Healthy Foundations for Healthy Youth:

A Report of the NCIOM Task Force on Adolescent Health

November 2012 Update

North Carolina Institute of Medicine

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NCIOM

2012 UPDATE TO HEALTHY FOUNDATIONS FOR HEALTHY YOUTH: A REPORT OF THE NCIOM TASK FORCE ON ADOLESCENT HEALTH

In 2011, 15% of North Carolina's population (1.45 million) were adolescents between the ages of 10 and 20.[a] These youth are in a period of great transition, as they develop from children into young adults. Aside from infancy, there is no other time period when a person experiences such profound changes in their physical, cognitive, emotional, and social development. During this metamorphosis, new health behaviors emerge and many health habits that affect life outcomes are established. .[b] Unfortunately, many youth engage in behaviors that compromise their health; between the ages of 10 and 20, rates of death and serious health problems double—primarily because of problematic adolescent behaviors. Intervening during adolescence provides a unique opportunity to improve adolescents' immediate health, and also their long-term health and well-being.

In order to help ensure that North Carolina adolescents have the greatest chance of success in life, The Duke Endowment generously funded the North Carolina Metamorphosis Project (NCMP) to study ways to improve adolescent health in our state. The North Carolina Institute of Medicine (NCIOM) Task Force on Adolescent Health was one part of this larger project. The Task Force focused most of its work on examining the critical health issues for youth as identified by the Centers for Disease Control and Prevention (CDC), including unintentional injury, substance use and abuse, mental health, violence, sexual health, and prevention of chronic illnesses. Instead of focusing solely on preventing certain adolescent health issues, the Task Force also examined ways to invest in youth so they can develop the skills and attributes needed to become productive adults. The Task Force made a total of 32 recommendations to improve adolescent health.

In December 2009, the North Carolina Institute of Medicine (NCIOM) released a report entitled "Healthy Foundations for Healthy Youth: A Report of the NCIOM Task Force on Adolescent Health." The report was the culmination of 18 months of work by the NCIOM Task Force on Adolescent Health. The Task Force was part of a larger effort, the North Carolina Metamorphosis Project (NCMP), a collaborative effort of the University of North Carolina at Chapel Hill (UNC-CH) School of Medicine and Gillings School of Global Public Health, NC MARCH, the NCIOM, the North Carolina Division of Public Health, and Action for Children North Carolina. Funded by The Duke Endowment, NCMP's goal is to increase awareness of unmet health needs of North Carolinians between 10 and 20 years of age and to produce and implement evidence-based recommendations to improve services, programs, and policies to address the high-priority health needs of this age group from 2010-2020.
As a component of the broader NCMP effort, the NCIOM convened the Task Force on Adolescent Health to develop a 10-year plan to improve the health and well-being of North Carolina's adolescents. The Task Force on Adolescent Health was charged with three tasks:

[a] NC Office of State Budget and Management. Certified County Total – Single Year Ages. http://www.osbm.state.nc.us/ncosbm/facts_and_figures/socioeconomic_data/population_estimates/demog/c11sag0.html. Published 08 May 2012. Accessed September 14, 2012.
[b] 2. Millstein SG, Petersen AC, Nightingale EO, eds. Promoting the Health of Adolescents. New York: Oxford University Press; 1993.

- Examine the most serious health and safety issues facing adolescents and young adults in North Carolina.
- Review evidence-based and promising interventions to improve adolescent and young adult health.
- Recommend strategies to address the high-priority needs of adolescents and young adults.

This 2012 update includes information about the progress, or lack thereof, in implementing the 2009 Task Force Recommendations. In total, progress has been made in implementing 23 (72%) of all the Task Force recommendations. No action has been taken to implement 9 (28%) of the 32 recommendations.

Total Recommendations: 32

- ***Fully Implemented*: 9 (28%)**
- ***Partially Implemented*: 14 (44%)**
- ***Not Implemented*: 9 (28%)**

CHAPTER 3: STRENGTHENING ADOLESCENT HEALTH LEADERSHIP AND INFRASTRUCTURE, AND IMPROVING THE QUALITY OF YOUTH POLICIES, PROGRAMS, AND SERVICES

Recommendation 3.1: Establish an Adolescent Health Resource Center
PARTIALLY IMPLEMENTED

An Adolescent Health Resource Center should be established within the Women and Children's Health Section of the Division of Public Health. The Center should be staffed by an Adolescent Health Director, an Adolescent Health Data Analyst, and an Adolescent Health Program Manager. Center staff should be responsible for supporting adolescent health around the state by coordinating the various health initiatives; expanding the use of evidence-based programs, practices, and policies; and providing adolescent health resources for youth, parents, and service providers. As part of its work, the Center should create and maintain a website that serves as a gateway to resources on adolescent health in North Carolina as well as provide links to relevant national resources. The North Carolina General Assembly should appropriate $300,000[c] in recurring funds beginning in SFY 2011 to support this effort.

In 2010, the School Health Unit of the Children and Youth Branch within the North Carolina Department of Health and Human Services (DHHS) Division of Public Health (DPH) gained approval for a family health program coordinator position. Although the family health program coordinator position was posted in 2010, it was frozen prior to hiring so it remained vacant and frozen until July 2012. Currently DPH is working to fill this position. The family health program coordinator's role will be focused on work with pre-adolescents and adolescents and is dedicated to the goals outlined in this recommendation. Another position that will impact on the adolescent work through the Children and Youth Branch is the behavioral health position, which was filled in the fall of 2012. A significant portion of the behavioral health position's time will be focused on system improvement work for adolescents. The family health program coordinator and the behavioral health position are both funded with the Title V/State match Federal block grant program.[d] In addition to these two positions within DPH, many experts, internal and external, will be invited to work in partnership with DPH to advance the goals outlined in this recommendation.

Recommendation 3.2: Fund Evidence-Based Programs that Meet the Needs of the Population Being Served (Priority Recommendation)
PARTIALLY IMPLEMENTED

Public and private funders supporting adolescent initiatives in North Carolina should place priority on funding evidence-based programs to address adolescent health behaviors,

[c] The Division of Public Health estimates it would cost $300,000 in salary and benefits to support a health director, data analyst, and program manager for the Adolescent Health Resource Center. (Petersen R. Chief, Chronic Disease and Injury Section, Division of Public Health, North Carolina Department of Health and Human Services. Oral communication. March, 25, 2009.

[d] Carol Tant, Head, Children and Youth Branch, Women's and Children's Health Section, Division of Public Health. Written (email) communication, August 31, 2012.

including validation of the program's fidelity to the proven model. Program 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 promising programs and to those programs that are theory-based and incorporate elements identified in the research literature as critical elements of effective programs.

- **a) The North Carolina General Assembly should amend the purpose of the North Carolina Child and Family Leadership Council[e] to include increasing coordination between North Carolina's Departments that provide funding, programs, and/or services to youth. Whenever possible the North Carolina Child and Family Leadership Council should encourage departments and agencies to adopt common evidence-based community prevention programs that have demonstrated positive outcomes for adolescents across multiple protective and risk behaviors, and to share training and monitoring costs for these programs. This initiative should focus on evidence-based strategies that have demonstrated positive outcomes for adolescents in reducing substance use, teen pregnancies, violence, and improving mental health and school outcomes. To facilitate this work:**
  1. **The North Carolina Child and Family Leadership Council (Council) should work to identify a small number of evidence-based programs that have demonstrated positive outcomes across multiple criteria listed above. As part of this work, the Council should collaborate with groups that have already done similar work to ensure coordinated efforts. All youth-serving agencies should agree to place a priority on funding the evidence-based programs identified. Each agency should dedicate existing staff to provide technical assistance and support to communities implementing one of the chosen evidence-based programs.**
  2. **Agencies should identify state and federal funds that can be used to support these initiatives. Each agency should work to redirect existing funds into evidence-based programs and to use new funds for this purpose as they become available. Agencies can support programs individually or blend their funding with funds from other agencies.**
  3. **Funding should be made available to communities on a multi-year and competitive basis. Funding priority should be given to communities that are high-risk based on the behaviors listed in the report. Communities could apply to use a best or promising program or practice if they can demonstrate why existing evidence-based programs and practices will not meet the needs of their community. In such cases, a program evaluation should be a condition of funding.**

[e] The North Carolina Child and Family Leadership council includes the Secretary of the Department of Health and Human Services, the Superintendent of the Department of Public Instruction, the Chair of the State Board of Education, the Secretary of the Department of Juvenile Justice and Delinquency Prevention, the Director of the Administrative Office of the Courts, and others as appointed by the Governor.

4) **The North Carolina General Assembly should appropriate $25,000[f] in recurring funds beginning in SFY 2011 to the Council to support their work.**

b) **The agencies and other members of the Alliance for Evidence-Based Family Strengthening Programs should identify funds that could be blended to support family strengthening programs that focus on families of adolescents.**

c) **North Carolina foundations should fund pilots and evaluations of existing evidence-based parent-focused interventions. If found to be effective, the North Carolina General Assembly and North Carolina foundations should support statewide program dissemination and implementation. Pilot programs should include those targeted for specific health domains that are aimed at universal and selected populations.**

No changes have been made to the mission of the North Carolina Child and Family Leadership Council, however, there are many evidence-based initiatives targeting adolescents and/or their parents being funded by public and private funders across the state. Funders are increasingly requiring grantees to use of evidence-based or promising practices. The following are some examples of the initiatives:

- The Duke Endowment, Kate B. Reynolds Charitable Trust, North Carolina Governor's Crime Commission, the North Carolina Division of Social Services, and the North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMHDDSAS) have all provided funding for the Child Treatment Program (CTP). CTP provides intensive, free training to therapists who are interested in offering evidence-based mental health treatment to traumatized children and families, trauma-focused cognitive behavioral therapy (TF-CBT). TF-CBT addresses emotional and behavioral difficulties for children (ages 3-18) following serious trauma or loss.
- Through a public-private partnership with the Governor's Crime Commission, The Duke Endowment, and Kate B. Reynolds Charitable Trust, the North Carolina Division of Juvenile Justice and DMHDDSAS are implementing Reclaiming Futures, a national evidence-based model to ensure that court-involved youth have access to a full continuum of services, such as substance abuse treatment.
- The Triple P Positive Parenting Program, a multi-level, evidence-based parenting and family support system designed to prevent behavioral, emotional, and developmental problems in children is being implemented in seven counties in North Carolina with support from the Kellogg Foundation (through the Centers for Disease Control and Prevention), the Children and Youth Branch of the Division of Public Health, and the Governor's Early Learning Challenge grant. Triple P provides an evidence-based public health approach to improving parenting and improving child outcomes.

