Division of Public Health
Agreement Addendum
FY 16-17

	Chronic Disease and Injury Section
Local Health Department Legal Name	**DPH Section/Branch Name**
	Sharon Nelson, 919-707-5207 sharon.boss.nelson@dhhs.nc.gov
886 Healthy Communities **Activity Number and Description**	**DPH Program Contact** (name, telephone number with area code, and email)
06/01/2016 – 05/31/2017 **Service Period**	**DPH Program Signature** **Date** (only required for a negotiable agreement addendum)
07/01/2016 – 06/30/2017 **Payment Period**	

☒ **Original Agreement Addendum**
☐ **Agreement Addendum Revision #** _____ (Please do not put the Budgetary Estimate revision # here.)

I. Background:

Every day in North Carolina, approximately 160 residents die of chronic disease, injury or violence. One in eight North Carolina adults reported a history of cardiovascular disease (stroke, heart attack, or coronary heart disease) in 2013. North Carolina's cardiovascular disease (CVD) prevalence rate places it among the quartile of states with the highest CVD rates in the nation. North Carolina is also in the quartile of states with the highest diabetes rate in the nation. In 2013, 11.4% of NC's adult population had diabetes. In 2009, nearly one in ten (9.7%) North Carolina adults reported that they had an injury that resulted in seeking medical attention and another 40% reported that they had such an injury more than 12 months ago. One in ten North Carolina children ages 0 to 17 had an injury in the past year that prohibited them from their usual activities for a day or more, and 16.2% had an injury in the past year that required medical attention. Racial disparities in chronic disease and injury prevalence and mortality persist as well. Non-Hispanic African Americans have higher rates than non-Hispanic whites for the majority of chronic diseases.

Estimates reveal that over half of the deaths caused by chronic disease may be due to preventable causes. The leading preventable causes of death in the state are tobacco use, unhealthy diet, inadequate physical activity, poor chronic disease management, and unintentional injury. Many North Carolinians die prematurely or suffer from diseases, injury and violence that could be prevented or more effectively managed.

Health Director Signature (use blue ink) Date

Local Health Department to complete: (If follow up information is needed by DPH)	LHD program contact name: _____ Phone number with area code: _____ Email address: _____

Signature on this page signifies you have read and accepted all pages of this document.

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II. Purpose:

The Healthy Communities Program, housed in the Chronic Disease and Injury (CDI) Section of the Division of Public Health (DPH), provides funding for county and district health departments to develop and implement community-based initiatives that address the risk factors of physical inactivity, poor nutrition, tobacco use, violence and unintentional injury. Research shows that implementing systems and environmental changes can result in positive behavior changes that decrease chronic diseases (e.g., cancer, heart disease, stroke, obesity and diabetes) and injuries and improve health. Examples of such broad-based strategies include providing access to nutritious foods and options for physical activity, promoting tobacco free facilities, supporting chronic disease screenings and management programs, and providing evidence-based practices and interventions for violence and injury prevention in communities.

Interventions should strive to provide opportunities for everyone in North Carolina to achieve their optimal level of health, regardless of race/ethnicity, socioeconomic status, geographic location, education status, disability status or sexual orientation.

III. Scope of Work and Deliverables:

As a recipient of Healthy Communities Program funding, the Local Health Department shall:

A. Designate one qualified staff member to carry out all duties outlined in this Agreement Addenda. The Health Director is responsible for notifying the Program Consultant within 30 days when this position is vacated and filled.

B. Ensure that a one-year Community Action Plan outlining all activities planned for State Fiscal Year 2017-18 is reviewed by the local health director and submitted electronically to the Program Consultant by March 15, 2017. Activities described in the Community Action Plan must be population and community based public health programs. The Community Action Plan must also detail how the Local Health Department will engage priority populations (e.g., racial/ethnic populations, those living in under-resourced and low-income communities) in the planning, implementation, and/or evaluation of at least one strategy.

C. Implement at least two of the following interventions:
   1. Increase the number of organizations that offer Diabetes Prevention Programs.

   2. Increase the number of worksites that complete the CDC Worksite Health ScoreCard and use the results to address chronic disease and injury.

   3. Increase the number of Local Health Departments that provide Diabetes Self-Management Education.

   4. Increase the number of community and transportation plans that include health considerations.

   5. Increase the number of community or small retail venues providing access to healthy foods.

   6. Increase the number of events held by community organizations aimed at increasing awareness of the need for colorectal cancer screenings.

   7. Increase the number of organizations in North Carolina that sign the national “80% by 2018” pledge to increase the number of people screened for colorectal cancer.

8. Conduct asthma home trigger assessments in collaboration with local clinical partners.

9. Increase the number of smoke-free/tobacco-free policies covering: 1) government buildings, government grounds and/or indoor public places through ordinances or Board of Health rules; 2) multi-unit housing; and/or 3) colleges/universities.

10. Conduct point of sale assessments of tobacco retail environments (using CounterTools or STARS) and educate local stakeholders about the results.

