


# NORTH CAROLINA ASSOCIATION of LOCAL HEALTH DIRECTORS

*An Affiliate of the North Carolina Association of County Commissioners*

May 1, 1998

## Memorandum

To: Local Health Directors

From: Joseph B. Bass, Jr., Past President, NCALHD 

Subject: Participation on Turning Point Project Work Groups

As you are aware, North Carolina is one of fourteen states awarded the Robert Wood Johnson/Kellogg grant to look at public health in our state and develop a system that is prepared to meet the health care challenges of the 21st century. We will be working closely with this project, especially in light of our visioning activity and implementation of any models for services.

The Executive Committee of the Turning Point Initiative met on Tuesday, April 28 and decided to have a consensus conference in November, 1998. Between now and the consensus conference, six work groups will be exploring various areas of study for the project. If you have an interest in participating on one of the work groups listed below or would like additional information regarding the work groups, please contact Mary Bobbitt-Cooke at 919-715-0416.

The work groups for the areas of study for the Turning Point initiative are:

- Assurance, Regulatory Responsibilities, Structure and Financing
- Public Health Services
- Assessment, Surveillance and Data Collection
- Policy Development and Leadership
- Public Health Communication and Education
- Public Health Work Force Preparedness

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Person County Health Department  
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*Secretary Treasurer*  
Tim Green, MPA  
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*Past President*  
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Fax: 704-982-8354  
NC Courier #05-94-09

CALHD Roster

age 2

County/Health Director

- 1 \_\_\_ Hoke/Donald Womble (M)
- 2 \_\_\_ Hyde/Linda Mayo
- 3 ~~AK~~ Iredell/Raymond Rabe (M)
- 4 \_\_\_ Jackson/Randall Turpin (M)
- 5 \_\_\_ Johnston/Dr. L.S. Woodall (M)
- 6 \_\_\_ Jones/Arthur T. Jones
- 7 ~~ML~~ Lee/Phyllis M. Lowry (M)
- 8 \_\_\_ Lenoir/Joey Huff
- 9 ~~WB~~ Lincoln/Margaret Dollar (E)
- 10 \_\_\_ Macon/Ann Hyder (M)
- 11 \_\_\_ Madison/Ken Ring (M)
- 12 \_\_\_ Martin-Tyrrell-Washington Dist/Bill Burgess
- 13 \_\_\_ Mecklenburg/Peter Safir (M)
- 14 ~~MA~~ Montgomery/Mike Hanes (E) (M)
- 15 \_\_\_ Moore/Robert Wittmann (M)
- 16 \_\_\_ Nash/William Hill, Jr. (M)
- 17 ~~LR~~ New Hanover/David Rice (M)
- 18 \_\_\_ Northampton/Sue Gay, Acting
- 19 \_\_\_ Onslow/Danny Jacob
- 20 ~~RS~~ Orange/Rosemary Summers, Interim (M)
- 21 \_\_\_ Pamlico/Jenny Lassiter (M)
- 22 \_\_\_ PPCC Dist/Howard Campbell
- 23 ~~JA~~ Pender/Jack Griffith (M)
- 24 ~~JM~~ Person/Tom Bridges (E) (M)
- 25 ~~IM~~ Pitt/Dr. John Morrow (E) (M)
- 26 ~~WC~~ Randolph/Mimi Cooper (M)
- 27 ~~TD~~ Richmond/Tommy Jarrell (M)
- 28 ~~V~~ Robeson/Bill Smith (E) (M)
- 29 \_\_\_ Rockingham/Glenn Martin (M)
- 30 \_\_\_ Rowan/John Shaw (E) (M)
- 31 ~~JW~~ Rutherford-Polk-McDowell Dist/Leonard Wood (M)
- 32 ~~WR~~ Sampson/Vacant (M) *Wanda Robinson (E)*
- 33 \_\_\_ Scotland/Curtis Holloman (M)
- 34 \_\_\_ Stanly/Joseph Barry Bass (E) (M)
- 35 \_\_\_ Stokes/Colleen Bridger (M)
- 36 \_\_\_ Surry/Dr. Walter Linz
- 37 \_\_\_ Toe River Dist/Tommy Singleton, Acting (M)
- 38 ~~PT~~ Transylvania/Terry Pierce (M)
- 39 \_\_\_ Union/Lorey White (M)
- 40 \_\_\_ Wake/Lou Brewer (M)
- 41 \_\_\_ Wayne/Robert Peck (M)
- 42 \_\_\_ Warren/Dennis Retzlaff (E) (M)
- 43 ~~GD~~ Wilkes/George O'Daniel (M)
- 44 ~~W~~ Wilson/Dr. Louis Latour (M)
- 45 ~~YB~~ Yadkin/Gayle Brown (M)

(M) = 1998 Dues Paying Member

County/Health Director

✓ Alamance/Tim Green (E) (M)

SR Alexander/Shelly Carraway (M)

MRK Anson/Marc Kolman (M)

\_\_\_ Appalachain Dist/Daniel Staley (M)

\_\_\_ Beaufort/Tamera Hower

\_\_\_ Bertie/Joann Jordan

NY Bladen/Myra Johnson, RN, Interim (M)

DL Brunswick/Don Younsey (E) (M)

\_\_\_ Buncombe/George Bond (E) (M)

AK Burke/Jenny Kirksey (M)

\_\_\_ Cabarrus/Dr. William Pilkington

\_\_\_ Caldwell/Vacant (M)

\_\_\_ Carteret/Dr. J.T. Garrett (M)

\_\_\_ Caswell/Anne Scott (M)

\_\_\_ Catawba/Barry A. Blick (M)

Chatham/Wayne Sherman (E) (M)

Cherokee/Elaine Russell (M)

\_\_\_ Clay/Janice Patterson (M)

\_\_\_ Cleveland/Denese Stallings (M)

\_\_\_ Columbus/Marian Duncan (M)

Craven/Wanda Sandele (M)

\_\_\_ Cumberland/Dr. Jesse Williams

\_\_\_ Currituck/Dr. John Sledge, Jr. (M)

Dare/Anne B. Thomas (E) (M)

DC Davidson/Diane Crouse (M)

\_\_\_ Davie/Dennis Harrington (E) (M)

\_\_\_ Duplin/Dr. Harriette Duncan

\_\_\_ Durham/Brian Letourneau (M)

\_\_\_ Edgecombe/James Baluss (M)

\_\_\_ Forsyth/Sherman Kahn (M)

\_\_\_ Franklin/Keith Patton (M)

Gaston/Bruce Parsons (M)

\_\_\_ Graham-Swain Dist/Emma Waldroup (M)

WRD Granville-Vance Dist/Dr. Roddy Drake (M)

\_\_\_ Greene/Doug Urland (M)

\_\_\_ Guilford/Dr. Harold Gabel (M)

\_\_\_ Halifax/Dr. Chris Szwagiel (M)

quw Harnett/Wayne Raynor (M)

lw Haywood/Bob Wood (E) (M)

ye Henderson/Thomas Johnson (M) *Barbara Stanley Interim*

JB Herford-Gates Dist/James Boehm (M)

OTHER ATTENDEES/GUESTS

NAME	REPRESENTING
CHERYL WALLER	Div Women's & Children's Health
Jill D Moore	IOG
Ajiana Register	NCLPHMSSA
Joy Reed	DHHS - Local Health Services/OPHNPS
Lee Davis	Div of. Com. Health
Steve Cline	DHHS - Dental
Dianne Rocco	ANCBM
Barbara Chavira	UNC-CH School of Public Health

# North Carolina Association of Local Health Directors

## Treasurer's Report April 21, 1998

	<u>CHECKING (\$)</u>	<u>SAVINGS (\$)</u>	<u>MONEY MKT. (\$)</u>	<u>CD (\$)</u>
<b>Account Balance brought forward 3/19/98</b>	\$31,008.87	\$32.07	\$10,895.56	\$40,000.00
<b>Receipts:</b>				
Interest Payments:				
April Statement	68.93	0.10	45.46	
Federal Back-up Withholding:				
April Statement	33.67	0.03		
Maintenance/Service Fee:				
April Statement	1.00			
Deposits:				
Transfer from checking				
Transfer from money market				
Dues	3,175.65			
	<b>\$34,218.78</b>	<b>\$32.14</b>	<b>\$10,941.02</b>	<b>\$40,000.00</b>
<b>Expenses:</b>				
# 0737 Chandler Office Supply - Acct. #110	11.87			
# 0738 NC Hlth. Care Infor. & Comm. All. - Acct #116	250.00			
<b>Account Balance as of 4/21/98</b>	<b>\$33,956.91</b>	<b>\$32.14</b>	<b>\$10,941.02</b>	<b>\$40,000.00</b>