Other evidence-based programs implemented in North Carolina are discussed elsewhere in this report including but not limited to: Teen Pregnancy Initiative (Recommendation 9.3), Parents Matter (Recommendation 9.2), Project Towards No Tobacco (Recommendation 10.1), Positive

[f] $25,000 would be used to support 1/3 of a full-time employee at the Department of Administration to provide administrative support to the North Carolina Child and Family Leadership Council.

Behavior Intervention and Support Initiative (Recommendation 5.1), and ASIST suicide prevention program (Recommendation 7.2).

Recommendation 3.3: Support Multi-Faceted Health Demonstration Projects
NOT IMPLEMENTED

The North Carolina General Assembly should provide $1.5 million annually for five years beginning in 2011 to the Division of Public Health to support four multi-component, locally-implemented adolescent health demonstration projects. Funds should be made available on a competitive basis.

a) **To qualify for funding, the demonstration project should involve families, adolescents, primary health care providers (which may include school-based health centers), schools, Juvenile Crime Prevention Councils, and local community organizations. Projects must include evidence-based components designed to improve health outcomes for at-risk adolescent populations and increase the proportion of adolescents who receive annual well visits that meet the quality of care guidelines of the US Preventive Services Task Force, Centers for Disease Control and Prevention, American Academy of Pediatrics/Bright Futures, and the Advisory Committee on Immunization Practices.**
b) **Priority will be given to projects that recognize and comprehensively address multiple adolescent risk factors, and to counties that have greater unmet health or educational needs, including but not limited to counties that have graduation rates below the state average, demonstrated health disparities or health access barriers, or high prevalence of adolescent risky health behaviors.**

Demonstration projects will be selected and provided with technical assistance in collaboration with the Department of Public Health (DPH), Department of Public Instruction, Community Care of North Carolina, and the NC School Community Health Alliance. These groups will work collaboratively to identify appropriate outcome indicators, which will include both health and education measures. As part of this project, DPH should contract for an independent evaluation of the demonstration projects.

Funding has not been provided by the NCGA to support multi-component adolescent health demonstration projects.

CHAPTER 4: HEALTH CARE

Recommendation 4.1: Cover and Improve Annual High-Quality Well Visits for Adolescents up to Age 20

PARTIALLY IMPLEMENTED

a) **The Division of Medical Assistance (DMA) should:**
   1) **Implement the DMA Adolescent Health Check Screening Assessment policy; and**
   2) **Review and update the DMA Adolescent Health Check Screening Assessment policy at least once every five years.**

b) **Other public and private health insurers, including the State Health Plan, should cover annual well visits for adolescents that meet the quality of care guidelines of the US Preventive Services Task Force, Centers for Disease Control and Prevention, American Academy of Pediatrics/Bright Futures, and Advisory Committee on Immunization Practices.**

c) **Community Care of North Carolina (CCNC), Area Health Education Centers (AHEC) Program, and the Division of Public Health should pilot tools and strategies to help primary care providers deliver high quality adolescent health checks. Strategies could include:**
   1) **Trainings and other educational opportunities around the components of the Adolescent Health Check including: dental screening, laboratory tests as clinically indicated (e.g. STD/HIV, dyslipidemia, pregnancy test, etc.), nutrition assessment, health risk screen and developmentally-appropriate psychosocial/behavioral & alcohol/drug use assessments, physical exam, immunizations, anticipatory guidance and follow-up/referral, and, for female adolescents, a family planning component.**
   2) **The development and implementation of a quality improvement model for improving adolescent health care.**

   North Carolina's foundations should provide $500,000 over three years to support this effort.

Based on a policy change published in the 2009 Health Check (Medicaid) Billing Guide (which became effective July 1, 2009), an annual visit is now recommended for all children and youth ages 2 through 20. The Division of Medical Assistance (DMA) has also started reimbursing for a subset of services that begin to enhance the *potential* quality of the adolescent preventive visit, including reimbursement for administration and interpretation of evidence-informed health risk assessment instruments and evidence-based, developmentally appropriate psychosocial/behavioral and alcohol/drug use assessments. Smoking and tobacco use cessation counseling is also reimbursed. Although an annual visit is now recommended and the services listed above are reimbursed, the consensus policy defining the quality components of the Adolescent Health Check Screening Assessment remains a proposed, unpublished policy at this moment. The policy has strong support from DMA and the practice community, and was developed by the Division of Public Health and the DMA in collaboration with clinical reviewers broadly representative of the private and public sectors and content experts. The policy has been approved by DMA's Physician Advisory Group, made available for public comment and a final

draft prepared. The North Carolina Department of Health and Human Services has been considering the fiscal impact and timing for publication of this policy in the midst of the state's budgetary crisis.[g]

Recommendation 4.2: Expand Health Insurance Coverage to More People
FULLY IMPLEMENTED

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:

a) **Provide funding for the Division of Medical Assistance to do the following:**
   1) **Expand outreach efforts and simplify the eligibility determination and recertification process to identify and enroll children and adolescents who are already eligible for Medicaid or NC Health Choice.**
   2) **Expand the income eligibility levels for adolescents 19-20 up to 200% of the federal poverty guidelines (FPG) or higher if the income limits are raised for younger children.**
b) **Expand coverage to children and adolescents with incomes up to 300% FPG on a sliding scale basis.**
c) **Change state laws to require insurance companies to offer parents the option to continue dependent coverage until the child reaches age 26, regardless of student status.**

The Division of Medical Assistance (DMA) is in the process of developing simplified processes for applications and renewals, especially through the development of their new case management system, North Carolina Families Accessing Services through Technology (NC FAST). In April 2011, DMA had two counties pilot an ex parte process for renewals for Medicaid for Infants and Children (MIC) and North Carolina Health Choice (NCHC), the North Carolina Child Health Insurance program. The process was implemented statewide effective July 2011. Individuals are sent a notice when it is time for reenrollment that explains they must report any changes, but they are not required to return a signed reenrollment form in order to complete the renewal. They are informed they will be contacted if any further information is needed. A caseworker is required to complete all data/electronic matches, and review other case records to determine if required information is available to determine ongoing eligibility. The individual is only required to provide additional information if the county cannot access what is needed through other means. The reenrollment rate prior to August 2011 was approximately 72-74% for MIC and NCHC. After implementing the ex parte renewal, the reenrollment rate has increased to approximately 90-91% and 82-84% for MIC and NCHC, respectively. These rates have remained consistent over the past year.[h]

[g] -Carolyn Sexton, Care Coordination for Children Project Manager, Children and Youth Branch, Division of Public Health, North Carolina Department of Health and Human Services. Written (email) communication June 4, 2010.
[h] Carolyn McClanahan, Chief, Medicaid Eligibility Unit, NC Division of Medical Assistance. Personal communication (email). September 10, 2012.

Beginning in 2014, the Affordable Care Act (ACA) gives state the option to expand Medicaid coverage to most uninsured adults with modified adjusted gross income (MAGI) no greater than 138% of the federal poverty limit. Children in families with incomes no greater than 200% FPL will continue to be eligible for Medicaid or North Carolina Health Choice.

Other people will gain coverage through private insurance offered through the Health Benefit Exchange (HBE) beginning in 2014. The ACA includes subsidies available through the HBE to make health insurance coverage more affordable. Subsidies will be available to single individuals or families with MAGI of up to 400% of the federal poverty level (FPL), if they do not have access to affordable employer-sponsored insurance and do not qualify for public coverage such as Medicaid. For the second lowest cost silver plan the maximum a family would have to pay is based on a percentage of their income (ranging from 2% for lower income families to 9.5% for those whose incomes are between 300-400% FPL). Lower income individuals and families, those with incomes below 250% FPL,will also receive subsidies to help pay for their out-of-pocket costs (such as deductibles, coinsurance, or copayments) if they enroll in a silver plan. American Indians with incomes below 300% FPL will pay no cost sharing. The federal government will pay the premium tax credits and the cost-sharing subsidies directly to health plans. All families with incomes below 250% FPL that receive a subsidy who purchase a silver plan will also qualify for reduced out-of-pocket annual limits. Eligible families must purchase their health insurance coverage through the HBE in order to receive the premium tax credit and cost-sharing subsidies.

Since 2010, the ACA has required insurance companies to offer parents the option to continue dependent coverage until the child reaches age 26.[i]

Recommendation 4.3: Fund School-Based Health Services in Middle and High Schools (Priority Recommendation)
PARTIALLY IMPLEMENTED

a) **The Department of Public Instruction and the Division of Public Health should work together to improve school-based health services in middle and high schools. The North Carolina General Assembly (NCGA) should appropriate $7.8 million in recurring funds in SFY 2011, $13.1 million in recurring funds in SFY 2012, and additional funding in future years to support school-based health services, including:**
    1) **$2.5 million[j] in recurring funds beginning in SFY 2011 to support school-based and school-linked health centers (SBLHC) and provide funding for five new SBLHCs.**
    2) **$5.3 million in recurring funds each year from SFY 2011-2015 (for a total cost of $26.8 million[k]) to the Division of Public Health to achieve the**

[i] PPACA Sec 1001, amending sec.2714 of the title XXVII of the Public Health Service Act (42 U.S.C. 300gg–14)
[j] $2.5 million is the estimated cost to fund 5 new school-based or school-linked health centers. (Tyson CF. School Health Unit Manager, Division of Public Health, North Carolina Department of Health and Human Services. Written (email) communication. March 23, 2009).
[k] $26.8 million is the estimated cost to achieve the recommended 1:750 ratio in middle and high schools. (Tyson CF. School Health Unit Manager, Division of Public Health, North Carolina Department of Health and Human Services. Written (email) communication. March 30, 2009).

recommended statewide ratio of 1 school nurse per 750 middle and high school students.

