

**NCALHD ATTENDANCE ROSTER
AUGUST 10, 2000**

| |
|--------------------------------|
| E = Executive Committee Member |
| R = Regional Representative |
| M = Dues Paying Member |

Initial County/Health Director

Initial County/Health Director

MG Alamance/Tim Green
 _____ Alexander/Shelley Carraway
 _____ Anson/James Roosen
 _____ Appalachain Dist/Danny Staley
 _____ Beaufort/Roxanne Frederick
WTF Bertie/Ron Freeman
 _____ Bladen/Myra Johnson (M)
 _____ Brunswick/Don Yousey
DLH Buncombe/George Bond (R)
DLH Burke/David L. Rust
DLH Cabarrus/Dr. William Pilkington
DLH Caldwell/Douglas W. Urland
 _____ Carteret/Dr. J.T. Garrett
 _____ Caswell/Vacant
 _____ Catawba/Barry Blick
WJ Chatham/Wayne Sherman (M)
WJ Cherokee/Elaine Russell
 _____ Clay/Janice Patterson
 _____ Cleveland/Denese Stallings
 _____ Columbus/Marian Duncan
 _____ Craven/Wanda Sandele
DMZ Cumberland/Dr. Janet Lindbloom
 _____ Currituck/John B. Sledge
AT Dare/Anne B. Thomas
 _____ Davidson/Diane Crouse
WBS Davie/Barry Bass
 _____ Duplin/~~Dr. Harriette Duncan~~
 _____ Durham/Brian Letourneau
WBS Edgecombe/James Baluss
 _____ Forsyth/Sherman Kahn, MD (M)
 _____ Franklin/Keith Patton
WBS Gaston/Bruce Parsons (E, R)
 _____ Graham/Marlene Orr
 _____ Granville-Vance Dist/Rodwell Drake, MD
 _____ Greene/Douglas Harr, PhD
HG Guilford/Harold Gabel, MD (R)
CMS Halifax/Chris Szwagiel, PhD
WNT Harnett/Wayne Raynor
 _____ Haywood/Robert Wood
WNT Henderson/Tom Bridges
CD Hertford-Gates Dist/Curtis Dickson
 _____ Hoke/Donald Womble
 _____ Hyde/Linda Mayo
AR Iredell/Raymond Rabe
 _____ Jackson/Randall Turpin
 _____ Johnston/L.S. Woodall, MD
 _____ Jones/Ruth Little
 _____ Lee/Mike Hanes

_____ Lenoir/Joel Huff
 _____ Lincoln/Margaret Dollar
 _____ Macon/Ann Hyder
 _____ Madison/Ken Ring
WCB Martin-Tyrrell-Wash Dist/~~Russ Childers~~ DIANNE BRADSHAW
 _____ Mecklenburg/Peter Safir
 _____ Montgomery/Kathleen DeVore-Jones
 _____ Moore/Robert Wittman
 _____ Nash/William Hill, Jr.
 _____ New Hanover/David Rice
JRO Northhampton/Sue Gay, Acting
JRO Onslow/George O'Daniel
LES Orange/Dr. Rosemary Summers (M)
 _____ Pamlico/Jenny Lassiter
 _____ PPCC Dist/Howard Campbell
 _____ Pender/Jack Griffin, PhD
 _____ Person/Marc Kolman
 _____ Pitt/John Morrow, MD (R)
 _____ Randolph/Mimi Cooper (M)
 _____ Richmond/Tommy Jarrell (M, E)
LS Robeson/Bill Smith
 _____ Rockingham/Glenn Martin
WNT Rowan/Leonard Wood
 _____ Rutherford-Polk-McDowell Dist/Joyce Sluder
 _____ Sampson/John Rouse
 _____ Scotland/Curtis Holloman
WJ Stanly/Jim Jones
 _____ Stokes/Colleen Bridger
 _____ Surry/Walter Linz, MD
 _____ Swain/Emma Waldroup
 _____ Toe River Dist/Tommy Singleton, Acting
 _____ Transylvania/Terry Pierce
 _____ Union/Lorey White, Jr.
WJ Wake/~~Paula Williams, Acting~~ GIRBIE HARRIS
 _____ Wayne/Kevin Watkins, MD (M)
 _____ Warren/Mildred Battle, Acting
 _____ Wilkes/Beth Lovette
W Wilson/Dr. Louis Latour
 _____ Yadkin/Gayle Brown (M)
SW Susan Smith-Wharton, NCALHD Exec. Dir.

NCALHD ATTENDANCE ROSTER
AUGUST 10, 2000

OTHERS IN ATTENDANCE

Lee Kyle Allen ANCBH CRAVEN County
Ann Vance DHHS/DPH/LHS

Shirley Bullard UNC Institute of PH
Susan Mory DHHS/DPH/SVS

Beth Rowe West DHHS/DPH/Immunization

Ed Rye
Steve Dine N.C. Assoc. of Co. Comm.
Stephen P. Keevan DHHS/DPH/Epi
Meddenburg Co. H.D.

Jill Malone IDG

~~Anna Thomas~~ ~~DCI/County HD~~

Caerene Rocco ANCBM

Joy Reed DPH/LHS/PHNPD

Nebash Rame NCPNA

**North Carolina Association of Local Health Directors
Treasurer's Report
July 26, 2000**

| | Checking | Savings | Money Market | CD |
|--|---------------------|-----------------|---------------------|---------------------|
| Account Balance Brought Forward | \$ 30,909.47 | \$ 34.04 | \$ 325.54 | \$ 40,000.00 |
| Receipts: | | | | |
| Interest Payments: | | | | |
| May 2000 | \$ 97.83 | | | |
| June 2000 | \$ 82.13 | \$ 0.10 | \$ 1.38 | |
| Federal Back-up Withholding: | | | | |
| May 2000 | \$ (31.46) | | | |
| June 2000 | \$ (30.33) | \$ (0.03) | | |
| Maintenance/Service Fee: | | | | |
| May 2000 & June 2000 | \$ (2.00) | | | |
| Deposits: | | | | |
| Transfer from Checking | | | | |
| Transfer from Money Market | | | | |
| Transfer to Checking (interest From Certificate): | | | | |
| May 2000 | \$ 188.53 | | | |
| June 2000 | \$ 194.81 | | | |
| Dues | \$ 1,026.17 | | | |
| Total | \$ 32,435.15 | \$ 34.11 | \$ 326.92 | \$ 40,000 |
| Total Expenses | | | | |
| 0829 Tom Bridges | \$ 361.19 | | | |
| Airline Ticket – NACCHO | | | | |
| NC PH Alliance | \$ 2,698.10 | | | |
| May salary–Susan S. Wharton | | | | |
| Total Expenses | \$ 3,059.29 | | | |
| Account Balance as of 07/13/00 | \$ 29,375.86 | \$ 34.11 | \$ 326.92 | \$ 40,000.00 |

