CONTINUATION REVIEW OF PROGRAMS

OFFICE OF MINORITY HEALTH AND HEALTH DISPARITIES

INTERIM REPORT

SESSION LAW 2015-241

SECTION 6.20.(a)

North Carolina
Department of Health and Human Services

December 1, 2015

Introduction

Session Law 2015-241, Section 6.20 describes the legislatively enacted Continuation Review Program (the Program). The Program is intended to assist the General Assembly in reviewing funds, agencies, divisions, and programs financed by State government, and to assist the General Assembly in determining whether to continue, reduce, or eliminate funding for them.

The legislation further requires state departments and agencies identified for the Continuation Review Program to report on preliminary findings of the continuation review to the Fiscal Research Division no later than December 1, 2015, and to submit a final report to the Fiscal Research Division no later than April 1, 2016. The Department of Health and Human Services' (DHHS) Office of Minority Health was identified for the Program. Continuation review reports are required to include the following information:

> (1) A description of the fund, agency, division, or program mission, goals, and objectives, including statutorily required functions and functions performed without specific statutory authority.
> (2) The performance measures for the fund, agency, division, or program and the problem or need addressed.
> (3) The extent to which the fund, agency, division, or program objectives and performance measures have been achieved.
> (4) A detailed accounting of all sources of funds for the fund, agency, division, or program.
> (5) Recommendations for statutory, budgetary, or administrative changes needed to improve efficiency and effectiveness of services delivered to the public.
> (6) The consequences of discontinuing funding.
> (7) Recommendations for improving services or reducing costs or duplication.
> (8) The identification of policy issues that should be brought to the attention of the General Assembly.
> (9) Other information necessary to fully support the General Assembly's Continuation Review Program along with any information included in instructions from the Fiscal Research Division.

The Department of Health and Human Services (DHHS) received a guidance letter from the Fiscal Research Division (FRD) of the North Carolina General Assembly on November 2, 2015. FRD provided guidance on components to be included in this Interim Report, as well as in the Final Report due April 1, 2016.

Unless otherwise noted, information on performance measures and funding sources for programs included in the review is provided for State Fiscal Year (SFY) 2014-2015. All DHHS Office of Minority Health and Health Disparities (OMHHD) programs are in the DHHS Open Window Service titled *Community Capacity Building to Eliminate Health Disparities*. Full time equivalent (FTE) estimates are made in cases where positions serve multiple programs in this same Open Window Service.

Using Evidence to Guide Decision-Making

In addition to addressing the reporting elements required in Session Law 2015-241, this report also identifies programs regarding whether or not they use strategies or interventions that are **evidence-based, evidence-informed, best practice, or not supported by evidence in literature**. The North Carolina Institute of Medicine (NC IOM) Task Force on Implementing Evidence-Based Strategies in Public Health (2012) noted that, in general, programs and services that use evidence-based strategies (EBS) or interventions are more likely over time to be successful at achieving better health outcomes. The use of EBS also increases the likelihood of efficient utilization of public resources.

There are varied definitions for terms describing effectiveness of programs or quality of evidence to support the use of programs. The definition of the term "evidence-based" varies across disciplines (such as medicine, social work, juvenile justice, early childhood education, and public health). This variety makes it difficult to assign terms of effectiveness evenly across programs which have decidedly different purposes and anticipated outcomes.

For the purposes of this report, the following definitions (and additional clarification) are used:

Evidence-based strategies or interventions

- "Evidence-based strategies, including programs, clinical interventions, and policies, are those that have been evaluated and shown to produce positive outcomes." (NC IOM).
- The NC IOM further notes that evidence-based strategies should produce positive outcomes when replicated accurately and adequately.
- The Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services, notes that the term evidence-based is in stark contrast to "approaches that are based on tradition, convention, belief, or anecdotal evidence."