3) **The NCGA should continue to support the Child and Family Support Teams (CFST) pilot and evaluation. If CFSTs are shown to improve health and educational outcomes for youth, they should be fully funded to allow for statewide implementation.**

Priority in funding should be given to schools and communities with higher populations of at-risk youth and/or greater identified need.

b) **North Carolina foundations should fund evaluations of the effectiveness of these initiatives.**

The Affordable Care Act appropriated $200,000,000 over FY 2010-2013 in funds for the Secretary of HHS to fund establishment and operation of school-based health center grants. The Secretary of HHS is to give preference to schools with large population qualifying for medical assistance under Medicaid or state child health plans; The funds under this grant are to be used on facilities (construction, acquisition, improvement), equipment, management and operations, and payment of salaries of personnel (physicians, nurses).[l] Approximately $109 million has been released to 323 sponsoring organizations in the first round, and they are expecting the announcement this fall on the second round. There were 11 sponsoring organizations in North Carolina that received grants totaling approximately $3 million. Counties with grants include: Alamance, Mitchell (2), Montgomery, Durham, Henderson, Rockingham, Caldwell, Yancey, Cherokee, and New Hanover. At least 6 more North Carolina applications have been submitted for the second round that is expected to award 160 grants for 2013.

The North Carolina Division of Public Health awarded 32 school centers operating funds this past year. Sixteen sponsoring organizations were recipients for the schools. The grants were approximately $45,000 for each school, which is slightly lower than grants in previous years. North Carolina is only one of three states that lost funding for school health center programs since 2001.

Several health department-sponsored school-based health centers were closed over the past 3 years as the North Carolina Department of Health and Human Services divested of primary care and Wake Teen Medical Services closed. However, this school year there are 57 centers actively operating in the state with several others in the planning process. The North Carolina General Assembly (NCGA) has not provided any new funds for school-based health centers.[m]
Youth Empowered Solutions (YES!), a nonprofit organization in North Carolina that empowers youth with adult support to create community change, has a project (Action Now) focusing on advocacy for school-based health centers (SBHCs). Action Now received a John Rex Endowment grant to advocate for school-based health centers for 3 years (2010-2013) [n] The John Rex Endowment project is entering its third year and the model of engaging youth in access to health care and SBHC work has produced an array of outcomes, including effective conversations with the school system and local health care providers in moving toward

[l] PPACA Sec 4101 [42 USC 280h-4]
[m] Parker, C., Executive Director, North Carolina School Community Health Alliance. Oral Communication, Sept 11, 2012.
[n] http://www.youthempoweredsolutions.org/?p=1458

establishing a new center. YES! is expanding their Wake County work and applying the model of engaging youth in both existing SBHCs and communities that are looking to establish SBHCs. This model of engaging that stakeholder population beyond the patient provider relationship will boost enrollment and access rates as well as the financial viability of the health care provider. Youth have lobbied twice for continued and additional funding for SBHCs across the state at the NCGA for Adolescent Health Advocacy Day and Chronic Disease Legislative Advocacy Day. Funding has remained consistent from the state towards SBHCs. The youth driven project resulted in the development of the first ever Wake School-Based Health Center Task Force, which is comprised of roughly 30 school health, educational, and health care partners around the county and region working to establish a SBHC in Wake County. Additionally, the youth driven project has resulted in four major health care providers coming to the table to back the establishment of a school-based health center: UNC Pediatric Department, Rex Hospital, and Wake Health Services, Inc., and Wake County Human Services. YES! plans on expanding their work outside of Wake County to start strengthening the capacity of existing SBHCs.[o]

School nurses in North Carolina serves an average of 1,200 students, almost 60% more students than the federally recommended ratio of 1 nurse per 750 students. Due to slight a slight decline in the number of school nurses during the 2010-2011 school year and increases in total student enrollment, the nurse to student ratio was worse for the first year since 2004.

Evaluation of the School Based Child and Family Support Teams[p] is in progress; they are targeting high-needs adolescents at risk of school failure or out-of-home placements as a result of physical, social, legal, emotional or developmental factors. The program links records across agencies such as, education, juvenile justice and social services, and provides family-centered services and supports to adolescents at risk.

[o] Parrish Ravelli, Team Lead, Access to Health Care. Written (email) communication August 1, 2012.
[p] http://childandfamilypolicy.duke.edu/project_detail.php?id=36;
http://childandfamilypolicy.duke.edu/pdfs/projects/CFST_2012_July_2012_Legislative_Report.pdf

Recommendation 4.4: Developing a Sixth Grade School Health Assessment
NOT IMPLEMENTED

The Women and Children's Health Section of the Division of Public Health should convene a working group to develop a plan to operationalize a sixth grade health assessment. The working group should include the Department of Public Instruction, Division of Medical Assistance, the North Carolina Pediatric Society, North Carolina Academy of Family Physicians, Community Care North Carolina (CCNC), representatives from local health departments, and other health professionals as needed. The plan should be presented to North Carolina School Health Forum and the North Carolina General Assembly by the beginning of the 2011 Session.

The School Health Unit supported research by the University of North Carolina Gillings School of Global Public Health graduate students assessing other states' experience with designing and implementing adolescent health assessments. The final report was released and presented to them on May 7, 2010.[q] No action has been taken to implement a sixth grade health assessment.

[q] Carol P. Tyson, School Health Unit Manager, Children & Youth Branch, Division of Public Health, North Carolina Department of Health and Human Services. Written (email) communication June 1, 2010.

CHAPTER 5: EDUCATION

Recommendation 5.1: Increase the High School Graduation Rate (Priority Recommendation)

FULLY IMPLEMENTED

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.**
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 that will support continuous learning, behavior modifications, appropriate youth development, and increased school success.**
4) **Expansion of the North Carolina Positive Behavior Support Initiative to include all schools in order to reduce short- and long-term suspensions and expulsions.**
5) **Raising the compulsory school attendance age.**

b) The SBE should work with appropriate staff members in DPI, including curriculum and finance representatives, and staff from the North Carolina General Assembly (NCGA) 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 NCGA and the Education Oversight Committee by April 1, 2010 so that they can appropriate recurring funds.

The state graduation rate increased above national average in 2011.[r] The high school graduation rate increased to 80.2% in 2012 from 70.3% in 2008, 74.2% in 2010, and 77% in 2011.[s] This represents an all-time high in the state's graduation rate. North Carolina has made substantial progress over the years, but more work still needs to be done to improve graduation rates in the state.[t] The improved graduation rate is the result of multiple efforts aimed at increasing the number of students who graduate from high school.

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

[r] http://www.ncpublicschools.org/newsroom/news/2010-11/20110607-01
[s] http://www.ncpublicschools.org/newsroom/news/2011-12/20111011-01
[t] Hildebrand, P., Chief Health and Community Relations Officer, North Carolina Department of Public Instruction. Written (email) communication. Oct 17, 2012.

counties across North Carolina in 2009.[u] In 2010, $10.8 million was awarded to 77 groups to improve high school graduation rates.[v] The grantees were also required to evaluate their program models.[w]

During the 2009 Session, NCGA Session Law 2009-330 "encouraged local businesses to adapt 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.[x]

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.{{4036 Horner, R.}}

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.[y] 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.[z]

Recommendation 5.2: Enhance North Carolina Healthy Schools Partnership (Priority Recommendation)

PARTIALLY IMPLEMENTED

a) **The North Carolina School Health Forum should be reconvened to ensure implementation of the coordinated school health approach and expansion of the North Carolina Healthy Schools Partnership (NCHSP).**
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**

[u] http://www.ncpublicschools.org/newsroom/news/2009-10/20091222-01
[v] http://www.ncpublicschools.org/newsroom/news/2010-11/20101102-01
[w] http://www.ncpublicschools.org/docs/dropout/grants/reports/summary-report.pdf
[x] http://www.ncleg.net/Sessions/2009/Bills/House/PDF/H187v5.pdf
[y] http://www.ncpublicschools.org/program-monitoring/grants/
[z] http://www.ncpublicschools.org/newsroom/news/2010-11/20110211-01

for students. When available, evidence-based policies should be adopted. The North Carolina School Health Forum and NCHSP should develop a system to recognize schools that adopt and fully implement model policies in each of the eight components.

c) **The Department of Public Instruction (DPI) should expand the NCHSP to include a local healthy schools coordinator in each local education agency (LEA). The North Carolina General Assembly should appropriate $1.64 million in recurring funds beginning in SFY 2011 increased by an additional $1.64 in recurring funds in each of the following six years (SFY 2012-2017) for a total of $11.5 million[aa] recurring 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 unmet 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 (SHAC), schools, local health departments, primary care and mental health providers, and community groups in their LEA 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 NCHSP should provide monitoring, evaluation, and technical assistance to the LEAs through the local healthy schools coordinators. The NCGA should appropriate $225,000[bb] in recurring funds beginning in SFY 2011 to DPI to support the addition of 3 full-time employees to do this work. Staff would be responsible for:**
    1) Implementing the monitoring system (including gathering data, measuring compliance, and reporting to the State Board of Education) for the Healthy Active Children Policy;
    2) Implementing the monitoring system (including gathering data, measuring compliance, and reporting to the State Board of Education) for the Youth Risk Behavior Survey (YRBS) and School Health Profiles Survey (Profiles);[cc]

[aa] This level of funding ($100,000 per LEA for 115 LEAs) would support one local healthy schools coordinator in each district as well as provide funding for travel, materials, and administrative support.

[bb] Each full-time employee estimated to cost $75,000 in salary and benefits. The NC Healthy Schools Section believes that 3 staff members would be needed to handle the new responsibilities. Gardner, D. Section Chief, North Carolina Healthy Schools, Department of Public Instruction; and Reeve R. Senior Advisor for Healthy Schools, North Carolina Healthy Schools, Division of Public Health, North Carolina Department of Health and Human Services. Written (email) communication. October 15, 2009.)

[cc] Note: The School Health Profiles are the way to monitor whether LEAs are making progress on their Coordinated LEA Health Action Plan.