NORTH CAROLINA ASSOCIATION OF LOCAL HEALTH DIRECTORS  
 1998 Budget  
 April 21, 1998

REVENUE	(\$) 1998 ADOPTED	(\$) 1998 ACTUAL
Dues	30,305	24,296.60
Checking Interest	1,200	177.55
Savings Interest	900	212.39
Transfers	6,500	15,000.00
<b>Total</b>	<b>\$38,905</b>	<b>\$39,686.54</b>

EXPENSES		
110 - Office Supplies	200	100.63
111 - Awards	300	139.71
112 - Contractual Services	14,905	750.00
113 - Printing/Postage	7,000	45.40
114 - Meeting Expenses	4,400	482.30
115 - President's Expenses	4,000	
116 - Miscellaneous	600	250.00
117 - Contributions	1,000	1,000.00
118 - Legislative Expenses	1,000	
119 - NACCHO Scholarship	3,000	
120 - NACCHOB Bd. Mb.	2,500	
<b>Total</b>	<b>\$38,905</b>	<b>\$2,768.04</b>

## RESOLUTION

Resolution to Recognize and Commend the Efforts of  
Chris Hoke, JD, MPH, Deputy State Health Director

**WHEREAS**, the N.C. Association of Local Health Directors deems it appropriate to recognize the efforts and achievements of individuals on behalf of public health in North Carolina and,

**WHEREAS**, Chris Hoke, Deputy State Health Director, is a dedicated public health professional and,

**WHEREAS**, he was instrumental in amending the public health laws in North Carolina and,

**WHEREAS**, he continues to be active in writing and drafting public health laws and legislation in North Carolina and,

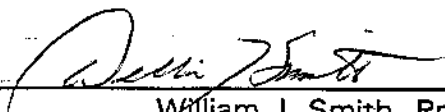
**WHEREAS**, he provides legal consultation, interpretation and technical assistance to public health at both the state and local levels and,

**WHEREAS**, he has been an invaluable advocate for local public health by working on the BCBS conversion issue, helping to retain the Health Check exemption for local public health departments, keeping environmental health programs within public health, and securing the distribution of Medicaid maximization funds to local health departments,

**NOW THEREFORE** be it Resolved by the North Carolina Association of Local Health Directors that,

**Chris Hoke** be recognized and commended for his exemplary contributions to public health at both the state and local level and that a copy of this resolution be sent to Andrew McBride, MD, State Health Director; Ron Levine, MD, Assistant Secretary, DHHS; and David Bruton, MD, Secretary, DHHS.

Adopted by the North Carolina Association of Local Health Directors this  
21st day of April, 1998.

  
\_\_\_\_\_  
William J. Smith, President  
North Carolina Association of Local Health Directors

**facsimile**  
TRANSMITTAL

**to:** Members of NC Local Health Directors' Association Epidemiology Liaison Committee

Sherman Kahn (chair), Forsyth, (336) 727-2434  
Jenny Lassiter, Pamlico, (252) 745-5111  
Raymond Rabe, Iredell, (704) 878-5300  
Joey Huff, Lenoir, (252) 527-7116  
Tommy Singleton, Toe River District, (828) 765-2368  
Robert Peck, Wayne, (919) 731-1000  
Peter Safir, Mecklenburg, (704) 336-4701  
Glenn Martin, Rockingham, (336) 342-8143  
David Rice, New Hanover, (910) 343-6500  
Walt Lintz, Surry, (336) 401-8400  
Bill Burgess, Martin-Tyrrell-Washington District, (252) 793-3023  
Robert Wittmann, Moore, (910) 947-3300  
Jack Griffith, Pender, (910) 259-1230  
Eunice Inman, Robeson, (910) 671-3200

**re:** Conference Call

**date:** April 1, 1998

**pages:** 1, including this cover sheet

There will be a conference call of committee members **this Friday (April 3) at 10:30 a.m.** to discuss proposed changes in the provision of medical services by the Tuberculosis Control Branch. **Please notify me ASAP** about whether or not you will be available at this time on Friday **and** verify whether the phone number I have listed for you above is correct by either phoning (919-715-7394), faxing (919-733-0490), or e-mailing (newt\_maccormack@mail.ehnr.state.nc.us) me.

If you are available for the call, please expect a call from the State Operator sometime between 10:15 and 10:30 a.m. Friday.

From the desk of

J. Newton MacCormack, M.D., M.P.H.  
Chief, General Communicable Disease Control  
Section  
NC Department of Health & Human Services  
P.O. Box 20601  
Raleigh, NC 27626-0601

(919) 733-3419  
Fax: (919) 733-0490

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**NORTH CAROLINA ASSOCIATION OF LOCAL HEALTH DIRECTORS  
EPIDEMIOLOGY COMMITTEE MINUTES  
FRIDAY, APRIL 3, 1998  
CONFERENCE CALL**

In attendance: Sherman Kahn, Jenny Lassiter, Raymond Rabe, Glenn Martin, David Rice, Walter Lintz, Robert Whittmann, Jack Griffith, John Morrow, Beth Jones (for Eunice Inman), Newt MacCormack, Jim Jones, Steve Martin.

The Epidemiology Committee Conference Call was called to order at 10:30 a.m.

The Committee was convened by telephone, at the request of Dr. Newt MacCormack, to discuss proposed changes in the provision of medical services by the Tuberculosis Control Branch. In summary, plans are for local health departments to begin contracting with local physicians for TB services.

**Background:** Dr. MacCormack provided a brief historical perspective, explaining the evolution of the TB Control program in North Carolina over the past ten years. In the 1980's, there were five "circuit riding" physicians providing services on a single or multi-county basis. Today, however, there are only two physicians still "circuit riding," with thirteen counties now providing clinical services for TB in various ways, ranging from having a full-time employed physician in the health department to paying a local physician on an hourly rate.

**Proposal:** The TB Control Section has developed a plan for restructuring the program, with the following features:


- One full-time Medical Director for the TB Control Section, based in Raleigh (by Oct. 1st):
  - assist counties with clinical arrangements
  - medical oversight and consultation with local health departments
  - review x-ray films, when questionable
  - continuing education for local physicians providing TB clinical services
  - ongoing quality assurance
  - policy development for the state TB Control program
- Contract physicians for the TB Control program until Medical Director in place, and arrangements are made regionally/locally;
- Proposed revisions to the Contract Addendum:
  - Funding formula for allocating additional TB money to the counties, based on caseload;
  - Funding used by local health departments to arrange for local medical services (i.e. seeing patients, reading x-rays, and writing orders, etc);
  - Health Departments manage preventive therapy, following the TB Policy Manual re: "Standing Orders"
- Projected Implementation date: July, 1998.

**Recommendation:** After considerable discussion of the issues, it was the consensus of the group to enthusiastically endorse the plan, as presented by Jim Jones and Newt MacCormack. A motion was made, seconded and unanimously approved by the voting members present to support the proposal as presented, and to offer this plan to the NCALHDs as a "Motion from Committee," at their next regularly meeting, scheduled for April 21st at the North Raleigh Hilton.

There being no further business to come before the Committee, the meeting was adjourned at 11:35 a.m.

The next meeting of the Epidemiology Committee will be scheduled during the month of May. Day and time to be announced.

Respectfully submitted,



Sherman E. Kahn, M.D.

Forsyth County Department of Public Health  
P.O. Box 686  
Winston-Salem, NC 27102-0686

## Public Health Authorities

Every county in North Carolina is required by law to provide public health services. In 1997, the General Assembly enacted a statute (G.S. Chapter 130A, Article 2, Part 1A) that permits counties to meet this obligation by forming public health authorities. A public health authority may be formed by a single county or by two or more counties jointly.