**Health Directors' Legal Conference
October 18-19, 2000
Friday Center, Chapel Hill**

Agenda

Wednesday, October 18

- | | |
|---------------|---|
| 8:00 | Registration & Continental Breakfast |
| 9:00 – 9:45 | Legislative Update Chris Hoke, Deputy State Health Director |
| 9:45 – 10:45 | Meetings: Your Frequently Asked Questions Answered Fleming Beil, Institute of Government |
| 10:45 – 11:00 | Break |
| 11:00 – 12:00 | Civil Liability of Health Department Employees Anita Brown-Graham, Institute of Government |
| 12:00 – 1:00 | Lunch |
| 1:00 – 2:30 | Law of Communicable Disease Control: Follow-Up on Issues from Spring Summit John Barkley, Assistant Attorney General Judy Owen-O'Dowd, Field Services Branch, HIV/STD Prevention & Care |
| 2:30 – 3:00 | Break |
| 3:00 – 4:30 | Communicable Disease Control continued |

Thursday, October 19

- | | |
|---------------|---|
| 8:00 | Continental Breakfast |
| 9:00 – 10:15 | Local Health Directors' Imminent Hazard & Public Health Nuisance Authority Milton Heath, Institute of Government |
| 10:15 – 10:30 | Break |
| 10:30 – 12:00 | Serving the Hispanic/Latino Community: Legal and Cultural Issues Jill Moore, Institute of Government Speaker from the North Carolina Center for International Understanding |
| 12:00 – 1:00 | Lunch for NCALHD members (pay separately) |
| 1:00 | Meeting of the NCALHD |

Moore, Jill D

From: Moore, Jill D
Sent: Tuesday, August 01, 2000 2:37 PM
To: 'dennis.harrington@ncmail.net'
Subject: Contracts & MOUs

Dennis,

I talked to Frayda Bluestein, the Institute's contracting expert, about your question. (Frayda is currently on maternity leave but was kind enough to take a phone call from me; unfortunately it will be late August before she is available for more extensive conversations about this subject).

I asked Frayda when an agency should use a contract and when a MOU might be sufficient. She said, the key distinction between a contract and a MOU is that a contract is legally binding and enforceable and a MOU is not. Therefore, any time an agency wants to be able to enforce the terms of an agreement, the agreement should be in the form of a contract. A MOU is non-binding and should not be used when enforceability is important, but it might be a useful document in some circumstances—for example, when the agreement is internal within the department or within a county, or when the purpose of the MOU is simply to memorialize agreements about a policy or procedure. Whenever you want to be able to legally hold the other person to the terms of the agreement, however, it needs to be in the form of a contract.

I asked Frayda if there was boilerplate language available for health directors to use in their contracts. She said there is not. She also agreed that this can be a real problem for agencies that don't have an attorney available to review every contract they enter. She had the following suggestions for health directors who find themselves in this situation:

- Make an appointment with the county attorney to discuss the issue of contracts generally. Let the attorney know what kinds of contracts the health department enters and how (and by whom) those contracts are written. Take some sample contracts and show them to the attorney. Ask the attorney if there is specific boilerplate the county likes to use in its contracts (preferences for boilerplate can vary from attorney to attorney and from county to county). Ask the attorney to help develop boilerplate for issues that are frequently addressed in your contracts.

- Local health departments could share copies of contracts they use with each other. It might be useful to provide a forum for the health directors to consolidate this information—perhaps the NCALHD could help with this.

- An excellent resource is the book, "Service Contracting: A Local Government Guide," which is put out by the International City/County Management Association. It discusses the issues in contracting and provides some boilerplate language. You can order the book from their website, www.icma.org.

I asked Frayda if there was any possibility of the Institute getting involved in developing model contracts for local agencies. She said this is something she has thought about in the past, but she has not been convinced it would be feasible to do. Apparently there are more variables that commonalities among local government agencies that make it a difficult task. She said she would be willing to discuss this further when she returns to work this fall.

I realize this is not a complete solution to the issue you raised, but I hope it is at least somewhat helpful. Please let me know if you have any questions about anything I've written here. Meanwhile, I will make a note to myself to discuss this issue with Frayda further when she returns to work.

Hope you are doing well.

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NORTH CAROLINA ASSOCIATION of LOCAL HEALTH DIRECTORS

An Affiliate of the North Carolina Association of County Commissioners

September 4, 2000

Mr. Jim Blackburn, General Counsel
N.C. Association of County Commissioners
P.O. Box 1488
Raleigh, North Carolina 27602-1488

Dear Mr. Blackburn:

On behalf of the N.C. Association of Local Health Directors (NCALHD) I would like to share with you our legislative issues for the 2001 legislative session and respectfully request your consideration and active support of these items. Adopted by our Executive Committee on August 10, 2000 they follow in priority order:

1. Reunite at the state level the Department of Environment and Natural Resources Division of Environmental Health with the Department of Health and Human Services Public Health Division. Probably no issue in the past five years has stirred our association to the extent this one has. The enclosed resolution and accompanying table indicate the widespread support of boards of health and commissioner boards that have adopted this resolution. Also, please find enclosed a "white paper" document dated 11/4/97 that will provide further background on this issue.
2. \$15.0 million to fund local core and essential public health services including assessment, policy development and assurance of services as outlined in the enclosed table. Included also in this funding would be a thirteen county tier one demonstration project. An executive summary of this project is enclosed. There has been no substantial infusion of state funding toward local public health since the early 1970's.
3. \$3.75 million to continue Healthy Carolinian funding to support local partnerships, mobilize resources to address North Carolina's Health Objectives for 2010, to coordinate county level assessment and health and safety initiatives. Jim, as you know the NCACC and NCALHD joint support of the Healthy Carolinians project last session proved very effective in securing this much needed funding.
4. It is generally recognized that computer technology is one of the crucial foundations for efficient and effective operation of any large system of human service delivery programs. There are now more than twenty-five distinctly different, fragmented public health information systems employed in providing

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and managing public health services among the county health departments and developmental evaluation centers across the state. The NCALHD supports and will actively pursue the development of a joint state/local public health management information system with technical and management responsibilities lodged with the state. Please see the enclosed background statement regarding this number 4 priority.

5. Concentrated Animal Feedlot Operation (CAFO) to be recognized as a business rather than as an agricultural operation. Jim, this legislative goal is more specifically stated in the enclosed resolution adopted May 2, 2000 by the NCALHD.

The NCALHD and the NCACC have enjoyed a longstanding, effective working relationship reflective of a strong spirit of mutual respect. It is through our concerted joint efforts that we can expect to see our shared goals continue to materialize.

Jim, thank you for your time, attention and support to the NCALHD's legislative goals for 2001.