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 YRBS and Profiles survey, including reporting on school-level impact measures (SLIMs);**
5) **Working with the North Carolina 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 NCHSP 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.**

The North Carolina Department of Public Instruction has created an agency-level School Health Advisory Council (State SHAC) to mirror and support the existing local SHACs. The State SHAC is comprised of various agency leaders who work in the eight components of coordinated school health and provide resources and services. The State SHAC meets quarterly and has most recently been working to find and expand on points of intersection between the roles and work of the members. Within the North Carolina Department of Health and Human Services, the School Health Matrix Team, comprised of representatives of numerous units within the Division of Public Health, meets monthly to stay abreast of health issues and programs affecting the student population. Members of the State SHAC (DPI) and the School Health Matrix Team (DHHS) communicate with each other on a regular basis and attend meetings together.

No funding was provided by NCGA for local healthy schools coordinators in each LEA to work with local SHACs. In addition, no funding was provided by NCGA for technical assistance, data collection, monitoring of the Healthy Active Children Policy, or the development of additional resources and education materials for parents.

Recommendation 5.3: Actively Support the Youth Risk Behavior Survey and School Health Profiles Survey
FULLY IMPLEMENTED

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:

a) **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(s) are administered, financial incentives, giving priority for 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.**
b) **Expect any LEA randomly 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.

c) 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.

The North Carolina State Board of Education (SBE) supports the administration of the Youth Risk Behavior Survey through the Department of Public Instruction. At this time, the SBE does not mandate LEA participation or the provision of incentives. A new process was used for the 2011 YRBS and 2012 Profiles, whereby principals of sampled schools were contacted directly. The state superintendent and the state health director co-signed a letter thanking principals for their participations in the YRBS and/or Profiles surveys. This procedural change, combined with a long history of YRBS implementation, helped achieve statewide representative data and successful completion of the two surveys.

Regarding the SBE creating policies about opting out, currently DPI follows instructions provided by the CDC, representing best practices in survey research with youth and families. With regard to oversampling and adding measures to the surveys, DPI holds an open forum prior to the creation of each survey to allow input of stakeholders.

Recommendation 5.4: Revise the Healthful Living Standard Course of Study Contract

PARTIALLY IMPLEMENTED

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

b) The NCGA should appropriate $1.15 million[dd] in recurring funding beginning 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 North Carolina Healthy Schools Partnership (NCHSP) should identify 3-5 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.

c) The 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 NCHSP should coordinate trainings[ee] for local school health professionals on the Centers for Disease Control and Prevention's Health Education Curriculum Assessment Tool (HECAT) and the Physical

[dd] $1.15 million in funding would provide $10,000 per local education agency to support the adoption of evidence-based curricula. Typically there are training and materials costs to adopting evidence-based curricula.

[ee] 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.

Education Curriculum Assessment Tool (PECAT) so that they are able to assess and evaluate health and physical education programs and curricula.

2) **SBE should require every LEA to complete the HECAT and PECAT for middle and high schools every 3 years beginning in 2013 and submit them to the North Carolina 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 the DPI's Accountability and Curriculum Reform Effort (ACRE).**

d) **The NCGA should require SBE to implement a five-year phase-in requirement of 225 minutes of weekly "Healthful Living" in middle schools and 2 units of "Healthful Living" as a graduation requirement for high schools. The new requirements should require equal time for health and physical education. SBE shall be required to annually report to the Joint Legislative Education Oversight Committee regarding implementation of the physical education and health education programs and the Healthy Active Children Policy. SBE should work with appropriate staff members in DPI, including curriculum and finance representatives, and NCGA fiscal research staff, to examine the experiences of other states and develop cost estimates for the five-year phase-in, which will be reported to the research division of the NCGA and the Joint Legislative Education Oversight Committee by April 1, 2010.**
e) **The SBE should encourage DPI to develop healthful living electives beyond the required courses, including, but not limited to, academically rigorous honors-level courses. Courses should provide more in-depth coverage of Healthful Living Course of Study Objectives. DPI and health partners should identify potential courses and help schools identify evidence-based curricula to teach Healthful Living electives.**

There is currently no directive from the North Carolina General Assembly (NCGA) regarding evidence-based curricula for the Healthful Living Essential Standards. However, the North Carolina Healthy Schools section and Curriculum and Instruction Division within the North Carolina Department of Public Instruction provide local education agencies (LEAs) with evidence-based curricula and resources to use in their selection process. There is legislation from the NCGA regarding one specific component of the Healthful Living Essential Standards: CPR. Students are required to successfully complete CPR instruction using American Heart Association, Red Cross, or other nationally recognized programs of study as a high school graduation requirement.

Currently the Healthy Schools section, with funding from the Centers for Disease Control and Prevention's physical activity, nutrition, and tobacco (PANT) program, provides teacher trainings in Towards No Tobacco (TNT), an evidence-based curriculum to prevent or reduce tobacco use among middle and high school students. The North Carolina School Health Training Center has provided professional development in tobacco use prevention. Efforts include developing and monitoring an online module for teachers and the delivery of workshops in Project TNT (Towards No Tobacco). Face-to-face professional development was provided to the following LEAs: Buncombe County, Charlotte-Mecklenburg, Union County, Pitt County, Winston-Salem Forsyth County, and the region including Burke, Catawba, and Caldwell.

The NCGA did not appropriate funds for LEAs to purchase and/or implement evidence-based programs that demonstrate positive change in health risk behaviors. However, DPI maintains a list of evidence-based curricula for LEA use.

While the State Board of Education (SBE) could create a policy requiring LEAs to complete the Centers for Disease Control and Prevention's Health Education Curriculum Assessment Tool (HECAT) and the Physical Education Curriculum Assessment Tool (PECAT), decisions about selection of curricula are generally left up to the LEAs. North Carolina Healthy Schools provides HECAT and PECAT training upon request. LEAs typically use curricula and resources that are recommended by the DPI Healthful Living Consultant. As part of DPI's READY initiative, which focuses on educators being prepared for DPI's new standards and accountability model, measures of student learning (MSLs) are currently being developed to assess standard implementation.

To date, the SBE had not required a 5-year phase-in of Healthful Living minutes, nor has the NCGA provided funds for the research required for the phase-in project. North Carolina ratified law (SL 2010-35) in 2010 directing the SBE to look at honors-level rigorous Healthful Living courses that can be offered at the high school level.[ff] DPI is creating an honors rubric to assist LEAs in the local development of Healthful Living honors courses.

[ff] http://www.ncleg.net/gascripts/billlookup/billlookup.pl?Session=2009&BillID=H901

CHAPTER 6: UNINTENTIONAL INJURY

Recommendation 6.1: Improve Driver Education (Priority Recommendation)
NOT IMPLEMENTED

The North Carolina General Assembly should continue funding driver education through the North Carolina Department of Transportation (DOT). The DOT should work to improve the comprehensive training program for young drivers. The revised driver education program should include the following components:

a) **The Governor's Highway Safety Program (GHSP) should work with the Center for the Study of Young Drivers at the University of North Carolina (and other appropriate groups) to conduct research to determine effective strategies for enhancing the quality of driver training and to develop pilot programs to improve driver education. The GHSP should work with the Department of Public Instruction to implement a large-scale trial of the program through the current driver education system in public schools. Any program developed should include materials to involve parents appropriately and effectively in young driver training. Materials should help educate parents as to what types of information, skills, and knowledge are critical to effectively teach their adolescents to drive.**
b) **The DOT should fund an independent evaluation of the pilot projects. Evaluation should include collecting data on the driving records of those exposed to the program and those exposed to traditional driver education. If the pilot programs are shown to be successful, they should be expanded statewide.**

The Governor's Highway Safety Program is funding a Driver Education Consultant within the North Carolina Department of Public Instruction (DPI). The Driver Education Consultant is supporting implementation of a statewide standardized curriculum for driver education and developing a strategic plan for driver education in North Carolina.[gg] Pilot projects are being conducted during the 2012-2013 school year and data is being collected to determine the most cost-effective means of educating young drivers. Results will be published in 2013.

The Driver Education program in North Carolina is offered in combination with the graduated driver license program. Due to funding decrease by the state, the Driver Education class was offered to students at a $45 fee to take the class. This increase in fee has led to a 20% reduction in demand for driver education in Wake County Public Schools. If the state loses driver education then the graduated driver license program will lose its base of support as graduated driver license is successful in part because of drivers education in schools. [hh]

[gg] North Carolina Governor's Highway Safety Program FY 2012 Highway Safety Plan.
[hh] Elizabeth Hudgins, Executive Director, Child Fatality Task Force. Written (email) communication. Sept 12, 2012.

Recommendation 6.2: Strengthen Driving While Intoxicated (DWI) Prevention Efforts
PARTIALLY IMPLEMENTED

a) **All North Carolina state and local law enforcement agencies with traffic responsibilities should actively enforce DWI laws throughout the year and should conduct highly-publicized checking stations. State and local law enforcement agencies should report at the beginning of each biennium their efforts to increase enforcement of DWI to the North Carolina House and Senate Appropriations Subcommittees on Justice and Public Safety.**
b) **The North Carolina General Assembly should increase the reinstatement fee for DWI offenders by $25. Funds from the increased DWI fees should be used to support DWI programs, including: training; maintenance of checking station vehicles and equipment; expanding the operation of DWI checking stations to additional locations and times; and expanding dissemination of the existing "Booze It & Lose It" campaign.**
c) **The North Carolina General Assembly should appropriate $750,000 [ii] in recurring funding beginning in SFY 2011 to the North Carolina Division of Public Health to work with the Governor's Highway Safety Program, the UNC Highway Safety Research Center, and other appropriate groups to improve the effectiveness of checking stations and to develop and implement an evidence-based dissemination plan for the existing Booze It & Lose It campaign. The plan should focus on reaching adolescents and young adults.**

The money paid to restore a driver license following a DWI is split among the Highway Fund, the Bowles Center for Alcohol Studies at the University of North Carolina at Chapel Hill, and the Forensics Tests for Alcohol Branch in the Chronic Disease and Injury Section of the Division of Public Health. The NCGA in 2010 increased the Drivers License Restoration Fee by $25 (from $75 to $100).[jj] The funds from the fee increase are allocated to the Forensics Tests for Alcohol Branch. This increase was intended to assure adequate resources for DWI deterrence, detection and enforcement. Increasing the fee paid to restore a license following conviction for impaired driving provides needed and stable funds to the Forensics Tests for Alcohol Branch which seeks to reduce the incidence of impaired driving by providing comprehensive training programs to law enforcement personnel in the detection and apprehension of impaired drivers.[kk]

Currently, the Department of Public Instruction Driver Education curriculum includes prevention education for DWI, including penalties for driving while impaired.