### Creating a Public Health Authority

A single-county public health authority is created by a resolution of the county commissioners. A multi-county authority is created by a joint resolution of the boards of commissioners and local boards of health of the affected counties. A county may join an existing public health authority upon a joint resolution of the boards of commissioners and local boards of health of the affected counties. In each case, the resolution must find that it is in the interest of the public health and welfare to create a public health authority to provide public health services.

Before adopting the resolution, the commissioners must hold a public hearing. Notice of the hearing must be published at least ten days before the hearing.

### Public Health Authority Board

A public health authority is governed by a public health authority board, which replaces the local board of health and assumes its functions, assets, and liabilities. The board is the policy-making, rule-making, and adjudicatory body for the public health authority.

### *Membership*

A single-county public health authority board is composed of seven to nine members appointed by the county commissioners. A multi-county board is composed of eight to eleven members. The chairs of the boards of commissioners of each county in a multi-county authority appoint one commissioner to serve on the board. The commissioners appointed to the board then select the remaining members of the board.

The members of the board must include a physician, a dentist, a county commissioner from each county in the authority, a member of the administrative staff of a hospital serving the authority's service area, a member of the general public, and two licensed or registered professionals from any of the following professions: optometry, veterinary science, nursing, pharmacy, engineering, or accounting. Board members serve staggered three-year terms. The board members elect a chair, who serves a one-year term.

### *Powers and Duties*

The public health authority board has the duty to protect and promote the public health, and may adopt rules necessary to meet that duty. The board may adopt, amend, and repeal bylaws for the conduct of its business. The board may appoint advisory boards, committees, and councils to advise the board.

The board has the authority to enter into contracts for necessary supplies, equipment, or services for the operation of its business. The board may establish and operate health care networks. It may contract with public or private organizations, agencies, or corporations for the provision of public health services.

The board has the following authorities related to the management and administration of the authority: appointing the public health director to serve at the pleasure of the authority board; establishing a fee schedule for services (this includes authority to make services available regardless of ability to pay); setting the salaries of authority employees; adopting and enforcing a professional reimbursement policy; and delegating appropriate powers and duties to its agents or employees.

The board has the following authorities related to the acquisition and use of property. The board may: construct, equip, operate, and maintain public health facilities; use property owned or controlled by the authority; acquire real or personal property; act as an agent for the federal, state, or local government in connection with the acquisition, construction, operation, or management of a public health facility; accept and take title to donations of money, personal property, or real estate for the benefit of the authority; lease a public health facility to a nonprofit association on terms and conditions consistent with the Public Health Authorities Act; lease a public health facility to any corporation on terms and conditions consistent with G.S. 160A-272; and sell surplus buildings, land, or equipment to any corporation or other business entity operated for profit.

The board may sue and be sued. It may insure its property or operations against risks, and it may insure itself, its board members, agents, or employees against liability. It may employ its own counsel and legal staff.

#### Public Health Authority Director

The public health authority board appoints a public health authority director after consulting with the boards of commissioners of all counties in the authority. The director serves as secretary to the board and performs duties prescribed by and under the supervision of the board. The director must be employed full-time in the field of public health.

The authority director is authorized: to administer programs; to enforce the rules of the public health authority board; to investigate the causes of diseases; to exercise quarantine and isolation authority; to disseminate public health information and promote good health; to advise local officials concerning public health matters; to enforce immunization requirements; to examine and investigate cases of sexually transmitted diseases, tuberculosis, and rabies; to abate public health nuisances and imminent hazards; and to employ, discipline, and dismiss employees of the public health authority.

#### Dissolving a Public Health Authority

A public health authority may be dissolved whenever the county commissioners of each county in the authority determines that the authority is not operating in the best health interests of the counties served. A single county may withdraw from a multi-county authority upon a similar determination. Dissolution or withdrawal is effective at the end of the fiscal year.

**Comparison of Powers and Duties—Local Boards of Health and Public Health Authority Boards**

	<b>Local Board of Health</b>	<b>Public Health Authority Board</b>
Serve as policy-making, rule-making, and adjudicatory body for public health	yes	yes
Protect and promote public health, and adopt rules necessary to that purpose	yes	yes
Appoint health director after consultation with county commissioners	yes	yes
Impose fees for services	limited <sup>1</sup>	yes
Enter contracts for supplies, equipment, or services	no <sup>2</sup>	yes
Set salaries of employees and professional reimbursement policies	no	yes
Delegate powers and duties to agents or employees	no	yes
Construct, equip, operate, and maintain public health facilities	no	yes
Lease public health facilities	no	yes
Sell surplus buildings, land, and equipment	no	yes
Employ legal counsel and staff	no	yes

<sup>1</sup> G.S. 130A-39(g) authorizes local boards of health to impose fees "except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State." G.S. 130A-45.3(a)(5), which authorizes public health authorities to impose fees, contains no similar limitation. It seems reasonable, however, to assume that public health authorities would be similarly limited. I have nevertheless described the local board of health's authority as limited when compared to the public health authority board's authority, because fees imposed by a local board of health must be based upon a plan recommended by the health director and approved by the county commissioners. Public health authority boards have no similar limitation.

<sup>2</sup> The local board of health has no contracting authority. The local health director is authorized to enter contracts on behalf of the local health department; however, the local health director's authority may not be construed to abrogate the authority of the county commissioners.

**WCH Liaison Committee Meeting**  
**April 20, 1998**  
**Minutes**

**Attending:** Peter Morris, Myra Johnson, Harold Gabel, Diane Crouse, Bob Wood, and John Morrow

**Staff:** Ann Wolfe, Alice Lenihan, Barry Goldstein, Cheryl Waller, Tom Vitaglione, and Kevin Ryan

**Women's Health Summit**

We heard a report from Kevin Ryan on the recent Women's Health Summit that was sponsored by the newly formed Office of Women's Health. Unfortunately this conference competed with the recent rural health conference held in Greensboro. There were approximately 135 participants. The summit addressed life span issues of Women's Health.

**Health Check**

There was discussion concerning the new agreement on exemption for health departments dealing with Health Check. There are still questions about the details of the contracts between primary care providers, health departments, and DMA. There was also discussion on the issue of possible use of a blanket consent that could help simplify handling of records between providers. Ann Wolfe and Tom V. have agreed to get clarification on these issues prior to our next meeting.

**Accountability System**

Barry Goldstein discussed the new recommendations from the accountability work group. They recommended that if a county receives a very low program ranking for two consecutive years that a review team would be put together to address that issue. The review team as proposed would consist of five members including a regional consultant, a faculty member from the School of Public Health at UNC, a staff member from the State Center for Health Statistics, one member from the local health department, and also a private provider from that community. There was discussion concerning the makeup of this review team and the possible input from the health director and other health department staff concerning the selection of these members.

**Children's Health Insurance Plan**

It appears that the general assembly is leaning towards adopting the state employee's health plan as the model for CHIP. This negotiation presently does include up to 200% of the FPL. There will be premiums, co-pays and also a six month waiting period initially. Vision and hearing services are likely to be included but there is more question about dental care at this point. Tom V. explained that Blue Cross and Blue Shield is presently the administrator for the SEHP and that this might be a concern for health departments who presently do not have the ability to bill Blue Cross Blue Shield. He also discussed the plan includes a Medicaid benefit package for kids with special needs and that health departments may likely be involved in the case management of these children. In response to this concern, a motion was made by Bob Wood and seconded that if and when this legislation is passed that our association immediately send a letter to the state employee's health plan voicing our concerns about the participation of the local health departments in this new system of care for children.

### **Streamlining**

Bill Smith recently sent a letter to Ann Wolfe concerning the competitiveness of local health departments to provide Health Check services in a timely manner. This comes at a time when other groups are studying the efficiency and effectiveness of preventive health screenings for children. After discussion of this, a motion was made and seconded that the association officially requests the Division of Women's and Children's Health to use the Child Health Committee of the Streamlining Task Force with the addition of representation from DMA, private physicians and health department physicians to define the minimal requirements of Health Check as well as studying CSC and MCC for possible streamline efforts. Motion passed unanimously.

Respectfully submitted by John H. Morrow

United States Senate

WASHINGTON, DC 20510-3305

March 30, 1998

Mr. William J. Smith  
President  
North Carolina Association of Local Health Directors  
460 Country Club Road  
Lumberton, North Carolina 28358

Dear Mr. Smith:

Thank you for your comments on my recently introduced legislation to improve the Centers for Disease Control and Prevention emergency response to public health alerts.