Evidence-informed strategies or interventions

- Evidence-informed strategies or interventions are "well-informed by the best available research evidence." (World Health Organization)
- Bowen and Zwi (2005) reviewed relevant literature from health, public policy, and the social sciences, including policy analysis theory. Their publication can be summarized as follows:
  - Evidence-informed practice means ensuring that health practice is guided by the best research and information available.
  - Good evidence identifies the potential benefits, harms and costs of an intervention.
  - Evidence may be of a qualitative or quantitative nature.
  - Evidence informed decision making models advocate for research evidence to be considered in conjunction with clinical expertise, patient preferences and values, and available resources.

Best practice

- "Best practice" is a procedure or set of procedures that is preferred or considered standard within an organization, industry, or discipline. Such practices are based on well-documented outcomes.
- Best practices are generally published as guidelines from reputable sources. As more research occurs, best practices are refined and republished across time.
- For health outcomes, sources of best practice may be the Centers for Disease Control and Prevention (CDC), or the U.S. Preventive Services Task Force (USPSTF).
- Other examples of organizations that publish best practices are the American College of Physicians (ACP), the American Congress of Obstetricians and Gynecologists (ACOG), and the American Dental Association (ADA).

Not supported by evidence in literature

- These are strategies or interventions for which there is no evidence documented in literature that indicates the intended positive outcomes can be achieved.

For strategies and interventions which are evidence-based, evidence-informed, or best practice, citations in included in the Resources section of the report.

Office of Minority Health and Health Disparities (OMHHD)

The North Carolina Office of Minority Health and Health Disparities (OMHHD) is housed within the North Carolina Department of Health and Humans Services' Division of Public Health (DPH) and was established by the North Carolina General Assembly in 1992, via HB1340, Part 24, Section 165. This law also established the Minority Health Advisory Council (MHAC) to advise the Governor and Secretary of the Department on health issues impacting minority communities. Since its inception and creation, OMHHD has engaged in projects in communities across North Carolina consistent with its mission to promote and advocate for the elimination of health disparities of all racial and ethnic minorities and other underserved populations in our state. The focus areas include: 1) research and data; 2) culture and language; 3) policy and legislation; 4) leadership development; and 5) partnership development.

The OMHHD's programs include Culturally and Linguistically Appropriate Services (CLAS) Training and Interpreter Services, as well as the Community Focused Eliminating Health Disparities Initiative (CFEHDI).

Culturally and Linguistically Appropriate Services (CLAS) Training and Interpreter Services

Open Window Service: Community Capacity Building to Eliminate Health Disparities

Current Environment

Description of Mission, Goals, Objectives, and Functions:

Culturally and Linguistically Appropriate Services (CLAS)

- The goal of the CLAS Training Program is to reduce cultural and linguistic barriers to care by providing local health departments (LHDs), tribal governments, health care organizations, Division of Public Health (DPH) staff, community-based and faith-based organizations, and policy makers with the training, skills, information and resources needed to address the changing demographics and health care needs of North Carolinians.
- CLAS' focus on organizational-level cultural competence allows organizations to address specific cultural competence needs through trainings and technical assistance on:
  - Improving the quality of care provided to vulnerable populations.
  - Utilizing best practices in multi-cultural care.
  - Implementing the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards).

Interpreters Services

- In 2005, the North Carolina General Assembly appropriated a recurring amount of $250,000 to fund a pilot program for Interpreters Grants, aimed at creating new positions for Interpreter Services at local health departments to enhance their capacity to serve Limited English Proficiency (LEP) clients.

- The Interpreters Grants were provided from State Fiscal Years (SFYs) 2005 to 2010. Due to budget cuts, the original funding was reduced to a $239,000 for SFYs 2011 through 2014. Interpreters Grants were not awarded after SFY 2013-2014.

Program Activities:

Culturally and Linguistically Appropriate Services (CLAS)

- CLAS provides trainings (in person and via webinars), workshops and presentations, educational and informational materials, and technical assistance on cultural competence, the National CLAS Standards, health literacy, health equity and best practices to LHDs, health centers, DPH staff, community-based organizations and community members.
- CLAS staffs participate on state and community workgroups and committees to ensure their proposed activities and interventions are culturally and linguistically appropriate and implement health equity principles.
- CLAS facilitates relationships between organizations across the state in order to share best practices and successful intervention strategies.