[ii] The North Carolina Department of Transportation estimates it would cost $750,000 to improve the effectiveness of checking statesions and to develop and implement an evidence-based dissemination plan for the existing Booze It & Lose It campaign. (Nail D. Assistant Director, Governor's Highway Safety Program, North Carolina Department of Transportation. Written (email) communication. June 12, 2009.)
[jj] http://www.ncleg.net/gascripts/BillLookUp/BillLookUp.pl?Session=2009&BillID=S655
[kk] Elizabeth Hudgins, Executive Director, Child Fatality Task Force. Written (email) communication. Sept 11, 2012.

Recommendation 6.3: Fund Injury Prevention Educators
PARTIALLY IMPLEMENTED

a) **The University of North Carolina Injury Prevention Research Center should hire three full-time employees for the dissemination of evidence-based injury prevention programs and policies to schools and youth sports clubs across the state. Staff would:**
    1) **Train coaches and other youth athletic staff/volunteers and employees of local Parks and Recreation Departments on how to implement evidence-based programs proven to reduce youth sports and recreation injuries, such as those developed by staff at the University of North Carolina Injury Prevention Research Center.**
    2) **Develop and distribute materials targeting parents to increase awareness of the frequency of sports and recreation injuries and to provide information on how to prevent the most common sports and recreation injuries.**
    3) **Implement injury prevention programs in schools and youth sports leagues and monitor compliance.**
b) **The North Carolina General Assembly should appropriate $300,000[ll] in recurring funds beginning in SFY 2011 to support this effort.**

In 2011, the North Carolina General Assembly directed that $200,000 from the General Fund to the Board of Governors of The University of North Carolina be allocated in both 2011-2012 and 2012-2013 to the University of North Carolina Injury Prevention Research Center to hire staff to disseminate evidence-based injury prevention programs and policies for youth sports.[mm]

[ll] The UNC Injury Prevention Research Center estimates it would cost $300,000 in salary and benefits to support three full-time employees for the dissemination of evidence-based injury prevention programs and policies to schools and youth sports clubs across the state..
[mm] http://www.ncga.state.nc.us/Sessions/2011/Bills/Senate/HTML/S100v1.html.

CHAPTER 7: SUBSTANCE ABUSE AND MENTAL HEALTH

Recommendation 7.1: Review Substance Use and Mental Health Prevention and Services in Educational Settings

NOT IMPLEMENTED

a) **The North Carolina General Assembly should direct the State Board of Education, Office of Non-Public Education, North Carolina Community College System, and University of North Carolina System to review their existing substance abuse and mental health prevention plans, programs, and policies, as well as the availability of substance abuse and mental health screening and treatment services, in order to ensure that these educational institutions offer comprehensive substance abuse and mental health prevention, early intervention, and treatment services to students enrolled in their schools. These institutions should submit a description of their prevention plans, programs, and policies, procedures for early identification of students with substance abuse or mental health problems, and information on screening, treatment, and referral services to the Education Cabinet, Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the Appropriations Subcommittee on Education, and Education Committees upon the convening of the legislative session every other year beginning in 2011.**
b) **The Department of Public Instruction, North Carolina Community College System, and University of North Carolina system should coordinate their prevention efforts with the other prevention activities led by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to ensure the development of consistent messages and optimization of prevention efforts. Prevention efforts should employ evidence-based programs that focus on intervening early and at each stage of development with age appropriate strategies to reduce risk factors and strengthen protective factors before problems develop.**

This recommendation has not been implemented.

Recommendation 7.2: Support the North Carolina Youth Suicide Prevention Plan

FULLY IMPLEMENTED

The North Carolina Youth Suicide Prevention Task Force along with the Division of Public Health's Injury and Violence Prevention Branch should implement the recommendations in *Saving Tomorrows Today: the North Carolina Plan to Prevent Youth Suicide*. The North Carolina General Assembly should appropriate $112,500[nn] in recurring funds beginning in SFY 2011 to the Division of Public Health's Injury and Violence Prevention Branch for 1.5 full-time employees to support this effort.

[nn] The Injury and Violence Prevention Branch estimates it would cost $112,500 in salary and benefits to support the one 1.5 full-time employees needed to oversee implementation of the recommendations in *Saving Tomorrows Today: the North Carolina Plan to Prevent Youth Suicide*.

Saving Tomorrows Today, North Carolina's Plan to Prevent Youth Suicide, identified six priority goal areas: 1) Promote awareness that suicide is a public health problem that is preventable; 2) Develop and implement community based suicide prevention programs; 3) Promote efforts to reduce access to lethal means and methods of self harm; 4) Implement training for recognition of at-risk behavior and delivery of effective treatment; 5) Improve access to and community linkages with mental health and substance abuse services; and 6) Improve and expand surveillance systems. The North Carolina Youth Suicide Prevention Task Force has accomplished activities to promote these goals.

Since October of 2009, the North Carolina School Health Training Center has provided professional development for school personnel in three evidence-based intervention and prevention models and curricula: *Applied Suicide Intervention Skills Training (ASIST), safeTALK*, and *Lifelines*.[oo] Fifteen new Applied Suicide Intervention Skills Training (ASIST) and 8 new safeTALK trainers were trained in North Carolina. Evaluation of these trainers has shown an increase in knowledge in multiple areas, such as a competent trainer cadre has been created. They also trained 199 school and school-related staff in ASIST and 201 school and school-related staff in safeTALK. This resulted in 41 at-risk youth identified by school staff and referred to services and/or further risk assessment from October 2009 to May 2010.These projects are funded by the Youth Suicide Prevention Project at North Carolina Division of Public Health. Professional development events have been provided statewide to school systems with Child and Family Support Teams and, more recently to school systems with high numbers of military families (Cumberland, Hoke, Onslow, Currituck). In a three year period, 1,800 professionals representing 80 of the 100 counties have been trained in suicide awareness, prevention, or intervention.

Additionally, a workshop is scheduled to train individuals to teach a school-based suicide prevention curriculum that can be implemented within schools' health education classes. The North Carolina Youth Suicide Prevention Task Force has developed a youth oriented web site, which went live during Suicide Awareness Month in September 2012.[pp]

Recommendation 7.3: Develop and Implement a Comprehensive Substance Abuse Prevention Plan
NOT IMPLEMENTED

a) The North Carolina 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 delay the onset of use of alcohol, tobacco, or other drugs, reduce the use of addictive

[oo] Donna Breitenstein, Director, North Carolina School Health Training Center, Appalachian State University. Written (email) communication September 3, 2010.

[pp] - Sharon Rhyne, Health Promotion Manager, Chronic Disease and Injury Section, Division of Public Health, North Carolina Department of Health and Human Services. Written (email) communication 6/2/2010.

substances among users, identify those who need treatment, and help them obtain services earlier in the disease process.

1) **The Division of Mental Health, Developmental Disabilities and Substance Abuse Services 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 (LEAs), 2- and 4-year colleges, universities, 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, and reducing teen pregnancy.**

b) **The North Carolina General Assembly should appropriate $1.95 million in SFY 2010 and $3.72 million in SFY 2011 in recurring funds to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services to support and evaluate these efforts.**[qq]

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has not developed a comprehensive substance abuse prevention plan. There are ongoing efforts within DMH/DD/SAS to patient care management through the local management entities/managed care organization (LME/MCOs) system. Additionally DMH/DD/SAS has set up the NC Practice Improvement Collaborative (NC PIC), which provides a registry of evidence-based programs, including those that effectively treat substance abuse.

Youth Empowered Solutions (YES!), in conjunction with the NC-Preventing Underage Drinking Initiative, is pilot testing the ***Talk It Up. Lock It Up!™*** initiative which focuses on making homes a no underage drinking zone and locking up alcohol to prevent accessibility to underage users. [rr]

[qq] The appropriation requests were developed by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services as part of the North Carolina Institute of Medicine Task Force on Substance Abuse Services.

[rr] Parrish Ravelli, Team Lead, Access to Health Care. Written (email) communication August 23, 2012.

Recommendation 7.4: Increase Alcohol Taxes
NOT IMPLEMENTED

The excise taxes on malt beverages and wine should be indexed to the consumer price index so they can keep pace with inflation. The increased fees should be used to fund effective prevention and treatment efforts for alcohol, tobacco, and other drugs.

No alcohol tax increase has occurred.

Recommendation 7.5: Drinking Age Remain 21
FULLY IMPLEMENTED

The North Carolina General Assembly should not lower the minimum drinking age below age 21.

Drinking age has not been changed.

Recommendation 7.6: Integrate Behavioral Health into Health Care Settings
PARTIALLY IMPLEMENTED

a) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should work with the Office of Rural Health and Community Care, Governors Institute on Alcohol and Substance Abuse, and Area Health Education Centers (AHEC) to expand the use of Screening, Brief Intervention and Referral into Treatment (SBIRT) in Community Care North Carolina (CCNC) networks and other healthcare settings to increase the early identification and referral into treatment of patients with problematic substance use. A similar evidence-based model for screening, brief intervention, and referral to treatment should be identified and expanded to increase the early identification and referral of patients with mental health concerns.**
b) **The North Carolina Office of Rural Health and Community Care should work in collaboration with the DMHDDSAS, the Governors Institute on Alcohol and Substance Abuse, the ICARE partnership, and other professional associations to support and expand co-location in primary care practices of licensed health professionals trained in providing mental health and substance abuse services.**
c) **The North Carolina General Assembly should appropriate $2.25 million in recurring funds in SFY 2011 beginning in SFY 2011 to support these efforts; $1.5 million to DMHDDSAS and $750,000 to the North Carolina Office of Rural Health and Community Care.[ss]**

In 2009 the Division of Medical Assistance began reimbursing Medicaid providers for a subset of child and youth services including reimbursement for administration and interpretation of

[ss] These appropriation requests were developed by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the North Carolina Office of Rural Health and Community Care, respectively, as part of the North Carolina Institute of Medicine Task Force on Substance Abuse Services.

evidence-informed health risk assessment instruments and evidence-based, developmentally appropriate psychosocial/behavioral and alcohol/drug use assessments.