As you know, the CDC is our country's lead public health agency in responding to threats of viral epidemics and biological acts of terrorism in the United States. After speaking directly with CDC officials and North Carolina public health directors, I am convinced we can improve our critical front line defenses to address these threats adequately.

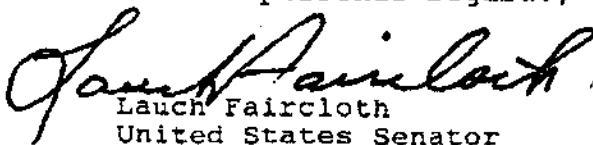
The growing threats of viral epidemics and bioterrorism are real. With fewer than 40 percent of our health departments computer trained and ready to connect and communicate directly with the CDC, our "disease warriors" clearly lack essential resources, infrastructure, and manpower to address these increasingly serious problems. It is imperative that the domestic response be improved to ensure the health and safety of American citizens on American soil.

For these reasons, I have introduced legislation (S. 1786) to initiate a study on the ability of CDC to combat the malevolent use of biological or chemical attacks or outbreaks of viral epidemics that threaten public health and safety. To uncover the breadth of this danger, I have requested the Senate Labor, Health and Human Services Appropriations Subcommittee, of which I am a member, to conduct a hearing on this matter as soon as possible.

Also, you may be assured that I am working hard to push for increased CDC funding. It is my hope that Congress will act swiftly and without hesitation in our pursuit for action that counteracts bioterrorism and affords the CDC adequate funding.

Again, thank you for your remarks on this legislation. For your review, I enclose a copy of my floor statement on this legislation.

Warmest personal regards,

  
Lauch Faircloth  
United States Senator

ROBESON COUNTY  
APR 06 1998

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# Congressional Record

By Mr. FAIRCLOTH:

S. 1786. A bill to provide for the conduct of a study and report concerning the ability of the Centers for Disease Control and Prevention to address the growing threat of viral epidemics and biological and chemical terrorism; to the Committee on Labor and Human Resources.

CENTERS FOR DISEASE CONTROL AND PREVENTION LEGISLATION

Mr. FAIRCLOTH. Mr. President, I rise today to introduce legislation to address the growing threats of viral epidemics and bioterrorism in our nation. I have serious concerns that one of our nation's first lines of defense, the CDC, may not have adequate resources to address these increasingly serious problems.

Scientists meeting at the International Conference on Emerging Infectious Disease in Atlanta last week concluded we were only slightly better prepared today to handle a biologic attack than we were in 1991 at the start of Desert Storm, and we were totally ill-prepared then! While the U.S. military prepares to vaccinate our troops against anthrax, there is currently no national plan to protect civilians from this deadly virus.

Ironically, the day after the International Infectious Disease conference, a business located in Phoenix was threatened with a bioterrorism attack involving an envelope supposedly soaked with the deadly anthrax virus, sending ten employees to the hospital. This comes on the heels of an earlier FBI arrest of two men in Las Vegas who claimed to have anthrax in their possession.

This growing threat is real, and not limited to germs used in war. The first recorded case of bioterrorism occurred in 1994, when members of a religious cult in Oregon deliberately contaminated local salad bars with the salmonella bacteria, causing 751 cases of fever, diarrhea and abdominal pain. Their goal had been to incapacitate voters so they could sway a local election.

More recently, we've seen many diseases we thought we'd conquered reappear in more virulent forms. Since December, 26 Texans have died and hundreds fallen ill from an outbreak of an invasive Group A streptococcus bacteria. In Milwaukee, contaminated drinking water sickened 400,000 citizens and sent 4,000 to the hospital with over 50 deaths.

Mr. President, I voiced my concern that the Centers for Disease Control does not have the resources necessary to fight these wars with Secretary Shalala at the Labor, Health and Human Services Appropriations Subcommittee hearing last week, and have asked that the Subcommittee Chairman, my colleague from Pennsylvania, Senator Specter join me in holding a hearing on the agency's role and abilities to meet these growing threats.

Let me take a few moments now to share my concern with my colleagues by asking a question: What do bioterrorism, natural and manmade disasters, contaminated food and water supplies, and epidemics have in common? The answer may come as a surprise—the lynchpin to combating any of these life-threatening situations are the 3,000 state, county and local health departments in this country, working in cooperation with the Centers for Disease Control.

Most people would be shocked to learn that the very network that is supposed to play a role in providing a first line of defense against these threats—the 3,000 health departments scattered across the United States—are in most cases not computer linked with the command center, CDC. Only 40 percent of our health departments are on-line today. The remainder need computer hardware, training and manpower to be able to connect. Local health departments also need laboratory capability to be able to test the agents suspected of causing a threat—presently these samples have to be shipped off-site to be tested, wasting valuable response time.

The warning signs are there. Were this a military operation, with the enemy amassing on our borders, we would have no hesitation nor would we question the need for additional resources. We should do nothing less when lives are threatened by disease. CDC forms a bridge with state and local health departments and other important governmental agencies to combat disease and biologic threats.

While CDC has become well known world-wide as the "disease detectives," the public and many of my colleagues are probably unaware of the work they perform, with their law enforcement, military and intelligence agency colleagues in the biologic and chemical warfare arena. CDC's Epidemiologic Intelligence Service school produces highly trained epidemiologists from these agencies to deal with these deadly, newly emerging threats. Every state should have at least one graduate from the Epidemiologic Intelligence Service School—currently, less than half have someone with these skills.

Additionally, CDC's National Center for Infectious Diseases, the Public Health Practice Program Office and the National Center for Environmental Health also play key roles in ensuring the preparedness of the public health response.

The legislation I'm introducing today is simple. It asks that the Centers for Disease Control report to Congress within sixty days in regard to their resources and readiness to respond to the growing threats of viral epidemics, biologic and chemical threats. I intend to focus on this when we discuss this at a future hearing, and am looking forward to learning how we can improve our ability to address this growing threat.

Unfortunately, our public health departments are operating under severe constraints with about one-third lacking even the most basic technology for communications or access to advanced training. One thing is certain, not one link in our public health defense can operate in a vacuum because disease knows no political or geographic boundaries.

In the days ahead as we set our priorities for appropriations and budget, it is time, and past time, that we place a priority on investing in local public health department infrastructure. Otherwise, we may find that the cost of our neglect is more than any of us are willing to pay.

Mr. President, I ask unanimous consent that the text of the bill be printed in the Record.

There being no objection, the bill was ordered to be printed in the Record, as follows:

S. 1786

*As it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

SECTION 1. STUDY CONCERNING THE CAPABILITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study concerning the ability of, and resources available to, the Centers for Disease Control and Prevention to address the growing threats of viral epidemics and biologic and chemical terrorism.

(b) REPORT.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report concerning the results of the study conducted under subsection (a), including the recommendations of the Secretary for improving the ability and resources of the Centers for Disease Control and Prevention to address the growing threats of viral epidemics and biologic and chemical terrorism.

March 17, 1998

CONGRESSIONAL RECORD—SENATE

S2123

17

**CAROLYN B. MALONEY**  
 14TH DISTRICT, NEW YORK  
 1220 LONGWORTH BUILDING  
 WASHINGTON, DC 20519-3214  
 (202) 225-7944

COMMITTEE  
**BANKING AND FINANCIAL SERVICES**

GOVERNMENT REFORM AND OVERSIGHT

JOINT ECONOMIC COMMITTEE



**Congress of the United States**  
**House of Representatives**  
 Washington, DC 20515-3214

202 225 4709 P. 03/04

DISTRICT OFFICE:  
 110 EAST 60TH STREET  
 2ND FLOOR  
 NEW YORK, NY 10022  
 (212) 673-8681

28-11 ASTORIA BOULEVARD  
 ASTORIA, NY 11102  
 (716) 972-1006

619 LOWER STREET  
 BURLINGAME, NY 11271  
 (718) 348-1200

**H.R. 3531**  
**New Mothers' Breastfeeding Promotion and Protection Act**  
**BILL SUMMARY**

*A BILL to support breastfeeding by new mothers and encourage employers to support workplace lactation programs, and for other purposes.*

