basis and analyzes the data annually. BRFSS is a random telephone survey of North Carolina adults over the age of 18.[160] To collect data on students under the age of 18, DPI conducts the School Health Profiles Survey every two years.[161]

The North Carolina Cancer Registry (NCCR) has not received new state funding. In 2013, House Bill 399 required electronic reporting of all cancer diagnoses to the NCCR by no later than October 1, 2014. Electronic reporting will streamline the data collection process. Electronic reports must be transmitted within six months of diagnosis.[162]

Recommendation 13.2: Identify and Disseminate Effective Nutrition, Physical Activity, Obesity, and Chronic Disease Prevention Practices in North Carolina

PARTIALLY IMPLEMENTED

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[157] Minutes of the North Carolina State Board of Education, August 6, 2014. http://stateboard.ncpublicschools.gov/minutes-actions/sbe-minutes/2014-minutes/08minutes.pdf. Accessed July 22, 2015.

[158] NC Healthy Schools. Data Sources. http://www.nchealthyschools.org/data/. Accessed July 27, 2015.

[159] Essick E. Section Chief, NC Healthy Schools, North Carolina Department of Public Instruction. Written (email) communication, July 30, 2015.

[160] North Carolina State Center for Health Statistics. Behavioral Risk Factor Surveillance System (BRFSS). http://www.schs.state.nc.us/units/stat/brfss/. Published November 21, 2013. Accessed July 30, 2015.

[161] NC Healthy Schools. Data Sources. http://www.nchealthyschools.org/data/. Accessed July 27, 2015.

[162] General Assembly of North Carolina Session 2013. House Bill 399. http://www.schs.state.nc.us/units/ccr/documents/HB399.pdf. Published October 1, 2013. Accessed July 27, 2015.

The UNC Center for Health Promotion and Disease Prevention should work with North Carolina foundations to identify effective practice-level nutrition, physical activity, obesity, and chronic disease prevention interventions within the state.

a) **North Carolina foundations should provide $50,000 annually beginning in SFY 2011 to the UNC Center for Health Promotion and Disease Prevention to use an existing systematic process to review five foundation-funded prevention interventions within North Carolina that have not been formally evaluated and disseminate these interventions through a web-based interface designed for, and accessible to, all public health practitioners and community partners.**
b) **The website should be used:**
    1) **To provide toolkits for users to replicate interventions at the community practice level.**
    2) **As a resource for potential grantees.**
    3) **As a mechanism for sharing the results of funded and reviewed projects with other grantees.**

The UNC Center for Health Promotion and Disease Prevention has not received foundation funding, but has received a USDA grant that supports the efforts of the Center for Training and Research Translation (Center TRT) initiatives around the Supplemental Nutrition Assistance Program Education (SNAP-Ed) and the Expanded Food and Nutrition Education Program (EFNEP).[163] Center TRT is a CDC-funded Prevention Research Center based in the UNC Center for Health Promotion and Disease Prevention that reviews and disseminates evidence-based practices around obesity prevention, nutrition, and physical activity.[164]

The USDA grant designates UNC-Chapel Hill as one of four national Regional Nutrition Education and Obesity Prevention Centers of Excellence (RNECE).[165] The goal of the RNECEs is to improve the health of low-income Americans by acting as clearinghouses for evidence-based practices, evaluating interventions, and collaborating with SNAP-Ed and EFNEP directors to advance research efforts.[166]

Center TRT offers free online training for public health practitioners, all of which is available on their website. Over 1,500 professionals have benefitted from the online training modules. Center TRT also disseminates information through regular webinars, and other resources available through their website.[167]

The US Department of Health and Human Services and the Duke Endowment are funding a partnership to produce an app for North Carolina public health practitioners that will act as a clearinghouse and implementation guide for evidence-based interventions. The Healthy NC Improvement App (IMAPP) is being created through a partnership between the North Carolina Division of Public Health, UNC Center for Health Promotion and Disease Prevention, the Center for Public Health Quality, Center for Healthy NC, and Prevention Partners.[168] Launched in October 2015 in North Carolina, IMAPP offers guidance to public health professionals on selecting and implementing evidence-based interventions. Selected features of IMAPP include:

- Specific interventions and clear guidance for implementation

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[163] Ammerman A. Director, Center for Health Promotion and Disease Prevention, UNC Gillings School of Global Public Health. Written (email) communication. June 20, 2015.

[164] Center TRT. Who We Are. http://www.centertrt.org/?p=about_who. Accessed August 2, 2015.

[165] US Department of Agriculture, National Institute of Food and Agriculture. Supplemental Nutrition Assistance Program and Expanded Food and Nutrition Education Program (SNAP &EFNEP): Regional Nutrition Education and Obesity Prevention Centers of Excellence (RNECE) http://nifa.usda.gov/sites/default/files/resources/RNECE%20Regional%20%26%20National%20Coordination%20Center%20Contacts_0.pdf. Published February 4, 2015. Accessed August 2, 2015.

[166] US Department of Agriculture, National Institute of Food and Agriculture. Regional Nutrition Education and Obesity Prevention Centers of Excellence (RNECE). http://nifa.usda.gov/program/regional-nutrition-education-and-obesity-prevention-centers-excellence-rnece. Accessed August 2, 2015.

[167] Center TRT. Web-based Trainings. http://www.centertrt.org/?p=training_webtrainings. Accessed August 2, 2015.

[168] Randolph G. Director, Center for Public Health Quality. Written (email) communication. June 23, 2015.

- 10 search filters to help practitioners customize interventions to meet the needs of their community (i.e. level of difficulty, return on investment, level of evidence)
- Links to general and state-specific resources including webinars, trainings, and funding opportunities
- Communities can submit evidence-based interventions that they have used for review and inclusion
- Community resource and knowledge sharing[169]

[169] IMAPP. http://www.publichealthimap.org/. Accessed August 2, 2015.