Sincerely,



Tim Green
Chairman, Policy and Planning Committee

Enclosures

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NORTH CAROLINA ASSOCIATION of LOCAL HEALTH DIRECTORS

An Affiliate of the North Carolina Association of County Commissioners

North Carolina Association of Local Health Directors Legislative Goals and Priorities 2001

1. Reunite at the state level the Department of Environment and Natural Resources Division of Environmental Health with the Department of Health and Human Services Public Health Division
2. \$5.0 million to fund local public health services including assessment, policy development and assurance relative to essential and core public health services
3. \$3.75 million to continue Healthy Carolinian funding to support local partnerships, mobilize resources to address NC's Health Objectives for 2010, to coordinate county level assessment and health and safety initiatives. A cash or in-kind local match would likely be required.
4. Thirteen County (Tier One) Demonstration Project for funding Core Public Health Functions and Essential Services--\$2.0 million over four years.
5. Concentrated Animal Feedlot Operations (CAFO) to be recognized as a business rather than as an agricultural operation

6. Technology (Partnership w/ State): "Public Health Information System"

8-10-00
Add'l
@ NCAHLD
M King

August 7, 2000



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**MANAGED CARE AND REIMBURSEMENT COMMITTEE
NCALHD**

Date: August 10, 2000

Attendees: Health Directors – Barry Bass, Tim Green, Leonard Wood, Bill Smith
State Representatives – Joy Reed, Chris Hoke,
NCALHD/Alliance Exec. Director Susan Smith-Wharton

Action:

NCALHD requests that the Intra-agency Agreement between Public Health, Early Intervention, IRM, DMA and Controller's Office contain language that states that the Controller's Medicaid Reimbursement Staff will "provide the necessary cost analysis *on an annual basis* to support reimbursement rates established for *all Medicaid reimbursed services provided by the local health departments and DEC's.*" (Italicized wording is added to the original draft). Additionally wording in another section would state "conduct *annual cost determination activities.*"

Rationale: Carol Chandler and Stephen Gardner (who handle the cost settlement activities for LHD) have been moved from Public Health to the Controller's Office. While there have been no priority conflicts since this move occurred, the concern is that if the analysts or Dennis Harrington change, there might be a philosophical change which could impact the annual settlement activities. It was noted that these positions were established using aid to county money with a 50% Medicaid match. By including this wording, we can be assured that the settlement and analysis activities are done in a timely fashion.

Information:

CDT coding – dental coding begins October 1, 2000. Local training is scheduled over PHTIN September 5 (1:00 to 4:00) and September 19 (9:00 to 12:00) for LHD only.

CPT Conversion – the July 25 teleconference handles almost all of the simple questions; some policy questions now have to go DMA. There are still some glitches with HSIS such as pregnancy outcomes being required to be entered when it is not even a pregnancy-related service. August 17 the first billing tape goes to DMA, so that could be a real crunch time for HSIS interfacing with ED. A state team will review all coding problems that have statewide implications on August 24. Follow-up teleconference will be September 27 (after results of second tape are known).

A course on coding through UNC has been proposed for new personnel. In the meantime a site that contains all memos and other information is available at www.sph.unc.edu/courses/coding

HIPAA – although rules have been promised they are still not published (two year implementation schedule after publication), but Republicans state \$30 to 60 billion price tag too expensive. May not come to pass as proposed depending upon the election. Medicaid nationwide is collaborating to look at state created codes that do not have CPT. Joy provided a rationale for our 27 codes (note: mental health has volumes of state codes)

Minutes by Bill Smith, Chair

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Ray Rabe

From: Ray Rabe
Sent: Wednesday, September 06, 2000 11:45 AM
To: 'ncs0845@interpath.com'
Subject: Technology Committee Minutes

Jim,

Sorry! These minutes were written some time ago but I neglected to send them to you. The motion you requested is toward the end of the minutes. Ray

Local Health Directors' Association
Technology Committee Minutes
August 10, 2000

The Technology Committee of the North Carolina Health Directors' Association met at 9:30 a.m. on August 10, 2000. Those in attendance included Gustavo Fernandez, State Center for Health Statistics; Donna Gulas, Wake County Human Services; Ann Nance, DHHS/DPH/LHSS; Betsy Clayton, DENR/ DEH; Chris Cowan, Wayne County Health Department; Leonard Wood, Rowan County Health Department; Mark Prakke, DHHS/DIRM; Chris Swagiel, Halifax County Health Department; Libby Stephens, DHHS/LHSS; Tom Bridges, Henderson County Health Department; Kwane Yebool, DHHS-HIPAA Program Office; and Ray Rabe, Iredell County Health Department.

The Technology Committee was given a presentation by Holt Anderson, Executive Director of the North Carolina Healthcare Information and Communications Alliance, Inc. (NCHICA). Mr. Anderson provided committee members with a brief review of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as some insight into the "self-evaluation tool" NCHICA has developed in response to HIPAA.

HIPAA was passed in 1996 in an attempt to improve portability and continuity of health insurance coverage while combating waste, fraud and abuse in health insurance and health care delivery. However, the major impact on local health departments comes from a portion of the legislation aimed at "administrative simplification." The Congress hoped to improve "the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information." The primary thrust of the changes for health services providers will be that everyone will be required to use a uniform set of transaction codes for data elements, there will be a requirement for use of unique health identifiers, and major new efforts will be needed to conform to new standards with regard to the security of health data and protecting the privacy of individuals' health information.

A tentative conclusion reached by the Committee during discussions about the impact of HIPAA was that we are going to have to follow through on our long-term effort to develop a better data and information management system for local health departments. We are not going to be able to comply with the HIPAA standards unless we have a more sophisticated system. Substantial penalties, including imprisonment and financial, can be imposed on those who do not make a reasonable effort to comply with the new standards.

Mr. Anderson, also briefed the Committee on a "self-evaluation tool" NCHICA has developed. The tool is composed of over 500 questions that will help an organization identify where its current operation does not comply with the new requirements. The tool addresses the "security" component of the statute but NCHICA is working on the development of similar tools for the other portions of the law. Mr. Anderson emphasized that this process does not tell you what you have to do to remedy shortcomings. The committee discussed the value of developing a template to remedy shortcomings for the membership. Such a template could be sold to others and serve as a source of revenue to support the Association and NCAPHA activities. The *HIPAA EarlyView* tool costs \$100 for non-members and \$50 for members (NCHICA membership is \$250). The possibility of establishing a "special" rate for Association members was also discussed. It was agreed that we should attempt to arrange for good educational opportunities for the NCALHD membership as soon as possible. Mr. Anderson informed the group that workshops on HIPAA have been scheduled in late October and early November.

The Committee then turned to follow up on the motion passed at the July Association meeting regarding NC Public Health Automation. The Committee reviewed the motion passed and a draft follow up motion prepared by Marc Kolman of the Health Services Management System (HSMS) Steering Committee. The discussion revolved around the idea that we are at an important crossroads with regard to the technology development issue. Clearly, the earlier HIPAA discussion demonstrates the need for local health departments to upgrade their automation status, and very soon. Also, it has been about four years since the Association encumbered the \$3 million in Medicaid Maximization funds. DHHS officials are indicating a strong desire to "partner" with the Health Directors to build the needed system. However, there are not currently any state funds specifically designated for this venture. Committee members indicated a need to have a stronger commitment from the state in the form of a satisfactorily worded joint Memorandum of Understanding as a precursor to unequivocal commitment of our funds. The total

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membership should be given the clear opportunity to say yea or nay to this continued effort. A decision needs to be made as soon as possible so we can participate effectively in the development of the expansion budget. The following motion (Moved by Chris Szwagiel, seconded by Tom Bridges) was then approved.