**The bill will:**

- 1. Protect a woman's right to breastfeed or express milk**  
 Clarify the Pregnancy Discrimination Act to ensure that Breastfeeding is protected under civil rights law, requiring that women cannot be fired or discriminated against in the workplace for expressing milk, breastfeeding, or related activities.
- 2. Encourage employers to facilitate lactation**  
 Encourage employers to set up a safe, private, and sanitary environment for women to express milk by providing a tax credit for employers who set up a lactation location, purchase or rent lactation-related equipment, hire a lactation consultant, or otherwise promote a lactation-friendly environment.
- 3. Offer mother's milk breaks to working new mothers**  
 Grant working women breastmilk breaks of up to one hour per day for up to one year following the birth of a child to breastfeed or express milk. This time would be unpaid, and could be taken in 2 or 3 breaks during the day.
- 4. Develop minimum quality standards for breastpumps**  
 Require the FDA to develop minimum quality standards for breast pumps to ensure that products on the market are safe and effective.
- 5. Promote a breastfeeding awareness campaign**  
 Support a campaign aimed at health professionals and the general public to promote the benefits of breastfeeding for infants, mothers, and families.
- 6. Expand WIC's breastfeeding promotion program**  
 Provide increased support for WIC's breastfeeding promotion, education, and support initiative by giving states flexibility in drawing from both the food and NSA (nutritional support and administration) pools of money -- including money from the infant formula rebate -- to be used for breastfeeding support.

*For more information about the New Mothers' Breastfeeding Promotion and Protection Act, please contact Rep. Carolyn Maloney's office at 202-225-7944 or visit [www.house.gov/maloney/](http://www.house.gov/maloney/)*

# High Point Merchants Association

DANNY M. COURTNEY  
PRESIDENT

SHARON C. SMITH  
EXECUTIVE VICE PRESIDENT  
CORPORATE SECRETARY

SANDRA N. ASHBURN  
VICE PRESIDENT

CREDIT BUREAU

COLLECTION SERVICE

RECEIVED

APR 13 1998

LINCOLN CO.  
HEALTH DEPT

A System Affiliate of Equifax Credit Information Services, Inc.

March 31, 1998

Mr. Richard French  
County Manager  
Lincoln County Government  
115 W. Main St.  
Lincolnton, NC 28092

Dear Mr. French:

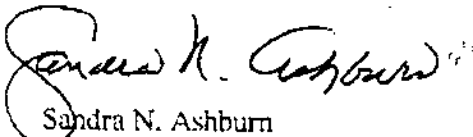
Thank you so much for the signed service agreement, which we received today. We appreciate your giving us the opportunity of providing you with important screening information on your employment applications.

Also, I appreciate Maggie Dollar meeting with me several weeks ago and listening to our presentation. For your information, and as I had indicated to Maggie, we are continuing to work with the North Carolina Association for Home Health along with the Senate Judiciary Committee in an effort to change the law that now says your industry has to perform background checks through the SBI. If we are successful in getting this law changed, the new law will allow you to use either the SBI or a private agency for your background checks. This will certainly be more cost efficient for the agencies because it will eliminate your dual process of investigations.

If you or your staff ever has a question or special need, please let us know. It is very important to us that we provide our clients with excellent customer service and quality information.

We look forward to receiving your first request!

Sincerely,



Sandra N. Ashburn  
Vice President

cc: Maggie Dollar



HAYWOOD COUNTY HEALTH DEPARTMENT  
2177 Asheville Road • Waynesville, North Carolina 28786  
Telephone (704) 452-6675

Robert C. Wood  
Health Director

April 14, 1998

To: Bill Smith

From: Bob Wood

Re: Activities with the WNC Health Network

Thought you might be interested in the activities of the WNC Network and Public Health. Attached is part of the strategic business plan for the Network. The Health Directors feel very good about the position statement and the hospital CEO's commitment for us to be involved in regional network activities and future initiatives.

Cc: Maggie Dollar  
Barry Bass

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THE WESTERN NORTH CAROLINA  
HEALTH NETWORK  
STRATEGIC BUSINESS PLAN

LAST UPDATED APRIL 8, 1998

MISSION

THE WESTERN NORTH CAROLINA HEALTH NETWORK WILL SERVE AS A MECHANISM FOR ITS MEMBERS TO MEET THE CHALLENGES OF THE CHANGING HEALTHCARE ENVIRONMENT IN WESTERN NORTH CAROLINA

VISION

THE WESTERN NORTH CAROLINA HEALTH NETWORK WILL SUPPORT AND COORDINATE THE DELIVERY OF COST EFFECTIVE, QUALITY HEALTH SERVICES FOR THE RESIDENTS OF THE COMMUNITIES SERVED BY ITS MEMBERS.

VALUES

THE CORE VALUES THAT THE WNCHN APPLY TO CONDUCT ITS BUSINESS ARE: A VISIONARY COMMUNITY FOCUS SUPPORTED BY COLLABORATION, INTEGRITY AND RESPECT.

GOAL

WNCHN WILL SUPPORT ITS MEMBERS IN MEETING THE CHALLENGES OF THE CHANGING HEALTH CARE ENVIRONMENT IN WESTERN NORTH CAROLINA

POSITION STATEMENT

THE CHANGING HEALTH CARE ENVIRONMENT IS BRINGING NEW OPPORTUNITIES TO WNC. PUBLIC HEALTH SERVICES ARE A VITAL PART OF THE HEALTH CARE SYSTEM AND MUST BE AN INTEGRAL PART OF ANY FORMAL ORGANIZATION DEALING WITH THE DELIVERY OF SERVICES WITHIN WNC. HEALTH CARE PROVIDERS RECOGNIZE THE VITAL ROLE OF LOCAL PUBLIC HEALTH AND BELIEVE THAT IT SHOULD HAVE A VOICE IN THE FUTURE OF HEALTH CARE IN WNC. THE HEALTH CARE AREA MUST BE AN ENVIRONMENT OF ALL PROVIDERS WORKING TOGETHER TO ADDRESS THE VARIETY OF PROBLEMS AND CONCERNS OF THE COMMUNITY.

**V. CONTINUED DEVELOPMENT OF REGIONAL COMMUNITY BENEFIT INITIATIVES**

**OBJECTIVE:** The WNHCHN will continue existing initiatives and evaluate new regional programs/services to serve both its member organizations and the communities they serve.

**STRATEGY:** Service the region's health needs from health provider resources within the region.

<u>ACTION</u>	<u>COST</u>	<u>TIME FRAME</u>	<u>SUCCESS INDICATOR</u>	<u>PARTY RESP.</u>
Establish a mechanism for prioritizing community benefit initiatives for the Network using the community diagnoses reports from each health department, and using the Tri-County 2000 model.		Work group established 3 <sup>rd</sup> quarter 97/98. Mechanism approved 1 <sup>st</sup> quarter 98/99	Work group established. Mechanism approved by the Network	ED and Work Group Leader
Provide an advocacy role regarding state allocation of funds for public health. Evaluate options for a Network dental project		Quarterly beginning 4 <sup>th</sup> qtr 97/98 Work group established 3 <sup>rd</sup> quarter 97/98. Project approved 4 <sup>th</sup> quarter 97/98 Ongoing	Report of advocacy efforts made quarterly Work group established. Project approved.	Bob Wood & Peggy Cook  Peggy Cook & Work Group Leader
Evaluate the impact of mobile mammography services in the region, need for multiple units, continuous improvements in the operation of the program.			Report on the Program to the CEOs 3 <sup>rd</sup> quarter	Cara Andrews
Expand current mobile mammography services by 12 scheduled hours Continue collaboration with the Rural Primary Care Network by:		3 <sup>rd</sup> qtr 97/98	Services expanded.	Peggy Cook
<ul style="list-style-type: none"> <li>Develop an educational document explaining the recruitment / retention components of the RPCN and how each local medical community (LMC) can access &amp; support it</li> <li>Explore opportunities within the AHEC system to share resident names &amp; addresses with LMCs for recruitment purposes</li> </ul>	To Be Determined	3 <sup>rd</sup> quarter Apr/May/June	Document developed by June 1 <sup>st</sup>	Jackie Hatlum
	None	June '98	Topic on the AHEC director's agenda	Teck Penland
Support the evaluation of a mobile MRI project for Network members		3 <sup>rd</sup> quarter	Follow-up report with conclusions submitted.	Peggy Cook

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SENT BY THE HEALTH DEPT, 3-8-98 1:42PM, 7047329034 -- 910 570 6746; #9/10

# A Newsletter for the

# WNC HEALTH NETWORK

*Providers Working Together*

**April 1998**

This first newsletter identifies the many people involved in Network activities. Information will be provided on specific groups in future issues.