Community Care of North Carolina (CCNC) is working to expand the availability of behavioral health services in coordination with physical health services. CCNC's Behavioral Health Integration Initiative (BHI) aims to increase access to and enhance integrated health care. The integration of behavioral health and primary care is a step towards moving beyond a "siloed" system of care that too often fails to meet the needs of those patients who have both behavioral and physical comorbidities. BHI recognizes the commitment to enhance integrated care and moves beyond a health care delivery system that splits the mind and body as if they were independent of each other. At the CCNC central office, a psychiatrist directs the BHI initiative and leads a team comprised of a second psychiatrist and associate director, a behavioral health pharmacist, and a behavioral health care coordination program manager. In addition, each network now includes the services of a psychiatrist and a behavioral health coordinator dedicated to the implementation of BHI at the local level. At the local level, CCNC practices aim to become the medical home for children and youth enrolled in Medicaid and Health Choice with mild to moderate behavioral health issues being served in the primary care system, as well as for enrollees with severe and persistent mental illness being served in our specialty behavioral health system. CCNC believes it is extremely important that North Carolina's delivery system embrace a more integrated approach to physical and behavioral health. Projects that are currently under the Behavioral Health Integration Initiative include: Integrated Care/Co-location, A+Kids, Chronic Pain Initiative, SBIRT, ASAP, NC ACCEPT, Motivational Interviewing, and the Depression Toolkit for Primary Care.

The North Carolina Foundation for Advanced Health Programs (NCFAHP) was initially funded by the North Carolina Health and Wellness Trust Fund and DMA to create a Center of Excellence for Integrated Care. The work is now supported by other contracts and foundations, including funding from the federal CHIPRA Quality demonstration grant, Kate B. Reynolds Charitable Trust, and a contract with the Governor's Institute on Substance Abuse. The Center works to improve patient outcomes through integrating mental health, substance abuse services, and primary medical care. It provides trainings, learning collaboratives, and technical assistance to primary care and behavioral health providers, health departments, Local Management Entities (LMEs), and Critical Access Behavioral Health Agencies (CABHA) to help them implement integrated care models to better serve patients with underlying medical problems, mental health conditions, substance abuse disorders, and/or certain intellectual or developmental disabilities. The Center currently has funding to support integrative practices in primary care and mental health and substance abuse settings in seven of the 14 CCNC networks, including 27 primary care practices. The Center provides training, technical assistance, and learning collaboratives around integrated care processes; brief intervention and referral into treatment for substance abuse disorder, depression, and other forms of mental illness; identification and support for children with autism spectrum disorder; maternal depression; and childhood obesity.

Recommendation 7.7: Ensure the Availability of Substance Abuse and Mental Health Services for Adolescents
(Priority Recommendation)
NOT IMPLEMENTED

a) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a plan for a comprehensive system that is available and accessible across the state to address adolescents' substance abuse treatment needs. In developing this plan, DMHDDSAS should:
   1) Ensure a comprehensive array of local or regional substance abuse services and supports;
   2) Develop performance based contracts to ensure timely engagement, active participation in treatment, retention, and program completion;
   3) Ensure effective coordination of care between substance abuse providers and other health professionals, such as primary care providers, emergency departments or school health professionals;
   4) Identify barriers and strategies to increase quality and quantity of mental health and substance abuse providers in the state;
   5) Immediately begin expanding capacity of adolescent substance abuse treatment services; and
   6) Include identification of co-occurring disorders and dual diagnoses, including screening all adolescents with mental health disorders for substance use and abuse and vice versa.
b) DMHDDSAS should review the availability of mental health treatment services for adolescents among public and private providers.

A comprehensive system specifically for adolescents has not been implemented.

CHAPTER 8: YOUTH VIOLENCE

Recommendation 8.1: Enhance Injury Surveillance Evaluation
PARTIALLY IMPLEMENTED

a) **The Department of Juvenile Justice and Delinquency Prevention should collect gang activity data from schools each year.**
b) **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.**
c) **The North Carolina General Assembly should appropriate $175,000 in recurring funds beginning in SFY 2011 to the Department of Public Heath 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 the Injury and Violence Prevention Branch and done in collaboration with the North Carolina Medical Society, North Carolina Pediatric 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, Carolinas Poison Center (state poison control center) at Carolinas Medical Center, North Carolina Office of the Chief Medical Examiner, Department of Juvenile Justice and Delinquency Prevention, and others as appropriate. 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).**

In 2012, the Department of Juvenile Justice and Delinquency Prevention (DJJDP) and the Department of Corrections were consolidated into the North Carolina Department of Public Safety (DPS). Juvenile justice and delinquency prevention activities are now carried out by the Division of Juvenile Justice (DJJ) within DPS. DJJ continues to conduct annual census of School Resource Officer programs, officers who provide coverage of schools for law enforcement, law-related counseling, and law-related education. This also includes gang activity in schools data.

Injury and violence prevention is still not part of essential public health services in §130A-1.1[tt] and no funds have been appropriated to improve the intentional and unintentional injury surveillance system.

Recommendation 8.2: Support Evidence-Based Prevention Programs in the Community (Priority Recommendation)
PARTIALLY IMPLEMENTED

a) **The Department of Juvenile Justice and Delinquency Prevention (DJJDP) should strongly encourage Juvenile Crime Prevention Councils (JCPC) to fund evidence-based juvenile justice prevention and treatment programs, including prevention of youth violence and substance use, and community-based alternatives to incarceration. Additionally DJJDP should strongly encourage JCPC-funded programs to address multiple health domains in addition to violence prevention.**

[tt] http://law.onecle.com/north-carolina/130a-public-health/130a-1.1.html

b) DJJDP should restructure JCPC funding grants to allow grants of longer than one year duration so that programs have the resources and commitment to implement and support evidence-based programs with fidelity.

For many years DJJDP, now DJJ, contracted with a youth camping program to provide services for DJJ involved youth. In 2011, that contract expired and DJJ determined there were more effective and efficient ways to serve high-risk adjudicated youth. Resources that had previously gone to the youth camping program were redirected into evidence-based alternatives for youth involved with DJJ. Funding supports a number of options across the state including cognitive behavior therapy, an evidence-based therapy model, reentry programs, which support an evidence-based process of reintegration into the community, and evidence-based mentoring programs.

The North Carolina Department of Public Instruction, in partnership with Division of Public Health, Children and Youth Branch, has developed a free, online module for teachers to improve their ability to manage student behavior in the classroom, thereby avoiding involvement of the School Resource Officer and entry into the juvenile justice system.

In 2010, North Carolina received a $6.5 million Centers for Disease Control and Prevention grant to establish the North Carolina Academic Center for Excellence in Youth Violence Prevention, the nation's first rurally focused violence prevention center, in Robeson County. The Center will focus on conducting youth violence prevention research and providing support to rural communities to combat youth violence. The center is a collaborative partnership between the University of North Carolina at Chapel Hill (UNC) School of Social Work, the UNC Injury Prevention Research Center (IPRC), and community agencies in Robeson County, including the Robeson County Health Department, Department of Juvenile Services, and Public Schools of Robeson County.

Recommendation 8.3: Raise the Age of Court Jurisdiction

NOT IMPLEMENTED

The North Carolina General Assembly should enact legislation to raise the age of juvenile court jurisdiction from 16 to 18. Full implementation of the increased age for juvenile court jurisdiction should be delayed two years to enable the Youth Accountability Planning Task Force to report back recommendations on implementation and costs to the General Assembly.

A bill to raise the age of juvenile court jurisdiction from 16 to 18 has been proposed during the last three legislative sessions, but has never been voted on.

CHAPTER 9: SEXUAL HEALTH

Recommendation 9.1: Increase Immunization Rates for Vaccine-Preventable Diseases
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 but not limited to the human papillomavirus (HPV) vaccine which is 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. The HPV vaccine 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 HPV vaccine 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 the HPV vaccines through the UCVDP, work with insurers to ensure first dollar coverage and adequate reimbursement for 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 all the recommended childhood vaccines among all North Carolinians. The North Carolina General Assembly should appropriate $1.5 million in recurring funds beginning in SFY 2011 to support this effort.**

The North Carolina Immunization Branch within the Division of Public Health is doing routine assessments of practices serving adolescents, sharing with them practice- specific immunization rates. During these assessments, in addition to receiving the rates for their practices, providers are taught best practices to improve adolescent rates and how to use the reminder/recall function of the North Carolina Immunization Registry to recall adolescents who may be missing vaccines. Additionally, all health care providers that are a part of the North Carolina Immunization Branch program are required to offer vaccines that are appropriate for the population that they serve. This includes the adolescent vaccines.

The North Carolina Immunization Branch also provides educational materials to elementary, middle and high schools that can be passed along to the parents about the required and recommended immunizations. Examples of these materials can be found here: http://immunize.nc.gov/schools/resourcesforschools.htm. An outreach campaign was conducted

from Sept-Dec of 2011 promoting vaccinations. However, the North Carolina General Assembly appropriated no funds for this campaign.

The Patient Protection and Affordable Care Act of 2010 includes first dollar coverage for Advisory Committee on Immunization Practices (ACIP)-recommended vaccines starting September 2010. The first dollar coverage means that co-payments, deductibles, or coinsurance will not apply for the ACIP-recommended vaccines.[uu] The ACIP recommends routine vaccination of females and males aged 11 or 12 years, beginning as early as 9 years, with the HPV vaccine. Vaccination is also recommended for females aged 13 through 26 years and males 13 through 21 who have not been vaccinated previously or who have not completed the vaccination series.[vv]

Adolescent (ages 13-17) vaccination rates have improved significantly since 2009 for the tetanus toxoid-diphtheria vaccine and the meningococcal conjugate vaccine (now at 77.8 and 65.9% respectively). Additionally, 65.4% of adolescent females in North Carolina have completed the human papillomavirus vaccine (HPV) 3 dose series. Data are not yet available for male HPV vaccination rates. North Carolina's vaccination rates are close to the US average for each of the listed vaccines,[ww]

Recommendation 9.2: Ensure Comprehensive Sexuality Education for More Young People in North Carolina
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 Authorities 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[xx] of 2009 changed school curricula from abstinence only to comprehensive reproductive health and safety education program. In October 2010, the North Carolina Division of Public Instruction received $1.5 million in Title V funds to support implementation of comprehensive sex education pursuant to the "Healthy Youth Act of 2009."