Interpreters Services

- Up to SFY 2013-2014, provided matching grants of $20,900 each to 10 Local Health Departments (LHDs).
- Grant recipients were expected to:
    - Provide interpreter services to a limited English proficiency (LEP) population.
    - Match the $20,900 with sufficient local funds to hire one interpreter into a full-time position (salaries and fringe benefits).
    - Demonstrate the progress and effectiveness of the program by presenting by the end of each fiscal year the results of patient and staff satisfaction qualitative surveys related to the services offered by the interpreter hired with the grant.
    - Reach 30% of the limited English speaking population within the county served by the LHD.
    - Submit an annual report.
    - Provide services both off-site and on-site to 100% of the individuals seeking LEP services.
    - Ensure that the interpreter hired by the LHD attended at least one interpreters training session per year provided by the Office of Minority Health and Health Disparities.

Evidence to support strategies or interventions:

Culturally and Linguistically Appropriate Services (CLAS)

- Uses evidence-informed strategies or interventions and best practices set forth by the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Committee for Quality Assurance, and the National Institutes of Health.
- Promotes the use of evidence-based programs to clients.

Interpreters Services

Best Practice (use of interpreters in local health departments)

Administering Agencies:

Culturally and Linguistically Appropriate Services (CLAS)
NC Division of Public Health Office of Minority Health and Health Disparities
Interpreters Services
No longer applicable (LHDs not funded since SFY 2013-2014).

Availability/Reach/Areas Served:

Culturally and Linguistically Appropriate Services (CLAS)
Statewide
Interpreters Services
Up to SFY 2013-2014, only ten LHDs were funded (Cabarrus, Henderson, Chatham, Jones, Dare, New Hanover, Duplin, Orange, Halifax, and Robeson counties).

Statutorily Required Functions:

Title VI of the Civil Rights Act requires that programs and operations of all entities that receive assistance from the federal government (including state agencies, local agencies, and private and nonprofit entities) comply with the Act's provisions regarding discrimination. The United States Supreme Court (Lau v. Nichols, 1974) stated that one type of national origin discrimination is discrimination based on a person's inability to speak, read, write, or understand English.

Source of Funds (State Fiscal Year 2014-2015):

Culturally and Linguistically Appropriate Services (CLAS)

SFY 14-15 Funding Source	Funding Type	Amount
Office of Minority Health State Partnership Grant *	Federal	$122,464
	GRAND TOTAL	**$122,464**

Included 1 FTE
** Federal grant was not awarded to North Carolina after SFY 2014-2015. Efforts around culturally and linguistically appropriate services were aligned and streamlined for greater efficiency by combining CLAS with the former Interpreter Services program beginning SFY 2015-2016.*

Interpreters Services

SFY 14-15 Funding Source	Funding Type	Amount
State Appropriations	State	$214,614
	GRAND TOTAL	**$214,614**

Includes 1 FTE

Discussion and Analysis of Performance Measures and Data

Problem or Need Addressed:

- North Carolina ranks 40th out of 50 states in terms of life expectancy at birth due to health care access barriers, racial and ethnic disparities, and the high prevalence of unhealthy behavior throughout the state.
- Despite culturally and linguistically appropriate services and interventions being more effective, improving service delivery, reducing medical errors and increasing cost savings for providers, only 34% of the public health and health care providers surveyed by CLAS were aware of the National CLAS Standards and only 29% said their organizations utilize the National CLAS Standards (Total surveyed = 176; surveys conducted between June and September 2015).
- Cultural competence eliminates two of the root causes of health disparities and health inequity (cultural and linguistic barriers) by enabling public health and health care systems to create and tailor interventions and care plans that meet the social, cultural, and linguistic needs of their diverse clients.
- Effective communication and the elimination of cultural and language barriers are essential to understand and give directions to a client to improve their health and their access to both health and human services. Clients with improved health ultimately require fewer health services over time, leading to reduced financial burden on both the state and county.