The NCALHD Executive Committee authorizes the HSMS Steering Committee to make recommendation to the NCALHD for approval of a draft Memorandum of Understanding between DEH, DPH, DIRM, and the NCALHD to coordinate the development of a statewide public health automation solution for action at the September NCALHD meeting. The draft will be sent out electronically to the Association membership and DPH, DIRM, DEH representatives as soon as possible. Feedback to the HSMS Steering Committee will be provided and considered prior to the September meeting. The motion that was adopted at the July 27 NCALHD meeting will also be included in this mailing.

There being no further business the meeting was adjourned at 11:55 a.m.

Respectfully submitted,
/s/
Raymond Rabe, Recorder
Acting Chairman

NOTE: The day following the Technology Committee meeting the first portion of the standards (Transactions and Code Sets) was published. Standards are required to be implemented within two years of the effective date of a final rule, which is generally 60 days after publication of a rule. Consequently, we are just over two years away from being required to meet this component of the standards.

Raymond R. Rabe

Health Director
Iredell County Health Department
318 Turnersburg Highway
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Office (704)878-5303
Fax (704)878-5357
rabe@co.iredell.nc.us

Opinions expressed in this message may not represent the policy of Iredell County.

**DRAFT 2 INTRA-AGENCY AGREEMENT
BETWEEN THE
DIVISION OF MEDICAL ASSISTANCE,
DIVISION OF PUBLIC HEALTH,
DIVISION OF EARLY INTERVENTION AND EDUCATION,
DIVISION OF INFORMATION RESOURCE MANAGEMENT
AND
THE CONTROLLER'S OFFICE
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

SECTION A: FISCAL INTERMEDIARY FUNCTIONS

Controller's Office Medicaid Reimbursement Staff will:

- 1. Conduct cost determination activities *annually* to maintain accounting records for Medicaid services provided in accordance with the approved Medicaid State Plan. Cost determination methods utilized must be approved by DMA's Assistant Director of Financial Operations. The Controller becomes liable for such accounting upon signature of this Agreement.**
- 2. Provide the necessary cost analysis *on an annual basis* to support reimbursement rates established for *all Medicaid-reimbursed* services provided by local health departments and Developmental Evaluation Centers.**
- 3. Furnish upon request to DMA, HCFA or Attorney General Fraud Control Unit, any information maintained under item 1 above.**

DIRM will:

- 1. Serve as fiscal intermediary between DMA and local health departments and Developmental Evaluation Centers (DECs) for services covered by the Intra-Agency Agreement between DMA and DPH (attached) and for services covered by the Intra-Agency Agreement between the Division of Medical Assistance and the Division of Early Intervention and Education (attached).**
- 2. Prepare and submit claims to the DMA fiscal agency in accordance with DMA requirements for claims processing and in a format suitable for processing by the DMA fiscal agent.**
- 3. Produce remittance advices by procedure type for local health departments and DECs that detail the services included in payments made by DMA's fiscal agent.**
- 4. As applicable establish and maintain a system to identify and bill third parties.**

SECTION B: ARRANGEMENTS FOR PERIODIC REVIEW AND JOINT PLANNING

This IA and the policies established herein shall be reviewed annually and evaluated as to need for modifications or amendments by mutual determination of the involved agencies. In the event the federal and/or state laws should be amended or judicially interpreted so as to render the fulfillment of the IA, on the part of any party, not feasible or possible, or if the parties of this document shall be unable to agree upon modifying amendments which would be needed to enable substantial continuation of the IA, the Division of Medical Assistance, the Division of Public Health, the Division of Early Intervention and Education, the Division of Information

NCALHD COMMITTEE MINUTES

NCALHD COMMITTEE: Women's and Children's Health

CHAIR: Wanda Sandelé

DATE SUBMITTED: August 22, 2000

DATE OF COMMITTEE MEETING: July 26, 2000

COMMITTEE MEMBERS PRESENT: Wanda Sandelé, Kevin Ryan, , Marian Duncan, , Jenny Lassiter, Diane Crouse, , Alice Lenihan, Carol Tant, Dorothy Cilenti, John Morrow, Danny Staley, John Rouse, Sheree Smith, Shelley Carraway

GUESTS/OTHERS: _____

I. ACTION ITEMS:

None

II INFORMATION ITEMS:

1. There have been no reported new rubella cases in the past week. Thus far there have been 87 cases as of the date of this meeting. The new Hispanic outreach coordinator will be working with counties to reach adults who should be vaccinated.
2. The Governor met with WCH staff to discuss plans for further reduction in infant mortality rates. There was considerable discussion regarding issues surrounding the causes of infant mortality. WCH is putting together a plan with proposed strategies for reducing the rate state wide.
3. WCH has applied for new Title X funding for non-traditional providers of family planning services. Latino populations have been asked to partner with non-traditional clinical providers. The grants will be \$250,000 for two years. Four to six awards of \$30,000 -60,000 will be made based on an RFP process.
4. The committee was informed about the recent interest in alternative medicine. A survey of female patients will be performed at 10 sites asking about the use of herbal medicines. J.T. Garrett of Carteret County is the Health Director representative on the Alternative Medicine workgroup.

III NEXT MEETING Conference Call 3:00 on September 18th, Raleigh will call you.