## Board Of Directors

### Angel Medical Center

Michael E. Zuliani, II CEO (WNCHN Secretary)

### Community CarePartners

Charles D. Norvell, CEO

### District Memorial Hospital

Dan C. White, CEO

### Haywood Regional Medical Center

David O. Rice, Sr, President

### Highlands-Cashiers Hospital

Jack Calloway, President and CEO

### Margaret R. Pardee Memorial Hospital

Frank J. Aaron, Jr., CEO

### Mission St. Joseph's

Robert F. Burgin, President and CEO

### Mission St. Joseph's

David S. Spillers, SVP (WNCHN Treasurer)

### Murphy Medical Center

Mike Stevenson, CEO

### Park Ridge Hospital

Michael V. Gentry, President

### Rutherford Hospital

Robert D. Jones, CEO

### St. Luke's Hospital

C. Cameron Highsmith, President

### The McDowell Hospital

Jeffrey M. Judd, CEO

### Transylvania Community Hospital

Robert J. Bednarek, CEO (WNCHN Chairman)

### WestCare Health System

Mark Leonard, Administrator

## AFFILIATE MEMBERS

### Mountain Area Health Education Center (MAHEC)

Teck Pealand, President and CEO

### Western Region Health Department

Robert Wood, Director



Education & Awards Committee  
Meeting Minutes  
April 21, 1998

The annual Spring Workshop was held on April 21-22 at the North Raleigh Hilton. The theme this year was "Leadership In the Next Millenium".

NACCHO Scholarship winners for financial assistance to attend the annual NACCHO Conference in St. Louis were announced:

Anson County	-	Marc Coleman \$1000
Richmond County	-	Tommy Jarrell \$1000
Warren County	-	Dennis Retzlaff \$950

Health Director of the Year Award - Nomination forms on NCALEDWEB Page. Please forward nominations to Education & Awards Committee as soon as possible. Deadline 6/30/98.

The Committee has requested a retirement clock for Tom Johnson, Henderson County. Please let our committee know of any others.

Wayne Raynor - Chairman

**North Carolina Association of Local Health Directors  
Environmental Health Committee  
April 20, 1998**

1. **Call to Order:** The monthly meeting of the Environmental Committee was called to order at 1:00 p.m. by Mimi Cooper, Chairperson.
2. **Announcements and Introductions:** Ms. Sewall introduced Mr. Ken Carter the EHS Coordinator from Guilford County Health Department.
3. **Attendance:** See attached Attendance Roster.
4. **Old Business:**
  - A. **Environmental Review Commission Meeting (ERC) Update:** Ms. Gibson shared with the committee that the EHS Supervisors' Association had formed a group (like the White Paper Committee) to put together a presentation for the ERC. They had met in conjunction with the Septic Tank Installers and agreed to continue to meet and try to formulate their presentation. Ms. Sewall also shared that Mr. Lancaster had briefed the ERC on the "stakeholders' meeting" and asked that they (ERC) give the divisions more time to study the subject and make a proposal. Ms. Sewall said that the division was looking to volunteer to host an expanded "stakeholders" group to make a proposal also. She said the hang up appears to be the combining and realignment of several commissions and how the new structure should look. The ERC did not respond to Mr. Lancaster's presentation, but is expected to make a determination May 4<sup>th</sup>. The Committee agreed to take no action until we see which way the ERC goes. (Open, All)
  - B. **Local Well Ordinance:** Ms. Cooper reminded the Committee that last meeting Mr. Johnson had raised the question about whether we should just wait for the State to act on this or should we (EHS Committee) take a lead role. Mr. Johnson had been concerned that the State might pass an ordinance that would be weaker than the one Henderson County already had. Mr. Pierce offered that nothing precluded the Counties from having stronger ordinances as long as we met the requirement of the State Ordinance. Ms. Sewall stated that there were about 22 Counties that already had ordinances and that there was a lot of variance. Some are weak and some are strong. She said she agreed with Mr. Pierce's position that the Counties should start with the State Statute and work from there. Thus some could maintain their stricter requirements, but weaker ones would have to bring theirs in line with the State's. The idea that this was an unfunded mandate was discussed. While everyone agreed that the \$10,000 seed money included was not enough to run a program, at least it was a start. This coupled with an allowable fee was supposed to defray the cost of establishing a local well program. The group agreed that even with the doubts offered, a mandated program would force

Counties to take some action. Ms. Cooper spoke of the advantages of having an ordinance and the benefits of just meeting its minimal requirements.

The Committee agreed that there were several questions that needed to be answered before they could decide on whether to support such a State requirement. They are:

1. What Counties already have ordinances or inspection programs?
2. How much revenues do existing programs generate and will it be enough to support a program?
3. How do Counties who do not have an ordinance feel about the proposed State requirement to have a program?

Mr. Pierce offered that there was no incentive under the current system to build to standards as only a fraction of those presently being built will ever require upgrade. Thus, the installers are saving money by not building to standard. Ms. Sewall suggested that the "Installers' Certification" requested last year would have put some emphasis on doing the work right, but that it had not been approved by the Legislature. (Open, All)

- C. Shellfish Consumer Advisory Update:** Mr. Rhodes distributed copies of the Consumer Advisory Sign that is now required to advise customers of the dangers of consuming raw shellfish. He noted that there has been some discussion of how the requirement is going to be enforced and that this is still being discussed. He further stated that he did not feel there would be any resistance from permitted establishments to putting up the signs and that Counties would be responsible for enforcing the rule in restaurants only. Ms. Gibson asked if we (Counties) would be responsible to educate about the requirement and then enforce the rule without it being on the inspection sheet. Mr. Rhodes answered yes. Ms. Sewall offered that if this becomes a problem the division will consider adding the requirement to the grade sheet or possibly put an administrative penalty in place. (Info)
- D. Quality Improvement Committee (QIC):** Mr. Rhodes informed the Committee that the division was getting its Quality Improvement Committee up and running. He said that the division would be contacting the Directors' Association asking that two directors be assigned to serve. He added that there had been directors assigned in the past but that support/attendance had been sporadic at best. Mr. Rhodes emphasized that the division needs someone who is going to be there. Mr. Rhodes also stated that the division was looking at putting EHS Staff on some of our Association subcommittees (i.e. Technologies) when our goals and theirs were similar so that our efforts could be married instead of redundant. Ms. Scott offered to serve if no one else was interested. Ms. Cooper said she would check with those already assigned to see if they were still interested before identifying replacements. (Open, Ms. Cooper)

**5. New Business:**

**A. Pureflow System:** The Committee reviewed a letter from Mr. Jim Boehm of Gates County regarding the Pureflow System. Mr. Boehm's letter stated that Gates County had studied the system for a year and that Steve Berkowitz had drafted rules from the State to allow Pureflow to be used as an "innovative system." The system treats the effluent and thus may require less drain lines and may be placed closer to ground water sources. However, this must be evaluated by a soil scientist if the site is not totally suitable. The Committee agreed not to act on this as Ms. Sewall informed them that the rules were just days away from being passed anyway. (Closed)

**5. Environmental Health Division Report:** Ms. Sewall offered the following report:

**A. Outdoor Experiences:** The division had recently heard from a man in the western part of the state who complained that he knew of people who were living in tents, drinking creek water, etc. He was concerned because he had been "Shut down" because he did not have clean water, etc. Ms. Sewall wondered if the division and local public health should not be doing something in such situations where people were paying to experience the outdoors. She noted that people who participate in such experiences often sign away their liability in case of injury, but still had a right to safe food and drinking water. The group discussed numerous ways of controlling such activities in the hopes of identifying a way that was not impossible for health departments to carry out or too demanding on those initiating the activities. The Committee felt that with the wide variety of experiences, the wider variety of risks and the lack of documented illnesses that this should not be dealt with by rules formation. All in attendance agreed that these experiences should be dealt with on a case-by-case basis. (Closed)