The director and cadre of trainers from the NC School Health Training Center (NCSHTC) have provided consultation for school systems moving toward implementation of the Healthy Youth Act. Three services have been provided:

[uu] PPACA, Section 2713
[vv] http://www.cdc.gov/vaccines/pubs/ACIP-list.htm
[ww] National Immunization Survey teen data http://www.cdc.gov/vaccines/stats-surv/nis/default.htm#nisteen
[xx] http://www.ncleg.net/gascripts/billlookup/billlookup.pl?Session=2009&BillID=H88

- Review of evidence-based and promising programs: 10 curricula have been reviewed and the reviews have been posted on ncshtc.appstate.edu
- Writing of 16 lesson plans and PowerPoint presentations to meet each section of the new parts of the Healthy Youth Act
- Response to requests for clarification of the law with visits and phone calls, including recommendation for opt-out (or passive parental permission)
- Professional development in *Making Proud Choices*, *Reducing the Risk*, and the Healthy Youth Act lesson plans

To date, the NCSHTC has provided full-day (six-hours) professional development events in the Healthy Youth Act and teaching of Reproductive Health and Safety Education to more than 800 teachers and school administrators from more than 60 counties and all teachers of Healthful Living in the Juvenile Justice system.[yy]

The North Carolina School Health Training Center, with funding from the Department of Public Instruction, has provided professional development for teachers, counselors, nurses, administrators, and public health educators in Parents Matter. Parents Matter trains facilitators who will provide parents and guardians with the communication tools and information necessary to initiate important discussions related to sexual health, family values and personal responsibility with their child. The DPI grants in HIV Prevention and Title V Abstinence included sub-awards to local agencies for community sustainability. Local facilitators from the following counties have participated in a Parents Matter workshop: Anson, Avery, Buncombe, Caldwell, Durham, Forsyth, Gaston, Granville, Greene, Guilford, Halifax, Jackson, Lee, Lincoln, Mecklenburg, Nash, New Hanover, Onslow, Randolph, Robeson, Rockingham, Rowan, Wake, Watauga, Wayne, and Wilson.[zz]

Since education practices are determined at the local level, local school boards individually determine their consent processes for reproductive health and safety education. The majority of NC LEAs use opt-out consent. Currently the SBE has not required LEAs to report their procedures. APPCNC and other partners are working to compile data on the implementation of the Healthy Youth Act.

Recommendation 9.3: Expand Teen Pregnancy and STD Prevention Programs and Social Marketing Campaigns
(Priority Recommendation)
PARTIALLY IMPLEMENTED

a) The North Carolina Division of Public Health (DPH) should develop and disseminate an unintended pregnancy prevention campaign and expand the Teen Pregnancy Prevention Initiative to reach more adolescents. The North Carolina

[yy] Breitenstein, Donna. Professor and Coordinator of Health Education, Appalachian State University. Written (email) communication. September 3, 2012.
[zz] Breitenstein, Donna. Professor and Coordinator of Health Education, Appalachian State University. Written (email) communication. Oct 3, 2012.

General Assembly should appropriate $3.5 million[aaa] in recurring funds to DPH to support this effort.

b) DPH should expand the *Get Real. Get Tested*. campaign for HIV prevention; create sexually transmitted disease prevention messages; and collaborate with local health departments to offer non-traditional testing sites to increase community screenings for STDs and HIV among adolescents, young adults, and high-risk populations. The North Carolina General Assembly should appropriate $2.4 million[bbb] in recurring funding to DPH to support this effort.

The Adolescent Pregnancy Prevention Program (APPP) of the Teen Pregnancy Prevention Initiative (TPPI), within the Women's Health Branch of the Division of Public Health, funds agencies to implement an evidence-based APPP. The agencies are required to use programs to prevent pregnancies that have been shown to be effective at delaying sexual initiation, improving contraceptive use and/or reducing adolescent pregnancy. The agencies are given the flexibility to expand the scope of the APPP to include academic assistance, parent involvement, service learning, career awareness, job skills development, individual counseling, linkages with medical and preventive health services and information, cultural enrichment, and recreation.[ccc] Agencies across North Carolina are allowed to choose a program model from the following list: Becoming a Responsible Teen, ¡Cuidate! (Take Care of Yourself), Making Proud Choices, Reducing the Risk, Safer Choices, Smart Girls, Teen Outreach Program, Teen PEP, and Wise Guys (level one). These programs are either evidence-based or promising program models. In the proposal, applicants have to demonstrate a clear understanding of the chosen program model by clearly explaining how it will effectively address the risk and protective factors of the program participants and lead to a reduction in teen pregnancy. Applicants must implement the chosen program model with fidelity, and are expected to receive facilitation or implementation training regarding the program model. The agencies are encouraged to select a program that fits the needs of their communities.[ddd]

TPPI also provides funding to the North Carolina School Health Training Center to deliver professional development to high-risk, high-need counties in Making Proud Choices, an evidence-based prevention curriculum in HIV/STD/teen pregnancy. Middle school and high school teachers from these counties have been trained: Bladen, Burke, Cumberland, Duplin, Edgecombe, Macon, McDowell, Nash, Onslow, Pamlico, Robeson, Sampson, Scotland, Swain, Warren, Wayne, and Wilson.[eee] The North Carolina Department of Public Instruction, with funds

[aaa] The North Carolina Division of Public Health estimates it would cost $3.5 million to develop and disseminate an unintended pregnancy prevention campaign and expand the Teen Pregnancy Prevention Initiative to reach more adolescents (Holliday J., Head, Women's Health Branch, Division of Public Health, North Carolina Department of Health and Human Services. Oral communication. May 14, 2009.

[bbb] The North Carolina Division of Public Health estimates it would cost $2.4 million to expand the *Get Real. Get Tested*. campaign for HIV prevention; create sexually transmitted disease prevention messages; and collaborate with local health departments to offer non-traditional testing sites to increase community screenings for STDs and HIV among adolescents, young adults, and high-risk populations (Foust, EM. Head, HIV/STD Prevention and Care, Division of Public Health, North Carolina Department of Health and Human Services. Oral communication. May 14, 2009).

[ccc] http://www.teenpregnancy.ncdhhs.gov/appp.htm

[ddd] Atkinson, Sydney. Written (email) communication July 31, 2012.

[eee] Erausquin, J. Senior Advisor, Division of Public Health, NC Department of Health and Human Services. Written (email) communication. Oct 17, 2012.

from the US Health and Human Services, Administration for Children and Families, currently works in 19 high-risk local education agencies (LEAs) to provide mental health services, teacher training on evidence-based curricula, and technical assistance as a comprehensive approach to adolescent pregnancy prevention.[fff]

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

[fff] Erausquin, J. Senior Advisor, Division of Public Health, NC Department of Health and Human Services. Written (email) communication. Oct 17, 2012.

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

CHAPTER 10: PREVENTING ADULT-ONSET DISEASES

Recommendation 10.1: Support the Implementation of North Carolina's Comprehensive Tobacco Control Program (Priority Recommendation)

NOT IMPLEMENTED

a) **The North Carolina General Assembly (NCGA) should adopt measures to prevent and decrease adolescent smoking. As part of this effort, the NCGA should:**
   1) **Increase the tax on tobacco products and new revenues should be used for a broad range of prevention activities including preventing and reducing dependence on tobacco, alcohol, and other substances.**
      a. **The NCGA 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 NCGA 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.**
   2) **The NCGA should support the state's Comprehensive Tobacco Control Program by**
      a. **Protecting the North Carolina Health and Wellness Trust Fund's (HWTF) ability to continue to prevent and reduce tobacco use in North Carolina by**
         i. **Ensuring that no additional funds are diverted from HWTF's share of the Master Settlement Agreement; and**
         ii. **Releasing HWTF from its obligation to use over 65% of its annual MSA receipts to underwrite debt service for State Capital Facilities Act, 2004.**
      b. **The NCGA should better enable the Division of Public Health (DPH) and North Carolina Health and Wellness Trust Fund (HWTF) to prevent and reduce tobacco use in North Carolina by appropriating $26.7 million in recurring funds in SFY 2011 to support implementation of the Comprehensive Tobacco Control program. The NCGA should appropriate other funds as necessary until state funding, combined with HWTF's annual allocation for tobacco prevention (based on provision A), reaches the Centers for Disease Control and Prevention recommended amount of $106.8 million by 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. A significant portion of this funding should be targeted towards youth.**
   3) **The NCGA should amend current smoke-free laws to mandate that all worksites and public places are smoke-free.**

4) **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 public places, pursuant to NCGS §130A-497.**

b) **Comprehensive evidence-based tobacco cessation services should be available for all youth.**
   1) **Insurers, payers, and employers should cover comprehensive, evidence-based tobacco cessation services and benefits including counseling and appropriate medications.**
   2) **Providers should deliver comprehensive, evidence-based tobacco cessation services including counseling and appropriate medications.**

No new tobacco taxes have been implemented since the $0.35 cigarette tax increase in 2009. In 2011, the North Carolina General Assembly (NCGA) abolished the Health and Wellness Task Force. However, the NCGA included $17.3 million in their FY 2011-2012 budget, and $2.7 million in their FY 2012-2013 budget to preserve some of the tobacco prevention settlement money to fund the Tobacco Control Program.

The Affordable Care Act requires all health plans to cover US Preventive Services Task Force recommended preventive services without cost sharing beginning in 2014. The preventive tobacco services recommended by the US Preventive Services Task Force include screening all adults and pregnant women for tobacco use and providing tobacco cessation interventions. There was not enough evidence to support making a similar recommendation for children and adolescents.