Susan Smith-Wharton

From: Susan Smith-Wharton [ssw@ncha.org]
Sent: Wednesday, August 09, 2000 4:16 PM
To: bchdhd@coastalnet.com; mmcooper@co.randolph.nc.us; tesingleton@m-y.net; gayle@infoave.net; llatur@wilson-co.com; bethlovette@hotmail.com; wchd.dir@ncmail.net; myers@skybest.com; warrenhd@inet4u.com; lbrewer@co.wake.nc.us; anneT@co.dare.nc.us; gvdhd@gloryroad.net; lwhite@co.union.nc.us; tpierce@citicom.net; schd@advi.net; ncs0795@interpath.com; jjones@co.stanly.nc.us; holloman@hd.co.scotland.nc.us; schd@intrstar.net; rpmadm@blueridge.net; woodl@co.rowan.nc.us; nblakley@www.co.rockingham.nc.us; ncs0808@interpath.com; tjarrell@infoave.net; mimicooper@atomic.net; rpmadm@blueridge.net; jhmorrow@co.pitt.nc.us; mkolman.pchd@personco.com; hbc@nascar.pgcc.dst.nc.us; ncs0420@interpath.com; hbc@nascar.pgcc.dst.nc.us; pchd@pamlico.net; rsummers@orange.nc.us; georgeodaniel@co.onslow.nc.us; nhchd@coastalnet.com; drice@co.new-hanover.nc.us; william.hill@ncmail.net; rwittmann@co.moore.nc.us; montcohd@ac.net; tesingleton@m-y.net; safir@mindspring.com; rpmadm@blueridge.net; kring@madison.main.nc.us; mchd@drake.dnet.net; mdollar@vnet.net; jhuff@health.co.lenoir.nc.us; lcph@interpath.com; ncs0811@interpath.com; leonard.woodall@mail.co.johnston.nc.us; rabe@co.iredell.nc.us; hchd@coastalnet.com; ncs0790@interpath.com; curtis.dickson@ncmail.net; Tom Bridges; bwood@gov.haywood.co.nc.us; wraynor@harnett.org; Chris Szwagiel; hgabel@mail.co.guilford.nc.us; dharr@eastlink.net; gvdhd@gloryroad.net; grahamhd@dnet.net; lghealth@coastalnet.com; bparsons@gastongov.org; ncs0860@interpath.com; kahmse@iris.co.forsyth.nc.us; ncs0845@interpath.com; bletourneau@ph.co.durham.nc.us; jbbdaviae@ix.netcom.com; dcrouse@co.davidson.nc.us; hbc@nascar.pgcc.dst.nc.us; ncs0812@interpath.com; wsandele@co.craven.nc.us; colhealthdept@weblnk.net; dchd@duplinnet.com; claycohd@grove.net; hbc@nascar.pgcc.dst.nc.us; chkeechd@grove.net; wsherman@emji.net; barryblick@mail.co.catawba.nc.us; ncs0819@interpath.com; cchd2@ncnets.net; hbc@nascar.pgcc.dst.nc.us; durland@co.caldwell.nc.us; WFPilkington@co.cabarrus.nc.us; david.rust@ncmail.net; bondg@co.buncombe.nc.us; dyousey@brunseo.net; bladhlth@bladenco.org; Ronald Freeman; chase.bchd@coastalnet.com; tesingleton@m-y.net; Jim Roosen; myers@skybest.com; scarraway@co.alexander.nc.us
Cc: joy.reed@ncmail.net; Dennis.Harrington@ncmail.net
Subject: DOC Contract Pricing

The Alliance recommends setting a price between \$50-90 for each history and physical. In order to participate in this contract, you must be an Alliance member (or indicate that you will be joining the Alliance shortly, just e-mail me to that effect)

We are recommending a price range instead of one price because we realized that some rural Health Departments can charge more than urban Health Departments due to the lack of competitors in these rural areas. (In other words, setting a range for pricing will allow for optimum pricing for all areas.)

Some background information that will be helpful.

Last years ranges were \$35-\$115 with an average of \$55 per physical.

The highest price that was set last year was \$100 at the border of NC and TN (very rural area with no competitors).

Your competition will be private physicians, Doc-in-the-Boxes and possibly a clinic setting.

Roger Odum, the contract administrator with the DOC, stated to me that he may just "throw out contracts over \$100 unless it is the only provider in the area". If you have already sent your contract in with a higher price than \$100, you may want to re-submit an adjusted price.

IMPORTANT: Please set your individual Health Department price, read and sign your contract and mail it in to the DOC as soon as possible. YOU SHOULD RECEIVE A WRITTEN ACCEPTANCE OF YOUR CONTRACT FROM THE DOC BEFORE SEPT.1ST.

The contract must be received and validated BEFORE SEPT. 1st. You may want to fed-ex these contracts back to the DOC to make sure that they do not become lost in the mail.

All Health Departments received these contracts so if you did not receive yours, please call me as soon as possible. The addresses and names of Health Directors were pulled from the web page so if there has been a recent change in the Health Director's position, write out the new Health Director's name on the contract.

The providers that qualify to provide these physicals are MD's, PA's or FNP's. The F1 form is to be filled out by the DOC applicant BEFORE the physical. The F2 form will be the form signed by the

provider. Both forms will need to be sealed in an envelope upon completion and returned with the DOC applicant.

It is important to note that the DOC is asking for an appointment time in a 7 business day period. This may be important if you have a Dept. of Corrections facility near you as you may get a large number of DOC applicants. (There appears to be a high turnover rate of DOC employees)

The Department of Corrections reserves the right to extend this contract for an additional period of 2 years, in one year increments.

Payment for services performed will be sent directly to each Health Department from the DOC.

Please e-mail me if you have any additional questions or concerns. I will have additional copies of the contracts at tomorrow's NCALHD meeting.

Thanks, Susan

CRIMINAL JUSTICE EDUCATION AND TRAINING STANDARDS COMMISSION

CRIMINAL JUSTICE STANDARDS DIVISION

Post Office Drawer 149, Raleigh, NC 27602

Telephone: (919) 716-6470

Fax (919) 716-6752



MEDICAL HISTORY STATEMENT

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT
BE RELEASED TO UNAUTHORIZED PERSONS.

Form F-1(LE)
(Rev. 2/99)

INSTRUCTIONS:

To be completed by applicant for a certifiable position prior to the physical examination and presented to the examining physician at the time of examination. All questions must be answered completely and accurately. The original or a copy must be retained in personnel filed by the appointing agency.

DATE: _____

NAME: _____ DATE OF BIRTH _____ / _____ / _____
 Last First Middle

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____
TELEPHONE # () - _____ SS # _____ / _____ / _____

Prescription Medications: (Include pain relievers, birth control pills, etc.)

Over the Counter Medications: (Include all cold allergy, headache, vitamins, etc.)

ALLERGIES

Drug Allergies: (Include your reaction to the medication)

All Other Allergies: food, insects, seasons, animals, materials, etc. : (Include reaction)

(Continued on reverse side)

FAMILY HISTORY

Have any of your parents, brothers, or sisters suffered from: [check all that apply]

- Diabetes?
- Heart problems?
- High blood pressure?
- Arthritis?
- Neurologic or psychological problems? (Seizures, depression, schizophrenia, etc.)

PAST MEDICAL HISTORY

List ALL hospitalizations and operations since childhood:

(Include type of surgery, date of surgery, any complications or other significant information)

Have you EVER, in your life, had any of the following types of medical problems? [check all that apply to you]