Performance Measures Defined and State Fiscal Year 2014-2015 Status:

Culturally and Linguistically Appropriate Services (CLAS)

CLAS provided technical assistance, trainings and presentations to over 320 representing local health departments, DPH staff, health care organizations and universities in 28 counties between June and August 2015. Services were provided in the following counties:

• Avery	• Duplin	• Moore	• Rowan
• Brunswick	• Durham	• Onslow	• Stokes
• Buncombe	• Forsyth	• Orange	• Transylvania
• Burke	• Granville	• Pender	• Vance
• Caldwell	• Harnett	• Randolph	• Wake
• Carteret	• Haywood	• Roberson	• Watauga
• Chatham	• Mitchell	• Rockingham	• Yancey

CLAS did not have any planning or performance information in DHHS Open Window for SFY 2014-2015. However, its primary performance measures were:

- The number of annual CLAS information webinars:
    - Conducted 1 webinar on the National CLAS Standards in FY 14-15
    - 53 participants
- The percentage change per quarter web hits inclusive of CLAS information search and retrieval:
    - OMHHD total web site hits: 24,963 (January 2015 – June 2015)
    - 52 downloads of CLAS Webinar Slides (after June 2015 webinar)

- The number of annual presentations and workshop participants:
    - 293 workshop and presentation participants between June and August 2015
    - 63 workshop and presentation participants in June 2015
- Percentage change in awareness:
    - 87% of respondents self-reported increased learning of new material about the CLAS Standards from the OMHHD intervention (June 2015 – September 2015)
- The number of sites per year adopting and implementing CLAS standards:
    - 80% of respondents who completed a CLAS training session said that they planned to implement the CLAS Standards into their work or program (September 2015).

Interpreters Services

No longer applicable (LHDs not funded since SFY 2013-2014).

External Factors

Policy Issues or Other Relevant Information (CLAS and Interpreters Services):

Not applicable

Other

Recommendations for Change (Statutory, Budgetary, or Administrative):

None

Consequences of Discontinuing Funding:

Local health departments, tribal governments, health care organizations, DPH staff, community and faith based organizations, and policy makers would not have access to free service level and organizational level cultural competence trainings and technical assistance.

Recommendations for Improving Services, or Reducing Costs or Duplication:

- Federal funds dedicated to OMHHD for the National CLAS Standards Initiative through the OMH State Partnership Grant were not renewed for SFY 2015-2016.
- To improve delivery of services, OMHHD efforts around culturally and linguistically appropriate services were aligned and streamlined for greater efficiency by combining CLAS with the former Interpreter Services program beginning SFY 2015-2016.
- With this streamlining, CLAS will be expanded by implementing the program in approximately 15 Local Health Departments (LHDs) per year, spreading this best practice to all 85 LHDs over an approximate 5-year timeframe (versus solely funding 10 LHDs per year through the Interpreter Services program).
- The adoption and execution of the National CLAS Standards by LHDs will also align with state and national public health accreditation standards.

Community Focused Eliminating Health Disparities Initiative (CFEHDI)

Open Window Service: Community Capacity Building to Eliminate Health Disparities

Current Environment

Description of Mission, Goals, Objectives, and Functions:

- In 2005, the North Carolina General Assembly appropriated a non-recurring amount of $1M to fund a pilot program, the Community Focused Eliminating Health Disparities Initiative (CFEHDI).
- CFEHDI is a comprehensive, statewide initiative focused on strengthening and improving the health of North Carolina's 3 major racial/ethnic groups: African Americans, Hispanics/Latinos, and American Indians.
- CFEHDI grantees provide services such as screenings, education, evidence-based programming and community outreach in 8 disease focus areas including: diabetes, heart disease, stroke, obesity, infant mortality, low birth-weight, cancer, and HIV/AIDS/STDS.
- The initiative also aims to prepare community leaders and their organizations to become effective and informed public health leaders, advocates, and partners.
- State appropriations from SFYs 2006-2015 for CFEHDI have ranged from $1M to $3M annually with two to three year funding for grant recipients.