Youth Empowered Solutions (YES!) has trained over 1,000 tobacco prevention youth advocates, across North Carolina since July 2011. These youth advocates advocate for policy and environmental changes in their local community that support the state's Tobacco Control Program. YES! Youth advocates have engaged in many activites to reduce smoking including:

- Bele Chere Music Festival agreed to prohibit any sponsorship dollars that were coming in from tobacco companies and refrain from marketing those companies during the festival, which impacts roughly 350,000 people.
- The town of Black Mountain enacted a policy that all town-owned or operated buildings and grounds be tobacco free, impacting 7,900 people.
- Asheville-Buncombe Technical College, Randolph County Community College, and Rockingham County Community College have adopted 100% Tobacco Free Policies.[hhh]

Additionally, NC Tobacco Prevention and Control Branch received a two-year grant from the CDC American Recovery and Reinvestment Act (ARRA) funding to build support for a comprehensive smoke-free state law, increase the number of local model smoke-free ordinances and enhance cessation services through the NC Quitline. Buncombe County passed a

[hhh] Parrish Ravelli, Team Lead, Access to Health Care, Youth Empowered Solutions. Written (email) communication August 23, 2012.

comprehensive ordinance to prohibit smoking on all county grounds, including parks and recreational areas.[iii]

Recommendation 10.2: Improve School Nutrition in Middle and High Schools (Priority Recommendation)
PARTIAL IMPLEMENTATION

North Carolina funders should develop a competitive request for proposal to fund a collaborative effort between North Carolina Department of Public Instruction 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 the cost of implementing healthy meals.

Asheville High School and the School of Inquiry and Life Sciences at Asheville (SILSA) have enacted a Second-Chance Breakfast to create an increased amount of access to healthy foods at school, impacting 1,200 students. Additionally, Youth Empowered Solutions YES! has trained 31 youth across NC to advocate for better school nutrition and those youth are working in their local communities.

In Charlotte, North Carolina the a community garden program has been implemented at Pinewood Elementary School/Madison Park with a mobile food stand. Additionally Myers Park High School cafeteria is being redesigned to make healthy options more accessible to students. YES! youth are advocating for similar changes in other schools and communities. Additionally, YES! youth on the NC Farm to School (F2S) Statewide Coalition, will be conducting an inventory of NC F2S programs, resources, and distribution methods. Youth are working with adults to build this coalition and engage other youth across North Carolina is the movement to provide more fresh and local foods in the middle and high schools. [jjj]

Schools are also working to educate students to make better decisions about what they choose to eat. With Centers for Disease Control and Prevention funding, the Department of Public Instruction provided funding North Carolina School Health Training Center for Nutrition Education to design a education plan to meet new Healthful Living nutrition standards. MyPlate and More workshops were delivered to Lincoln County, Madison County, Union County, and participants in the NC Healthy Schools Institute in Wilmington. More than 100 teachers from Avery, Buncombe, Caldwell, Chatham, Lincoln, and Madison have been trained.

[iii] Jim D. Martin, MS, Director of Policy and Programs, NC Tobacco Prevention and Control Branch, Chronic Disease and Injury section, Division of Public Health. Written (email) communication September 7, 2010.
[jjj] Parrish Ravelli, Team Lead, Access to Health Care, Youth Empowered Solutions. Written (email) communication August 23, 2012.

Recommendation 10.3: Establish Joint-use Agreements for School and Community Recreational Facilities
FULLY IMPLEMENTATED

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-based 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 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.

a) 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-use park and school facilities.
   2) Include physical activity space in the facility needs survey for 2010 and subsequent years.

In 2012 the Healthy Schools section of the North Carolina Division of Public Instruction (DPI) received grant funds from the National Association of State Boards of Education (NASBE) to complete a policy guidance document on the topic of joint use. DPI worked in partnership with the Chronic Disease and Injury Section of the Division of Public Health (DPH) to produce a document, which focuses on joint use to promote physical activity in North Carolina communities. The document provides recommendations for building joint use facilities and developing joint use agreements covering existing facilities.

In 2011 DPH was awarded $7.4 million per year over five years to help communities make healthy living easier in North Carolina. This grant is a part of the U.S. Department of Health and Human Services' Community Transformation Grants (CTG) to support public health efforts to reduce chronic diseases, promote healthier lifestyles, reduce health disparities, and control health care spending. DPH will work with state and local partners to decrease tobacco use; increase physical activity; improve nutrition; and increase access to evidence-based clinical preventive services. This will require improving access to healthy living opportunities for all North Carolinians including racial and ethnic minorities, those of low socioeconomic status and individuals living in rural areas. DPH has funded 10 multi-county collaboratives, which align with the NC Association of Local Health Directors regions to implement jurisdiction-wide changes. The five years of project implementation span from October 2011 to September 2016. State and local partners will implement strategies with emphasis on health equity that support tobacco free living, active living, healthy eating, and access to evidence-based clinical preventive services. A primary emphasis of these efforts is placed on reaching populations experiencing the

greatest burden of chronic disease. The Project will be organized on a regional basis to maximize its reach across the state. Each of the ten multi-county collaborative has one local health department that has assumed responsibility for coordinating efforts and providing the infrastructure for the funding. These lead health departments administer approximately $440,000 annually and are charged with developing a regional plan informed by a regional leadership team(a Community Transformation Collaborative) may choose to address Joint Use with the strategy of increasing the number of joint-use agreements that increase access to physical activity opportunities.[kkk]

Recommendation 10.4: Fund Demonstration Projects in Promoting Physical Activity, Nutrition, and Healthy Weight [lll]
FULLY IMPLEMENTED

The North Carolina Division of Public Health, along with its partner organizations, should fully implement the *Eat Smart, Move More North Carolina Obesity Plan* for combating obesity in selected local communities and identify best practices for improving nutrition and increasing physical activity that will ultimately be adopted across the state. As part of this project, the North Carolina General Assembly should appropriate $500,000 in non-recurring funds for six years beginning in SFY 2011 to the North Carolina Division of Public Health for pilot programs of up to $100,000 per year to reduce overweight and obesity among adolescents. Funded programs should be evidence-based or promising practices and should include an evaluation of their effectiveness. If shown to be effective, programs should be expanded statewide.

The Eat Smart, Move More Community Grants Program supports local health departments in North Carolina to develop community-based interventions that encourage, promote and facilitate physical activity and healthy eating. The program's goal is to provide funding to local communities to implement strategies that advance the goals and objectives of North Carolina's Obesity Prevention Plan.[mmm] The members of the Eat Smart, Move More North Carolina Leadership Team and its partners across the state addressing healthy eating and active living have adopted all or parts of North Carolina's Obesity Prevention Plan to implement evidence based strategies that address overweight and obesity. As a member of Eat Smart, Move More North Carolina, the Division of Public Health (DPH) has used their Centers for Disease Control and Prevention (CDC) funding for Nutrition, Physical Activity and Obesity to fund Eat Smart, Move More Community Grants.

In 2009 the Robert Wood Johnson Foundation awarded funding to the DPH Physical Activity and Nutrition Branch to work with East Carolina University's Department of Public Health in evaluating the program. The grantees were studied to assess the impact the grants are having in

[kkk] Paula Hudson Hildebrand. Chief Health and Community Relations Officer, NC Department of Public Instruction. Written (email) communication. Oct 17, 2012.
[lll] This is one part of a recommendation is being adopted by the Prevention Task Force and the legislatively created Obesity Task Force. The full recommendation is for $10.5 million Division of Public Health to allow full implementation of the *Eat Smart, Move More North Carolina* state plan for obesity in selected local communities and to identify best practices for improving nutrition and increasing physical activity that will ultimately be adopted across the state.
[mmm] http://www.eatsmartmovemorenc.com/Funding/CommunityGrants.html

the communities that receive them. For this evaluation DPH funded 20 health departments (10 in 2010-11 and 10 more in 2011-2012) to target increasing physical activity and/or decreasing sedentary behaviors in disadvantaged youth. The following county or district health departments received funding in 2010-2011: Appalachian Health District (Ashe County), Beaufort, Buncombe, Clay, Cleveland, New Hanover, Orange, Stokes, Surry and Yadkin. In 2011-2012, funding went to the: Albemarle Health District (Currituck and Gates counties), Appalachian Health District (Alleghany County), Burke, Chatham, Gaston, Guilford, Henderson, Montgomery, Pitt and Sampson counties. DPH remains the sole funder for these grants. For 2012-2013, ten health departments and their partner agencies will implement strategies to prevent overweight and obesity and promote healthier eating and increased physical activity. The grantees receiving the funding are: Brunswick, Cabarrus, Catawba, Cleveland, Gaston, Henderson, Jackson, Orange, Rowan and Toe River District – Yancey County.[nnn]

Recommendation 10.5: Expand the CCNC Childhood Obesity Prevention Initiative
FULLY IMPLEMENTED

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.

As part of the federal Children's Health Insurance Program Reauthorization Act (CHIPRA), states were offered the opportunity to compete for children's health insurance quality demonstration grants. In 2009, North Carolina was awarded $9.3 million (over 5 years). This funding has, in part, supported the expansion of CCNC's Childhood Obesity Prevention Initiative. As part of the work to improve child health data, CCNC is now collecting information on BMI and using an assessment, prevention, and treatment guide for clinicians to start the conversation between providers and patients about obesity prevention. CCNC is also providing more in-depth training to a subset of practices through learning collaboratives focused on improving obesity prevention through the use of motivational interviewing and strategies practices can implement to emphasize healthy weight, physical activity, and less screen time at every visit.

In 2010, the North Carolina General Assembly passed legislation for the North Carolina Division of Medical Assistance to research body mass index screenings conducted by providers in the state and assess the feasibility of requiring all providers to conduct BMI screenings for children enrolled in Medicaid or NC Health Choice for Children. [ooo]

[nnn] Paula Hudson Hildebrand. Chief Health and Community Relations Officer, NC Department of Public Instruction. Written (email) communication. Oct 17, 2012.
[ooo] http://www.ncleg.net/enactedlegislation/sessionlaws/pdf/2009-2010/sl2010-152.pdf, SESSION LAW 2010-152 SENATE BILL 900