- 1. **CANCER:** any type of cancer including skin cancer, breast cancer, and leukemia?
- 2. **MAJOR INFECTIOUS DISEASE:** such as tuberculosis, hepatitis, HIV/AIDS, rheumatic fever and others?
- 3. **NEUROLOGICAL PROBLEMS:** such as seizure disorder, stroke, concussion, severe headache, skull fracture, recurrent vertigo, balance problems, encephalitis, meningitis, tremors, multiple sclerosis, Huntington=s chorea, peripheral neuropathy and others?
- 4. **PSYCHOLOGICAL PROBLEMS:** such as depression, manic episodes, psychotic episodes, post traumatic stress disorder and others?
- 5. **EYE PROBLEMS:** such as eye injury, color blindness, poor night vision (night blindness), glaucoma, blindness in one or both eyes, very poor vision when not corrected and others?
- 6. **EAR PROBLEMS:** such as ear injury, chronic ringing (tinnitus), chronic or long lasting ear infection, Meniere=s disease, moderate to severe hearing loss in one or both ears and others?
- 7. **NOSE PROBLEMS:** such as nose injury, allergies, nasal bleeding, loss of sense of smell, chronic or long lasting infections and others?
- 8. **MOUTH OR THROAT PROBLEMS:** such as injury, major dental work, any kind of speech defect, chronic or long lasting infections, abnormality of nose, mouth or throat that would interfere with wearing a respirator and others?
- 9. **LUNG PROBLEMS:** such as asthma, emphysema, chronic or recurrent bronchitis, pneumonia, tuberculosis or lung abscess and others?
- 10. **HEART AND CIRCULATION PROBLEMS:** such as heart murmur, heart disease, heart attack, irregular rhythm, valve abnormalities, varicose veins, phlebitis, peripheral vascular disease, Raynaud=s disease and others?
- 11. **DIGESTIVE SYSTEM PROBLEMS:** such as any kind of ulcer disease, hepatitis or liver disorder, any kind of colitis, Crohn=s disease, ulcerative colitis, irritable bowel syndrome, esophageal disorders, pancreatitis, gall stones, stomach or intestinal bleeding and others?
- 12. **HORMONE OR ENDOCRINE PROBLEMS:** such as diabetes, thyroid disease, parathyroid or adrenal problems and others?
- 13. **URINARY TRACT PROBLEMS:** such as kidney stones, pyelonephritis (kidney infection), nephrosis, single functioning kidney, polycystic kidney disease, repeated bladder infections and others?
- 14. **HERNIA:** such as inguinal, umbilical, ventral, femoral, hiatal or incisional hernias?
- 15. **MUSCLE, BONE AND JOINT PROBLEMS:** such as chronic back or neck pain, fibromyalgia, back or neck disk disease, osteomyelitis (bone infection), muscular dystrophy, arthritis, spinal curvature, loss of a finger or toe, and others?
- 16. **BLOOD SYSTEM PROBLEMS:** such as anemia, hemophilia or bleeding disorder, white blood cell abnormality and others?

(Continued on next page)

MALES ONLY:

- 17. Prostate problems such as enlargement or prostatitis?
- 18. Genital problems such as epididymitis or testicular injury?

FEMALES ONLY:

- 19. Currently pregnant?
- 20. History of endometriosis, pelvic inflammatory disease, abnormal Pap smear, PMS or other problem with your menstrual cycle?

IMMUNIZATIONS

- 21. Have you ever had a positive TB test?
- 22. Have you received Hepatitis B vaccinations?
- 23. When did you receive your last tetanus (lockjaw) immunization?

OCCUPATIONAL HISTORY

Have you ever been exposed to any of the following, whether at home, work, military or any other setting? [check all that apply]

- 24. Repetitive Loud Noises (Including guns, jet engines, loud machinery)?
- 25. Chemical exposure to skin or lungs?
- 26. Dusty conditions (sandblasting, grinding, mining or drilling of rock, coal, silica, asbestos)?

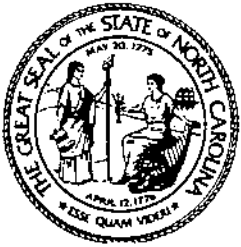
Check all YES answers:

- 27. Have you ever sustained an injury while at work that necessitated extended care by a health care provider?
- 28. Have you ever had a motor vehicle accident causing back or neck pain?
- 29. Are you limited or unable to perform any physical activity because of muscle or joint discomfort?
- 30. Do you have any missing limbs or non-functional joints?
- 31. Have you ever been advised by a physician to avoid lifting above a certain weight limit?
- 32. Have you ever been advised by a physician to avoid sitting or standing over a certain time?
- 33. Have you ever worked in law enforcement?
 - 33a. If yes, have you ever missed more than three consecutive days of work for any medical or psychological problem?
- 34. Have you ever served in any of the armed forces?
 - 34a. If yes, have you ever missed more than three consecutive days or service for any medical or psychological problem?
- 35. Do you have any difficulty in properly holding, aiming or firing a handgun, rifle or shotgun?
- 36. Do you have any difficulty driving at high speeds in a motorized vehicle?
- 37. Have you ever had an automobile accident while driving over sixty (60) miles per hour?
- 38. Have you ever had any automobile accidents as a result of losing control of your vehicle?
- 39. Do you have any difficulty driving for three (3) consecutive hours without stopping?
- 40. Do you have any difficulty running for five (5) consecutive minutes without stopping?
- 41. Have you ever passed out, temporarily lost control of any part of your body, or had blackout spells (episodes you do not remember)?

(Continued on reverse side)

EXPLANATION OF ANY YES ANSWERS: (Identify by number)

NORTH CAROLINA SHERIFFS' EDUCATION AND TRAINING STANDARDS COMMISSION



Michael F. Easley
Attorney General

Sheriffs' Standard Division
POST OFFICE BOX 629
RALEIGH, N. C. 27602
TELEPHONE: 919-716-6460
FAX: 919-716-6753



Julia Lohman
Director

Form F-2A
(REV. 1/98)

**INSTRUCTIONS TO AGENCY AND EXAMINER
FOR COMPLETION OF MEDICAL EXAMINATION REPORT (FORM F-2)**

TO AGENCY OR TRAINING DELIVERY SITE:

The attached form must be completed following a physical examination by a nurse practitioner, physician= assistant, physician or surgeon licensed in North Carolina. The physical examination must be conducted **either** prior to beginning Basic Law Enforcement Training, the Detention Officer Certification Course, or the Telecommunicator Certification Course; **or** prior to employment as a justice officer - **whichever occurs first**. The form is valid for one (1) year from the date it is signed by the physician. The original should be submitted to the Sheriffs= Standards Division as a part of the certification application. The employing agency and training delivery sites should maintain a copy for their files.

THE EMPLOYING AGENCY OR THE TRAINING DELIVERY SITE SHOULD PROVIDE THE EXAMINER WITH A COPY OF THE MEDICAL SCREENING GUIDELINES IMPLEMENTATION MANUAL AS PUBLISHED BY THE SHERIFFS= STANDARDS COMMISSION.

TO EXAMINER:

The person for whom this examination is being performed is a candidate for employment and training as a law enforcement officer, detention officer, or telecommunicator. This employment and training will involve the performance of tasks that will require a moderate degree of strength and manual dexterity.

*****PRIOR TO CONDUCTING THE PHYSICAL EXAMINATION, YOU MUST HAVE A COPY OF THE MEDICAL SCREENING GUIDELINES IMPLEMENTATION MANUAL AS PUBLISHED BY THE SHERIFFS= STANDARDS COMMISSION.******

TO EMPLOYING AGENCY, TRAINING DELIVERY SITE, AND EXAMINER:

IF YOU DO NOT HAVE A COPY OF THE MEDICAL SCREENING GUIDELINES IMPLEMENTATION MANUAL, OR IF YOU NEED ADDITIONAL COPIES PLEASE CONTACT THE SHERIFFS= STANDARDS DIVISION AT THE ADDRESS AND PHONE NUMBER ABOVE. YOU SHOULD ALSO FEEL FREE TO REPRODUCE THE MANUAL AS NEEDED.

