Division of Public Health
Agreement Addendum
FY 17-18

	Chronic Disease and Injury Section
Local Health Department Legal Name	**DPH Section / Branch Name**
886 Healthy Communities	Sharon Nelson, 919-707-5207, Sharon.boss.nelson@dhhs.nc.gov
Activity Number and Description	**DPH Program Contact** (name, phone number, and email)
06/01/2017 – 05/31/2018	
Service Period	**DPH Program Signature** **Date** (only required for a negotiable agreement addendum)
07/01/2017 – 06/30/2018	
Payment Period	

☒ **Original Agreement Addendum**
☐ **Agreement Addendum Revision #** ___

I. Background:

Every day in North Carolina, approximately 160 residents die of chronic disease, injury or violence.[1] North Carolina's cardiovascular disease (CVD) prevalence rate places it among the quartile of states with the highest CVD rates in the nation.[2] North Carolina is also in the quartile of states with the highest diabetes rate in the nation. In 2013, 11.4% of North Carolina's adult population had diabetes.[3] 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.[4] 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.

[1] State of North Carolina Coordinated Chronic Disease, Injury, and Health Promotion State Plan (2013). North Carolina Department of Health and Human Services.
[2] Trends in Key Health Objectives for North Carolina and the Nation, July 2012, p. 9 http://www.schs.state.nc.us/schs/pdf/2010_Trends_Report_20120814.pdf
[3] 2013 BRFSS Survey Results: NC, NC State Center for Health Statistics, Diabetes http://www.schs.state.nc.us/data/brfss/2013/nc/all/DIABETE3.html
[4] Trends in Key Health Objectives for North Carolina and the Nation, July 2012, p. 14 http://www.schs.state.nc.us/schs/pdf/2010_Trends_Report_20120814.pdf

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.

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.

The North Carolina Division of Public Health uses Preventive Health and Health Services (PHHS) Block Grant funding to administer the Healthy Communities Program through the Chronic Disease and Injury (CDI) Section. The aim of this program is to reduce the burden of chronic disease and injury in North Carolina. Research shows that implementing policy and systems changes can result in positive behavior changes that decrease chronic diseases and injuries and improve health. Examples of such 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 interventions for injury and violence prevention in communities.

II. Purpose:

The purpose of this Activity is to enable county and district health departments to implement community-based interventions that address poor nutrition, physical inactivity, tobacco use, violence and unintentional injury, and chronic disease screening and management. Interventions should strive to provide opportunities for everyone in North Carolina to achieve their optimal level of health, regardless of race or ethnicity, socioeconomic status, geographic location, education status, disability status or sexual orientation.

III. Scope of Work and Deliverables:

The Local Health Department shall:

A. Designate one qualified staff member to oversee all duties outlined in this Agreement Addenda. The local health director is responsible for notifying the Healthy Communities Program Consultant within 30 days when this position is vacated (including if the staff is on extended leave) and filled (including temporary designations due to extended leave).

B. Produce a one-year Community Action Plan and Budget for state fiscal year 2018-19, ensure it is reviewed by the local health director, and submit it electronically to the Healthy Communities Program Consultant by March 15, 2018. This Community Action Plan for 2018-19 shall:

   1. Outline strategies to address chronic disease and injury prevention selected from a pre-determined list created by Chronic Disease and Injury Section staff. This list will be shared with Local Health Department staff in January 2018.
   2. Support health equity by:
      a. Identifying priority populations based on demographic factors (e.g., race or ethnicity, socioeconomic status) and/or geography and
      b. Detailing how identified priority populations or organizations representing these populations will be engaged in the planning, implementation, or evaluation of at least one strategy.

C. Implement at least two of the following strategies from the 2017-18 Community Action Plan:

   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. Implement new Diabetes Self-Management Education and Support (DSMES) programs or expand existing DSMES programs in the county.
4. Increase the number of community or small retail venues providing access to healthy foods.
5. Increase the number of events held by community organizations aimed at increasing awareness of the need for colorectal cancer screenings.
6. Increase the number of organizations that provide educational interventions that address cancer risk factors (i.e., poor nutrition, physical inactivity, cancer screenings, tobacco use and avoiding UV exposure).
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. Increase the number of 100% smoke-free OR smoke-free/e-cigarette-free OR tobacco-free policies covering:
    a. Government buildings, government grounds and/or indoor public places through ordinances or Board of Health rules; or
    b. Colleges and universities (Note: The UNC system's strongest policy allowed is smoke-free within 100 linear feet of buildings).
9. Increase the number of smoke-free OR smoke-free/e-cigarette-free policies (minimum coverage of all indoor spaces and balconies, patios, and porches) covering:
    a. Public housing;
    b. Affordable multi-unit housing; and/or
    c. Market rate multi-unit housing.
10. Increase the number of funded partnerships with QuitlineNC to provide tobacco cessation services to tobacco users who want to quit.
11. Implement media and messaging campaigns that increase awareness of the risks of opioid poisoning, signs and symptoms of opioid overdose, where to access and how to administer naloxone in the event of an overdose.
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 a CDC HEADS UP head injury prevention initiative in middle and high schools in partnership with the local school athletic programs.
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. Conduct a county or district-wide Fruit and Vegetable Outlet Inventory (FVOI) assessment.