Program Activities:

Provide grants-in-aid to community-based organizations, faith-based organizations, local health departments, hospitals, and Community Care of North Carolina (CCNC) networks.

Evidence to support strategies or interventions (see Resources):

- A State's Office of Minority Health serving as a grant maker is unique in North Carolina in comparison to other states' Offices of Minority Health, and is not necessarily seen as best practice.
- OMHHD, however, has more recently promoted the use of evidence-based strategies by grantees. CFEHDI grantees implemented the following evidenced-based programs in their communities:
  - Stanford University School of Medicine's Patient Education Research Center's four programs, which CFEHDI grantees are licensed to use.
    - Chronic Disease Self-Management Program
    - Positive Self-Management Program
    - Diabetes Self-Management Program
    - Tomando Control de su Salud Self-Management Program
  - KidShape 2.0
  - Faithful Families Eating Smart Moving More

Administering Agencies:

The twelve SFY 2014-2015 CFEHDI grantees included 3 Local Health Departments, one American Indian Tribe, and 9 community based organizations as follows:

- AccessCare
- Appalachian Regional Healthcare System
- Buncombe County Health and Human Services
- Columbus County Health Department
- Community Health Interventions and Sickle Cell Agency, Inc.
- Lumbee Nation Tribal Programs, Inc.
- Opportunities Industrialization Center, Inc.
- RAIN, Inc.
- Scotland Community Health Clinic
- Wake County Medical Society Community Health Foundation
- Wayne County Health Department
- Western North Carolina AIDS Project, Inc.

Availability/Reach/Areas Served:

Twelve SFY 2014-2015 CFEHDI grantees serve the following 21 counties: Alamance, Avery, Buncombe, Caswell, Chatham, Columbus, Cumberland, Duplin, Edgecombe, Henderson, Hoke, Johnston, Mecklenburg, Nash, Orange, Robeson, Rowan, Scotland, Wake, Watauga, and Wayne.

Statutorily Required Functions:

No statutorily required functions.
Session Law 2015-241, Section 12E.3 requirements for CFEHDI are:

- The amount of any grant-in-aid is limited to $300,000.
- Only community-based organizations, faith-based organizations, local health departments, hospitals, and CCNC networks, located in urban and rural areas, of the Eastern, Piedmont, and Western regions of North Carolina are eligible to apply.
- Only 4 grants-in-aid can be awarded to applicants located in each of these 3 regions of the State.
- Eligible applicants should demonstrate substantial participation and involvement with all other categories of eligible applicants, in order to ensure an evidence-based medical home model that will affect change in health and geographic disparities.
- The minimum duration of the grant period for any grant-in-aid is two years.
- The maximum duration of the grant period for any grant-in-aid is three years.
- If approved for a grant-in-aid, the grantee cannot use more than 8% of the grant funds for overhead costs.

Source of Funds (State Fiscal Year 2014-2015):

SFY 14-15 Funding Source	Funding Type	Amount
State Appropriations	State	$2,597,355
	GRAND TOTAL	**$2,597,355**

No FTEs

Discussion and Analysis of Performance Measures and Data

Problem or Need Addressed:

North Carolina experiences significant disparities in health that primarily affect African-Americans, Hispanic/Latinos, and American Indians. They include, but are not limited to, cancer, diabetes, heart disease, stroke, obesity, asthma, HIV/AIDS/STDS, and infant mortality. Data reported by the NC State Center for Health Statistics for 2009—2013 show:

- American Indians have the highest heart disease mortality rate at 196.5 and the disparity ratio when compared to Whites is 1.2 for both American Indians and African-Americans.
- American Indians also have the highest diabetes mortality rate at 43.5 and the disparity ratio when compared to Whites is 2.5 for both American Indians and African-Americans.
- African-Americans have the highest HIV/AIDS mortality rate at 10.4 and the disparity ratio when compared to Whites is 11.6.
- African-American males have the highest prostate cancer mortality rate at 231.5 and the disparity ratio when compared to Whites is 1.7.
- African-Americans have the highest infant mortality rate at 13.6 and the disparity ratio when compared to Whites is 2.5.