CRIMINAL JUSTICE EDUCATION AND TRAINING STANDARDS COMMISSION

CRIMINAL JUSTICE STANDARDS DIVISION

Post Office Drawer 149, Raleigh, NC 27602

Telephone: (919) 716-6470

Fax (919) 716-6752



MEDICAL EXAMINATION REPORT

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS.

Form F-2(LE)
(Rev. 2/99)

INSTRUCTIONS:

To be completed by either a physician or surgeon licensed to practice medicine in N.C. or by a physician or surgeon authorized to practice medicine in accordance with the rules and regulations of the U.S. Armed Forces following an actual physical examination. The original or a copy of this report must be retained in personnel file by the appointing agency.

DATE: _____

NAME: _____
Last First Middle

DATE OF BIRTH ____ / ____ / ____

Height: _____ Weight: _____

- Well nourished
- Obese
- Muscular

VISION

Visual Acuity: **If applicant wears glasses or contacts, test and record acuity with and without glasses**

| | | | |
|------------------|----------------|----------------|-------------------|
| Without glasses: | R - 20 / _____ | L - 20 / _____ | Both - 20 / _____ |
| With glasses: | R - 20 / _____ | L - 20 / _____ | Both - 20 / _____ |

Depth Perception: - Normal - Abnormal:

Color Perception: - Normal - Abnormal:

Peripheral Vision: - Normal - Abnormal:

HEARING

Hearing Acuity: - Audiogram - or - 15' whispered conversation (check one)

Right ear: - Normal - Abnormal:

Left Ear: - Normal - Abnormal:

(Continued on reverse side)

CARDIOVASCULAR

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Blood Pressure: _____

Resting Pulse: _____

Cardiac Examination: - Normal - Abnormal:

Peripheral Circulation: - Normal - Abnormal:

ECG: - Indicated by hx or exam:

ABNORMAL DETAILS

NORMAL

- HEENT: _____
- LUNGS: _____
- ABDOMEN: _____
- MUSCULOSKELETAL: _____
- GENITOURINARY: _____
- NEUROLOGICAL: _____
- SKIN: _____

URINALYSIS - Normal - Abnormal:

TB SKIN TEST - Negative - Positive

Are there any conditions, physical, emotional or mental which, in your opinion, suggest further examination:

- No - Yes:

Do you have any reservations about this candidate=s ability to physically perform required duties:

- No - Yes:

I have read and fully understand the Medical Screening Guidelines Implementation Manual for the Certification of Criminal Justice Officers in the State of North Carolina.

Name and Address of Physician - Typed

Physician= Signature

Date

**REPORT of Public Health Nursing & Professional Development
to NCALHD
August 10, 2000**

1. Child Health Rostering:

See attached letter and note September 1, 2000 deadline.

2. Next Open Forum on CPT/ICD9 Coding:

Due to popular demand a second Open Forum on CPT/ICD9 coding issues has been scheduled for Wednesday, September 27 from 8:30 am – 12:30 pm. From 8:30 – 11:00, we will address issues related to all local health departments; from 11:00 – 12:30 we will focus on questions from batch counties.

3. Training on Dental Coding for local health departments:

As you know, effective October 1, local health departments must begin billing dental services using CDT. Training specific to local health departments on this new coding system will be done by EDS staff via PHTIN on the following dates:

- September 5, 2000 from 1:00 pm – 4:00 pm
- September 19, 2000 from 9:00 am – 12:00 noon.

This session will be available at all PHTIN sites: Jackson County Health Department, Sylva; Catawba County Health Department, Hickory; Mayes Center in Rosenau Hall, UNC-Chapel Hill; Cooper Building, Raleigh; Cumberland County Health Department, Fayetteville; Wilson County Health Department, Wilson; and Albemarle Regional Health Services (formerly PPCC District Health Department), Elizabeth City.

4. "Finance 101" Workshops:

Three sessions of "Finance 101" have been scheduled for the fall. These sessions cover the Consolidated Contract, time equivalencies, Expenditure Reports, the Interagency Agreement with DMA, etc. Since many of these documents and processes have changed during the past year, this workshop is critical for continuing staff as well as new Health Directors and Finance Officers. The brochure will be out by the end of August.

- October 4-5, 2000 in Hickory
- October 18-19, 2000 in Raleigh
- October 25-26, 200 in Greenville

5. Annual Jail Health Conference:

This will be held October 23-24, 200 at the Blockade Runner at Wrightsville Beach, NC. The second day of this conference focuses on legal aspects of health care delivery in the jail.

6. New Nurse Consultants:

I am delighted to announce that I have filled both vacant Nurse Consultant positions. Pamela Serrell, who started work on August 8, will replace Dianah Bradshaw and Eileen Kugler, who will begin her new position on October 1, will replace Milly Cooper. Following our meeting on August 17 counties will receive a revised consultant assignment map with contact information for these individuals.



North Carolina
Department of Health and Human Services
Division of Public Health
1330 St. Mary's Street • 1915 Mail Service Center • Raleigh, North Carolina 27699-1915
H. David Bruton, M.D., Secretary •

MEMORANDUM

TO: Local Health Directors and Directors of Nursing

FROM: Joy F. Reed, EdD, RN *JFR*
Head, Public Health Nursing & Professional Development

DATE: August 3, 2000

SUBJECT: Re-Rostering of Child Health Screeners

As you know, we have been in the process of determining who is eligible to remain rostered as a Child Health Screener. Two years ago agencies were notified that PHNs who were rostered would need to complete 20 hours of relevant continuing education and 200 hours of relevant clinical practice every two years to remain rostered. The first 2-year period ended June 30, 2000. At that time we sent forms to every rostered Child Health Screener in our database to ask for identification and verification that they had met the requirements to remain rostered. As a result we are finding a significant number of nurses who have not met either the required 20 hours of relevant continuing education or the 200 hours of clinical practice. The supervisor who signed the verification form is receiving a memo indicating the deficiency, asking if there is additional information to be provided and indicating that if no additional information is provided, the individual will be removed from the list of rostered screeners. This will be done on September 1, 2000 if no additional information indicating that the individual has met the requirements is received by that date AND we do not have notice from the agency that the individual plans to take the Child Health Clinical Challenge in order to remain rostered.

If your agency has a PHN who has not met the requirements to remain rostered and the agency wants the PHN to continue to be listed as a Rostered Child Health Screener, the agency should :

- ◆ *immediately contact the Child Health Training Program (336-370-0543) to arrange for the Clinical Challenge Exam; and*
- ◆ *notify my office before September 1, 2000 that the PHN is scheduled to take the challenge and the date of that scheduled exam.*

As of September 1, 2000, any PHN who has not done one of the following will be removed from the list of rostered Child Health Screeners:

- a. *submitted to the Office of Public Health Nursing & Professional Development documentation that s/he has met the requirements to remain rostered*

OR

- b. *notified my office that s/he is scheduled for the Clinical challenge exam.*

An individual whose name is removed from the roster may no longer provide Health Check screenings and the agency can NOT bill Medicaid (W8010 or W8016) or any other

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insurer/individual for child health screenings done by this PHN.