IV. Performance Measures/Reporting Requirements:

A. Performance Measures:

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.

2. Evidence that the 2018-19 Community Action Plan and Budget are submitted by required due dates and address health equity.

   Performance Indicators:

   a. Draft State Fiscal Year 2018-19 Community Action Plan and Budget are submitted by March 15, 2018.
   b. Revisions to the 2018-19 Community Action Plan and Budget are made based on technical assistance provided by the Program Consultant.
   c. Final 2018-19 Community Action Plan identifies priority populations and/or or partnering organizations representing these populations based on demographic factors (e.g., race or ethnicity, socioeconomic status) and/or geography.
   d. Final 2018-19 Community Action Plan includes details of how priority populations and/or organizations representing these populations are engaged in the planning, implementation, and/or evaluation of at least one strategy.
   e. Final 2018-19 Community Action Plan and Budget are submitted by May 15, 2018.

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

   Performance Indicators

   a. Information for all 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 use the results to address chronic disease and injury.
      3. Number of Local Health Departments that provide Diabetes Self-Management Education and Support (DSMES) with:
         a. new stand-alone DSMES;
         b. new satellite DSMES;
         c. enhancements to support existing DSMES within the Local Health Department; or,
         d. enhancements to support existing DSMES external to the Local Health Department.
      4. Number of:
         a. Community venues (e.g., food banks) providing access to healthy foods.
         b. Small retail venues (e.g., corner stores) providing access to healthy foods.
      5. Number of events held by community organizations aimed at increasing awareness of the need for colorectal cancer screenings.
      6. Number of organizations that provide educational interventions that address cancer risk factors (i.e. poor nutrition, physical inactivity, cancer screenings, tobacco use and avoiding UV exposure).
      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 100% smoke-free OR smoke-free/e-cigarette-free OR tobacco-free policies covering:
    a. Government buildings;
    b. Government grounds;
    c. Indoor public places; and/or
    d. Colleges and universities.
9. Number of units covered by smoke-free OR smoke-free/e-cigarette-free policies in:
    a. Public housing;
    b. Affordable multi-unit housing; and/or
    c. Market rate multi-unit housing.
10. Number of funded partnerships with QuitlineNC to provide tobacco cessation services to tobacco users who want to quit.
11. Number of media and messaging campaigns that increase awareness of the risks of opioid poisoning, signs and symptoms of opioid overdose, where to access and how to administer naloxone in the event of an overdose.
12. Number of gatekeeper training sessions for suicide prevention provided using:
    a. ASIST;
    b. QPR; and/or,
    c. Mental Health First Aid.
13. Number of CDC HEADS UP head injury prevention initiatives in middle and high schools in partnership with the local school athletic programs.
14. Number of media messages on DWI checking stations.

4. Evidence that progress on the 2017-18 Community Action Plan activities are reported by required deadlines.

    Performance Indicators:

    a. Progress reports about the implementation of the 2017-18 Community Action Plan are submitted quarterly, by September 10, December 10, March 10, and June 30. If these dates fall on a weekend, the reports are due the following Monday.
    b. Submission of at least one success story upon request by the Program Consultant.

5 Evidence that Fruit and Vegetable Outlet Inventory assessment results are submitted by August 1, 2017.

B. Reporting Requirements: The Local Health Department will submit quarterly progress reports as required.

V. **<u>Performance Monitoring and Quality Assurance</u>:**

The Healthy Communities Program is monitored through quarterly reports and conference calls with the Program Consultants to review progress towards completion of the Community Action Plan strategies. DPH shall maintain contact via email and telephone to monitor programmatic and fiscal performance. The Local Health Department will have its site visit once every three years.

If deficiencies in performance are identified, DPH shall notify the Local Health Department immediately via email or phone call and a corrective action plan may be required. Failure to comply with the requirements in the resulting corrective action plan may result in a decrease in funding or removal from consideration for future funding.

VI. Funding Guidelines or Restrictions:

A. Requirements for pass-through entities: In compliance with *2 CFR §200.331 – Requirements for pass-through* entities, the Division provides Federal Award Reporting Supplements to the Local Health Department receiving federally funded Agreement Addenda.

1. Definition: A Supplement discloses the required elements of a single federal award. Supplements address elements of federal funding sources only; state funding elements will not be included in the Supplement. Agreement Addenda (AAs) funded by more than one federal award will receive a disclosure Supplement for each federal award.

2. Frequency: Supplements will be generated as the Division receives information for federal grants. Supplements will be issued to the Local Health Department throughout the state fiscal year. For federally funded AAs, Supplements will accompany the original AA. If AAs are revised and if the revision affects federal funds, the AA Revisions will include Supplements. Supplements can also be sent to the Local Health Department even if no change is needed to the AA. In those instances, the Supplements will be sent to provide newly received federal grant information for funds already allocated in the existing AA.

B. 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 healthy eating, increase physical activity, reduced obesity, prevention of tobacco use, prevention of chronic diseases (e.g., cancer, heart disease, stroke, obesity and diabetes), support for chronic disease self-management or prevention of violence and injury.

C. 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.