Performance Measures Defined and State Fiscal Year 2014-2015 Status:

CFEHDI grantees were required to report the following information and measures for their service areas (see chart):

- Activities implemented to reduce health disparities among minority populations.
- Specific success in reducing disease incidence.
- Program activities that presented challenges and how these challenges were addressed.
- Activities in which their partnering agencies assisted in achieving the performance measures or deliverables.
- All evidence based programs implemented during SFY 2014-2015 and how they were implemented in achieving the performance measures and deliverables.
- The evidenced based program participants who increased their knowledge in disease focused education during SFY 2014-2015.
- The effectiveness of the evidence based programs as determined by self-reported client surveys.

Agency Name	Performance Measure	Projected	Actual
AccessCare	Number of Chronic Disease Self-Management Program workshops provided to 60 unduplicated individuals	6	8
	Number of Medical Nutrition Therapy (MNT) program workshops offered to 125 individuals to manage their diabetes and heart disease.	34	35
	Number of participants referred by community partners to Chronic Disease Self-Management Program and Carolina Health Net.	250	260
	Number of participants who shall receive assistance, education, eligibility, and other insurance options information for Medicaid/Medicare enrollment	115	120
	Number of partnership agreements that shall be maintained	4	4
	Number of unduplicated participants served	550	822
	Percent of participants educated in the Chronic Disease Self-Management Program workshops who shall increase their knowledge of risk factors for diabetes and heart disease	85%	85%
	Percent of American Diabetes Association (ADA) self-management program participants that report increased knowledge in managing their diabetes	75%	90%
	Percent of participants enrolled in the 10 American Diabetes Association (ADA) trainings that will report at their 3 month follow-up visit that they are practicing lessons learned (i.e. conducting daily foot exams)	75%	75%
	Percent of participants who shall be enrolled into Medicaid/Medicare for the management of their diabetes and heart disease	95%	100%
	Percent of participants who shall establish contact with the medical home or service providers to whom they were referred to for the management of their diabetes and heart disease	95%	100%
	Percentage of participants in American Diabetes Association (ADA) self-management program that will have blood pressure less than 130/80 at 3 month follow up appointment	75%	75%
	Percentage of participants in American Diabetes Association (ADA) self-management program that will have improved A1C level at 3 month follow up appointment	50%	85%
	Percentage of staff that report an increase in capacity regarding the implementation of effective and comprehensive disease management, prevention and outreach programs	100%	100%

Agency Name	**Performance Measure**	**Projected**	**Actual**
Appalachian Regional Healthcare System, Inc.	Number of action plans that shall be maintained with local partners to educate the target population on disease focus areas, Medicaid/Medicare enrollment, evaluation/data collection, and marketing	4	4
	Number of unduplicated families who shall be enrolled in the Kidshape/Building Lively Active Strong Tweens workshops	30	0
	Number of unduplicated participants that shall receive medical home services for the treatment and management of diabetes, obesity, heart disease and stroke, and the prevention of secondary conditions.	50	40
	Number of unduplicated participants that shall receive overweight/obese body mass index, hypertension and diabetes screenings	50	15
	Number of unduplicated participants who shall be enrolled in the Tomando/Diabetes Support Group workshops.	115	68
	Number of unduplicated participants who shall receive interpretation and transportation services for medical, dental, and behavioral health visits.	50	50
	Percent of participants newly enrolled into a medical home who shall increase their preventive care, including preventive health screenings.	90%	100%
	Percent of participants referred to a medical home who will increase knowledge on how to access health care services as an uninsured patient.	85%	100%
	Percent of participants who shall demonstrate an increase in physical activities and fruit and vegetable consumption as a result of attending KidShape and Tomando workshops.	60%	100%
Agency Name	**Performance Measure**	**Projected**	**Actual**
Community Health Interventions &Sickle Cell Agency	Number of HIV/STD and diabetes brochures that shall be disseminated.	8	8
	Number of unduplicated community leaders who shall participate in a minimum of 3 Healthy Living Diabetes Self-Management Program Leader Trainings.	20	25
	Number of unduplicated individuals who shall participate in the Diabetes Self Management Program in Cumberland, Lee, and Hoke counties	100	113
	Number of unduplicated newly diagnosed HIV-positive persons who are referred and linked to a medical home.	300	745
	Percentage of community leaders who shall receive training and report that they are now	100%	100%