11. Adopt a standing order and implement a distribution program to increase access to naloxone within and outside of the health department.

12. Provide or support gatekeeper training for suicide prevention, using the Applied Suicide Intervention Skills (ASIST); Question, Persuade, and Refer (QPR); or, Mental Health First Aid training programs, for county staff, partners, and/or identified high risk populations.

13. Implement an evidence-based falls prevention strategy (e.g., Tai Chi for Health, Matter of Balance, Stopping Elderly Accidents, Deaths, and Injuries [STEADI]) in partnership with the Area Agency on Aging.

14. Increase public awareness of DWI checking stations by partnering with the Forensic Tests for Alcohol Branch.

D. Report progress on implementation of selected strategies on a quarterly basis (September, December, March and June).

E. Coordinate with the Community and Clinical Connection for Prevention and Health Branch to conduct a county or district wide Fruit and Vegetable Outlet Inventory (FVOI) assessment.

IV. Performance Measures/Reporting Requirements:

Performance Measure #1: Evidence that staff is designated for the Healthy Communities Program.

Performance Indicators:
A. Staff contact information is submitted to the Program Consultant and updated as changes occur.

Performance Measure #2: Evidence that the Community Action Plan and quarterly progress reports are submitted.

Performance Indicators:
A. Draft State Fiscal Year 2017-18 Community Action Plan is submitted by March 15, 2017.
B. Revisions to Community Action Plan are made based on technical assistance provided by the Program Consultant.
C. Final Community Action Plan is revised and submitted by May 15, 2017.
D. Progress reports are submitted quarterly, by September 10, December 10, March 10, and June 30.
E. Submission of at least one success story upon request by the Program Consultant.
F. Submission of Fruit and Vegetable Outlet Inventory by August 2017.

Performance Measure #3: Evidence of policy changes and environmental supports that provide opportunities for healthy living and address health equity.

Performance Indicators

A. Information for a minimum of two strategies selected by the Local Health Department, from among these strategy options listed in Section III.C:

1. Number of organizations that offer Diabetes Prevention Programs.

2. Number of worksites that complete the CDC Worksite Health ScoreCard and the results to address chronic disease and injury.

3. Number of Local Health Departments that provide Diabetes Self-Management Education (DSME) with:
    a. new stand-alone DSME;
    b. new satellite DSME; or,
    c. enhancements to existing DSME.

4a. Number of community plans (e.g., Comprehensive Plans) that include health considerations.
4b. Number of transportation plans (e.g., Bicycle and Pedestrian Plans) that include health considerations

5a. Number of community venues (e.g., food banks) providing access to healthy foods.
5b. Number of small retail venues (e.g., corner stores) providing access to healthy foods.

6. Number of events held by community organizations aimed at increasing awareness of the need for colorectal cancer screenings.

7. Number of organizations in North Carolina that sign the national “80% by 2018” pledge to increase the number of people screened for colorectal cancer.

8. Number of asthma home trigger assessments conducted by local health department staff.

9. Number of smoke-free/tobacco-free policies covering:
    a. government buildings;
    b. government grounds;
    c. indoor public places through ordinances or Board of Health rules;
    d. multi-unit housing; and/or,
    e. colleges/universities.

10. Number of point of sale assessments of tobacco retail environments conducted.

11. Number of health departments that have a standing order to administer naloxone and implement a distribution program to increase access to naloxone within and outside of the health department.

12. Number of gatekeeper training for suicide prevention provided using:
    a. ASIST;
    b. QPR; and/or,
    c. Mental Health First Aid.

13. Number of evidence-based falls prevention strategies implemented in partnership with the Area Agency on Aging that use:
    a. Tai Chi for Health;

b. Matter of Balance;
c. STEADI; and/or,
d. other evidence-based falls prevention strategies.

14. Number of media impressions on DWI checking stations.

V. **Performance Monitoring and Quality Assurance:**

The Healthy Communities Program is monitored through quarterly reports and conference calls with the Program Consultants to review progress toward Community Action Plan objectives. DPH shall maintain contact via email and telephone to monitor programmatic and fiscal performance. If deficiencies in performance are identified, DPH shall notify the Local Health Department immediately via email or phone call and shall work with the Local Health Department to establish a plan within one week to address the deficiencies. Failure to comply with the requirements listed above may result in a decrease in funding or removal from consideration for future funding.

VI. **Funding Guidelines or Restrictions:** (if applicable)

The Local Health Department may expend funds only for reasonable program purposes, including personnel, travel, supplies, and services. Funds may be used for interventions that will result in increased physical activity, increased healthy eating, reduced obesity, prevention of tobacco use, prevention of chronic diseases (e.g., cancer, heart disease, stroke, obesity and diabetes), support for diabetes self-management or prevention of violence and injury.

Funds cannot be used for community health assessments, lobbying, research, clinical care, or reimbursement of pre-award costs. Recipients may not use Healthy Communities program funding for the purchase of office furniture or computer equipment without prior written approval from DPH.