For your information and future reference, the most common problem encountered in reviewing the forms sent in by the PHNs seeking to remain rostered is that the continuing education is not relevant to this role. The continuing education to be deemed relevant must be focused on issues related to doing assessments/screening exams on children. Courses on the new research on early brain development, Denver II training, asthma or lead poisoning in children and immunization updates are all relevant; however, CPR, management and supervision courses and courses specifically targeted to assessing or caring for adults are NOT relevant. In about two weeks I will send to nursing directors in each local health department a more complete list of courses which have been deemed relevant and those which – while important for other aspects of the PHN's position - can NOT be considered relevant for this purpose. Finally, be aware that the Child Health Training Program can NOT be used to meet the CE requirement, since a PHN must complete that prior to being initially rostered.

If you have questions or need additional information, please feel free to call me at (919) 715-4385 or e-mail me at joy.reed@ncmail.net.

cc: Dennis Harrington
Carol Tant
Kaye Holder
Michelle Myer
Ann Jessup
Regional Child Health Nurse Consultants
LHS Nurse Consultants

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Animal Burial Guidelines During A Declared Emergency
State Animal Response Team
May 2000

Introduction

Hurricane Floyd on September 15, 1999 combined with the weather conditions before and immediately after this hurricane resulted in the most severe flooding and devastation in North Carolina history. The flooding caused an estimated \$813 million in agricultural losses affecting 32,000 farmers. In addition to crop loss, there was significant loss of livestock including 2,860,827 poultry, 28,000 swine, and 619 cattle. Disposal of dead animals was a significant problem. Proper burial and disposal will prevent potential public health problems resulting from large numbers of dead and decaying animals include the spread of harmful pathogens, ground and surface water contamination, and pest control. In certain situations, burial of dead animals may be the best alternative for immediate disposal. These guidelines are designed to insure burial is done in a safe and effective manner.

Legal Authority

North Carolina General Statute 106-403 (NCGS) Disposition of dead domesticated animals states that is the responsibility of the owner or person in charge of his domesticated animals to bury dead animals appropriately within 24 hours after knowledge of the death. It is the responsibility of the municipal or county government to designate appropriate persons to dispose of any domestic dead animals whose owner cannot be identified. (See attached copy of NCGS 106-403 and companion opinion from the Attorney General's Office dated June 8, 1984.)

The NC Department of Agriculture - Veterinary Division is the lead state agency to oversee animal disposal as regulated under existing Administrative Rules, specifically, **Subchapter 52C - Control of Livestock Diseases: Miscellaneous Provisions, Section .0100 - Diseased and Dead Animals** (See Attached)

The State Health Director and by extension the Local Health Director in each county is charged with preventing health risks and disease and promoting a safe and healthful environment according to **NCGS 130A, Articles 1-20**. To the extent that dead animals become a threat to human health, the State and Local Health Director has broad authority to investigate and act on matters to protect health.

The Environmental Management Commission protects the groundwater quality in the State of North Carolina through rules established in **15A NCAC Subchapter 2L - "Classifications and Water Quality Standards Applicable to the Groundwaters of North Carolina."** These rules establish groundwater quality standards that may not be exceeded without a permit issued under the authority of the Commission. The Groundwater Section of the Division of Water Quality is responsible for the administration and enforcement of these rules. Any surface or subsurface activity that has the potential to cause groundwater standards to be exceeded is subject to the regulatory authority of the Commission.

Scope

While it is recognized that there are multiple types and degrees of emergencies that could create the need for dead animal burial, these guidelines focus on the most common cause and the most recent experience, flooding and electrical outages. For example, guidelines for managing dead animals during a foreign animal disease emergency may differ and would be managed through the State Veterinarian.

These guidelines are intended to address dead animal disposal during a declared emergency and therefore do not take the place of the dead animal disposal that occurs under the normal permitted operation of a farm. The Governor can declare a state of emergency in North Carolina with or without a federal declaration of the same.

Emergency Planning

Each farm operation shall make specific plans for animal disposal in the event of an emergency. When burial is determined to be the disposal method of choice, an attempt should be made first to bury the dead animals according to guidelines on the owner's farm. If proper burial is not possible on the farm then plans should be made for alternative sites.

Burial Standards

1. The bottom of the hole where dead animals are to be buried should be 3 feet above the seasonal high water table and must be at least 12 inches above the seasonal high water table in an area of well-drained soil. (Farm owners may contact the local NRCS agency or the local health department for assistance in determining the seasonal high water table.)
2. Standing water in the hole does not preclude animal burial as long as the bottom of the hole is at least 12 inches above the seasonal high water table, not in an area of standing water, and the other conditions for proper burial are met.
3. There must be at least 3 feet of soil covering any buried animal. This can be interpreted to mean soil mounded over the animals above the adjacent ground level.
4. The burial site must be at least 300 feet from any existing stream or public body of water.
5. The burial site must be at least 100 feet from any existing well.
6. The burial site must be at least 300 feet from any existing public water supply well.
7. The burial site cannot include any portion of a waste lagoon or lagoon wall.
8. In the case where the burial site is in a waste disposal spray field, the burial site is not available for subsequent waste spraying until a new viable crop is established on the site.
9. The burial site shall be located so as to minimize the effect of stormwater runoff.
10. Burial is not permitted in the tiled area of an underdrained field.
11. A record of the location of the approved site (GPS latitude and longitude coordinates if available), the burial history of each burial site to include the date, species, head count and age must be kept by the owner and reported to the Local Health Director who will in turn will report this information to the appropriate State agency - DENR Division of Water Quality, Groundwater Section.

12. Farm owners and operators are encouraged to consider measures that could be taken prior to an eminent emergency that could reduce the impact on the farm and the environment.

Collective Burial Site

A collective burial site may be designated to serve one or more counties in the event of a large-scale emergency whereby individual farm sites are not available. The responsibility for disposal of dead animals remains with the owner, lessee, or person in charge of any land upon which any domesticated animals die. The county or municipality should identify an appropriate burial site(s) with the capacity to bury up to 5% of the steady state live weight of livestock in that jurisdiction. The use of an existing county or municipal landfill as a dead animal burial site is legal and preferred.

Burial Site Approval

Best farm practices suggest that a burial site with the capacity to handle the type and number of animals most likely to be needed during an emergency for each farm operation be identified and pre-approved prior to the emergency. It is recommended that the emergency burial contingency plan be incorporated into the farm's existing Farm Support Agency (FSA) plan and duly reported to the appropriate state and local agency.

Contact Information

- N.C. Department of Environment and Natural Resources
Division of Water Quality/Groundwater Section
Arthur Mulberry - Section Chief
1636 Mail Service Center
Raleigh, NC 27699-1636
(919)733-3221
- N.C. Department of Health and Human Services
Division of Public Health/Epidemiology and Communicable Disease Section
Dr. Steve Cline - Section Chief
1902 Mail Service Center
Raleigh, NC 27699-1902
(919)733-3421
- SART (State Animal Response Team)