**B. Well Setback Discussion:** Ms. Sewall noted that the division had left the 25 foot to 10 foot setback change off in one place in the new rules. This mistake had been seen as "underhanded" and a move to not carry out the mandate to change the setback by others. From that, the Joint Legislative Administrative Procedure Oversight Committee (JLAPOC) then proposed applying these rules to other establishments (i.e. Bed and Breakfasts), questioned what a "foundation" was, etc. The JLAPOC felt that if the proposed change could be applied to foster homes, then it should be applied to others so that the division is not seen as "anti-business." This is still being looked at and Ms. Sewall will keep the Committee informed of the outcome. (Open, Ms. Sewall)

**7. Other:** N/A

**8. Adjournment:** The meeting was adjourned at 4:00 p.m.

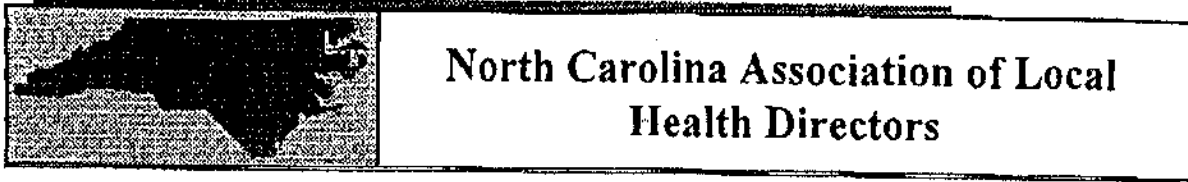
Environmental Health Committee  
Attendance Roster - 1998

NAME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Cooper	X	X	X	X								
Pierce	X	X	X	X								
Johnson	X	X	X									
Womble												
Crouse												
Kirtsey		X	X									
Garrett												
Brown				X								
Urland	X	X	X									
Yeasey	X	X	X	X								
Scott		X		X								
Sherman	X											
Ring			X									
Jones												

X = In Attendance

Blank Space = Absent

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**NCALHD 1998 Calendar of Events**

February	February 19, 1998 at 9:00am, Wake County Public Health Center, Board Room, 10 Sunnybrook Road, Raleigh
March	March 19, 1998 at 9:00am, Brownstone Hotel, 1707 Hillsborough Street, Raleigh
April	April 21, 1998 at 8:30am, North Raleigh Hilton
May	May 20, 1998 at 10:00am, Holiday Inn Select, off I-40, Hickory
June	June 18, 1998 at 9:00am, Wake County Commons, 4001 Cary Drive(off Poole Road), Raleigh
July	July 16, 1998 at 9:00am, Wake County Commons, 4001 Cary Drive(off Poole Road), Raleigh
August	August 20, 1998 at 9:00am, Wake County Public Health Center, Board Room, 10 Sunnybrook Road, Raleigh
September	September 17, 1998 at 9:00am, Holiday Inn Bordeaux, Fayetteville, NC
October	TBA
November	November 19, 1998 at 9:00am, Wake County Commons, 4001 Cary Drive(off Poole Road), Raleigh
December	December 17, 1998 at 9:00am, Wake County Public Health Center, Board Room, 10 Sunnybrook Road, Raleigh

**BACK** to

N.C. Association of Local Health Directors Home Page.

Go To the top of the page.

**Designed and Created by Russell Jones**



Send to [Ricnes.pchd@copson02.dhr.state.nc.us](mailto:Ricnes.pchd@copson02.dhr.state.nc.us)

*EH usually meets day before meetings.*

(30)

**TO :** All Health Directors

**FROM :** Louis Latour, PhD  
North Carolina Alliance of Public Health Agencies  
President

**DATE :** April 16, 1998

**RE :** NCAPHA Membership

Starting this fiscal year 1998-99, we are venturing into a new era in the growth of what has been referred to as "The Alliance". It will be the year when we look beyond the home health part of our operations and broaden our sights on positioning the whole health department for the future in a new health care market.

We started by binding together the public home health agencies across North Carolina to forge a unified effort to cope with the changing health care environment. From just a few agencies we have grown to encompass all the public agencies in our State. In the process of growth, we have broadened our services for members to include marketing and personnel services. These actions, over the few years of our existence, have been beneficial to members in order to increase efficiency and consistency; exchange ideas and information; plan for better state-wide marketing presence; deal with market forces; benchmark our services for managed care contracts; establish group purchasing arrangements; and increase visibility state-wide.

Home Health has had to make the shift from an "open door, sensitive provider" approach to one that is more business oriented. Although our focus has been on providing services, we will need contracts in place to assure our market share and payment for services. In the very near future, Medicaid and Medicare recipients will be choosing what HMO will manage their care. In order for agencies to assure that patients are receiving quality health care as well as health promotion, they will need to be on many provider lists. The Alliance has Staff to devote to marketing our services to managed care companies and make sure that the 'The Alliance' is on the provider's list. Beyond this point, 'The Alliance' gives counties a chance to help each other in many new and innovative ways. For Public Health to survive, we must change the way we do business.

We are now to the point of broadening the Alliance to encompass health departments, providing clinical services, that do not necessarily provide home health services. In these times of increased sensitivity to a growing competitive environment, we need a unified voice that is stronger than any one county can provide. Although we may have our particular differences, we are basically alike through our 'Public Health' philosophy. I urge you to become a member of the *North Carolina Alliance of Public Health Agencies* to give your agency a head start in the Health Care Industry.

**Dear Health Director :**

**These are some 'talking points' which you can use to incorporate in letters to your Congressional Legislators. Please take the time to write and inform them.**

- \* A lot has happened in Home Health since FY 1993-94 (the year that HCFA is using for IPS)**
- \* Public agencies have kept cost low ... which will hurt them with the IPS proposal**
- \* Patients needing highly technical skills for longer periods of time will fall to public agencies (no one will want them or afford to care for them)**
- \* IPS (Interim Payment System) will penalize efficient / low cost agencies**
- \* Visit utilization in home health has fluctuated very little over the past several years**
- \* Per beneficiary limits will be an incentive to "dump" patients to public providers**
- \* IPS violates the constitutional rights of the elderly to access home care services (law suites have already been filed against HCFA)**
- \* Delay implementation of IPS and correct inequities in payment to Home Health Agencies**
- \* An estimated 93 % of all home health agencies will be reimbursed less than their cost if IPS is implemented ... 58 % by the aggregate per-beneficiary limit and 35 % by the per-visit cost limit**
- \* The reduction in visits per patients under the pressure of cost reductions could lead to worse outcomes**
- \* IPS, according to recent 'Lewin Study', may :**
  - compromise access to care for high intensity patients**
  - reduce the quality of home care services**
  - result in shifting of care to inappropriate settings, i.e. nursing facilities**
  - increase beneficiaries out-of-pocket expenses**

Congressional Representatives / Senators

This letter is sent to solicit your support for the repeal of the *Interim Payment System* (IPS) proposed by the Health Care Financing Administration (HCFA) for Medicare home health services. This proposal will change the cost reimbursement system from one where all agencies in the country are subject to a single limit on costs per visit to a system with approximately 9,500 limits on costs per beneficiary. A different beneficiary limit for every home health agency in the Country would be very cumbersome.

Data from HCFA indicates that home health utilization in North Carolina is the lowest among the Southeastern and Southwestern states and is also well below the national average. The IPS approach bases figures on 1993-1994 costs per beneficiary. A lot has changed since that time !

The IPS approach, as presently proposed by HCFA, would have a very significant impact on home health care in North Carolina. The states with traditionally low cost per patient, like North Carolina, will have a much lower limit on the services they can receive under Medicare compared to states with traditionally higher costs per beneficiary.

A more equitable plan would be to reimburse agencies in the same region based on average cost. This would be a better cost containment plan than is presently proposed in HCFA's plan. Public agencies who traditionally have maintained low cost will be penalized under IPS while private companies, who had inflated cost in 1993-1994, will profit. This seems to defeat the purpose of containing cost. A per beneficiary limit of visits will be an incentive for companies not to accept highly technical patients. These will then fall on public agencies who historically have never turned down patients, but should be reimbursed for the care provided.

Home health care, in North Carolina, has been run effectively and efficiently for many years. This proposal would definitely penalize those that have worked so diligently to provide quality care at conservative cost.

Congressional Representatives / Senators

This letter is sent to solicit your support for the repeal of the *Interim Payment System (IPS)* proposed by the Health Care Financing Administration (HCFA) for Medicare home health services. This proposal will change the cost reimbursement system from one where all agencies in the country are subject to a single limit on costs per visit to a system with approximately 9,500 limits on costs per beneficiary. A different beneficiary limit for every home health agency in the Country would be very cumbersome.

Data from HCFA indicates that home health utilization in North Carolina is the lowest among the Southeastern and Southwestern states and is also well below the national average. The IPS approach bases figures on 1993-1994 costs per beneficiary. A lot has changed since that time !

The IPS approach, as presently proposed by HCFA, would have a very significant impact on home health care in North Carolina. The states with traditionally low cost per patient, like North Carolina, will have a much lower limit on the services they can receive under Medicare compared to states with traditionally higher costs per beneficiary.

A more equitable plan would be to reimburse agencies in the same region based on average cost. This would be a better cost containment plan than is presently proposed in HCFA's plan.

Home health care, in North Carolina, has been run effectively and efficiently for many years. This proposal would definitely penalize those that have worked so diligently to provide quality care at conservative cost

# NORTH CAROLINA ASSOCIATION of LOCAL HEALTH DIRECTORS

*An Affiliate of the North Carolina Association of County Commissioners*

April 21, 1998

Dear Colleague:

The N.C. Association of Local Health Directors in conjunction with HealthQuest, Inc., will hold a one day retreat on the **VISION for PUBLIC HEALTH in NORTH CAROLINA** to be held on Thursday, May 14, 1998 in Meeting Rooms 1 & 2 of the Forsyth County Health Department in Winston-Salem, N.C. from 10:00 AM until 4:00 PM.

The meeting will be facilitated by Linde Howell, President, HealthQuest Consulting, Inc. We will use lap-top computers to take us through a process determining recommendations and adjustments to models presented using Group Systems software.

The purpose of the retreat will be for local health directors and managers from the Division of Health Services, DHHS, to evaluate models for the delivery of public health services, and to develop strategies to evaluate the models presented. We should be working towards consensus in developing the most appropriate models for North Carolina.

**WE NEED FOR EACH AND EVERY HEALTH DIRECTOR IN NORTH CAROLINA TO PARTICIPATE IN THIS PROCESS!**

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To register please complete and forward the following registration, by mail, fax or e-mail by May 8 to:

Barry Bass  
1000 North First Street, Suite 3  
Albemarle, N.C. 28001

Courier: 05-94-09

Fax: 704-982-8354

E-main: SHEALTHDEPT@ctc.net

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Map To The  
**Forsyth County**  
**Health Department**

799 N. Highland Ave.  
 Winston-Salem, NC 27102

**From US 52**

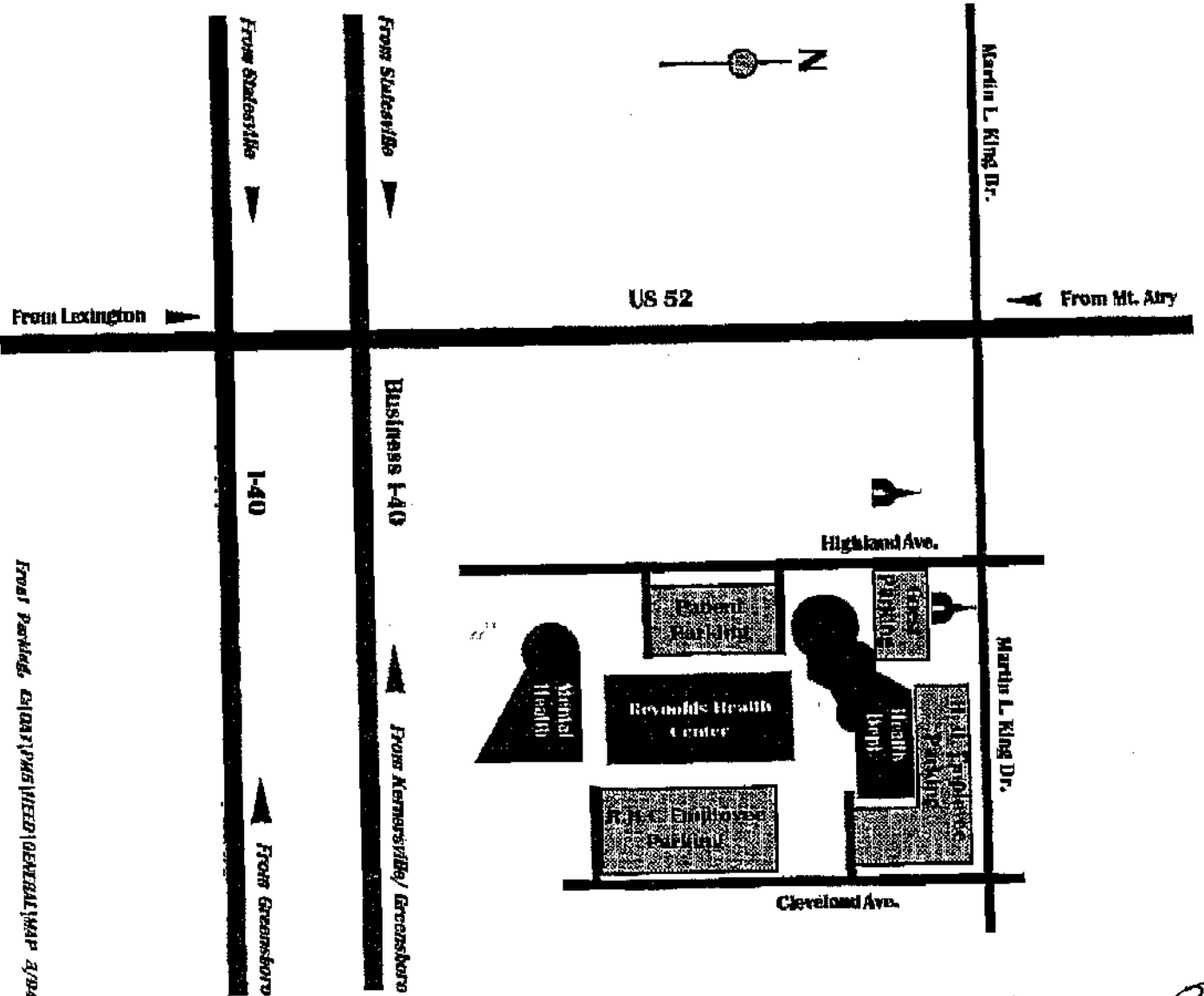
- From Mt. Airy**
  - Take M. L. King Dr. exit off US 52 South
  - Turn left onto M. L. King Dr.
  - Turn right onto Highland Ave.
  - Health Department on left

- From Lexington**
  - Take M. L. King Dr. exit off US 52 North
  - Turn right onto M. L. King Dr.
  - Turn right onto Highland Ave.
  - Health Department on left

**From I-40/Business I-40**

- From Statesville**
  - Take Airport/US 52 North exit
  - Take M. L. King Dr. exit off US 52 North
  - Turn right onto M. L. King Dr.
  - Turn right onto Highland Ave.
  - Health Department on left

- From Greensboro**
  - Take Airport/US 52 North exit
  - Take M. L. King Dr. exit off US 52 North
  - Turn right onto M. L. King Dr.
  - Turn right onto Highland Ave.
  - Health Department on left



From Parking, CLARIFYING VIEW | GENERAL MAP 3/94

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**HealthQuest Consulting**

P.O. Box 3783  
9463 E. Arbor Drive  
Englewood CO 80155-3783

Invoice submitted to:  
Mr. J. Barry Bass  
Stanly County Health Department  
1000-3 North First Street  
Albemarle NC 28001

April 3, 1998

Invoice # 10087  
Federal Tax ID#:  
84-1418364

**Professional services**

	<u>Hrs/Rate</u>	<u>Amount</u>
3/1/98 Environmental Assessment-25% of fees		6,685.50
For professional services rendered	0.00	\$6,685.50
<b>Additional charges:</b>		
3/24/98 Parking		10.00
Airfare		292.33
Cpying and Printing		47.41
Total costs		\$349.74
Total amount of this bill		\$7,035.24

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Mr. J. Barry Bass

Page 2

Amount

Balance due

\$7,035.24

*Payable upon receipt*