	equipped to effectively facilitate Healthy Living Diabetes Self-Management workshops within their communities.		
	Percentage of newly diagnosed HIV positive participants that shall be referred and linked to case management, mental and substance abuse services and/or a medical home for confirmatory follow-up and/or treatment.	90%	100%
	Percentage of participants who are tested that shall learn their HIV / Diabetes status	95%	100%
	Percentage of participants who shall receive education services who shall report a positive change in health knowledge, habits or awareness as it relates to diabetes, HIV, AIDS, STDs, and medical insurance options	90%	100%
	Percentage of Summit participants who report an increased knowledge regarding how to mobilize communities for action, how to effectively identify health factors and behaviors that impact rural racial and ethnic populations and how to develop innovative strategies to address minority health issues	80%	100%
Agency Name	**Performance Measure**	**Projected**	**Actual**
Lumbee Nation Tribal Programs, Inc.	Number of health education flyers and surveys disseminated to residents of Cumberland and Hoke counties to determine health habits.	300	400
	Number of partnership agreements established between provider organization and other partnering agencies.	2	2
	Number of unduplicated families of cancer patients receiving home visits for education on local services available to cancer patients.	5	5
	Number of unduplicated individuals educated and enrolled in Medicaid and Medicare in Robeson and Scotland Counties	140	150
	Number of unduplicated participants attending six workshops on cancer and obesity.	240	250
	Number of unduplicated participants attending two (2) healthy living workshops	40	60
	Number of unduplicated participants receiving education on medical homes through 2 workshops	144	150
	Number of unduplicated patients who are in need of a medical home referred to Robeson County Health Care Corporation.	100	105
	Number of unduplicated Tribal Health Advisors trained on the Chronic Disease Self-Management Program Living Heathy Curriculum	5	5
	Number of unduplicated Tribal staff participating in an annual two hour workshop on HIPAA	90	90

	(Health Insurance Portability and Accountability Act		
	Percentage of participants trained on the Chronic Disease Self-Management Program curriculum who increase their knowledge of chronic disease and strategies for healthy living.	80%	90%
	Percentage of unduplicated participants who establish contact with the medical home or service providers to whom they were referred.	85%	85%
	The percentage of cancer/obese education participants who shall increase their knowledge on self-management and local services available to them as cancer/obese patients to better manage their obesity and cancer	85%	95%
	The percentage of participants enrolled into Medicaid that utilize Medicaid and Medicare reimbursed medical services for continuum of care.	75%	85%
	The percentage of Tribal staff who demonstrate an increase in knowledge of HIPAA regulations and the definition and benefits of a medical home.	80%	100%
Agency Name	**Performance Measure**	**Projected**	**Actual**
Opportunities Industrialization Center, Inc., Rocky Mount	Number of diabetic participants measured and monitored for weight, body mass index (BMI) and A1C (blood glucose control) levels.	300	300
	Number of eligible participants enrolled into the Asthma Action Plan	235	260
	Number of face-to-face community outreach contacts made regarding prostate cancer	1,600	1,600
	Number of individuals reached through radio spots, church bulletins and health fairs for general community education	12,000	12,000
	Number of participants provided a stroke risk assessment and blood pressure screening and monitoring	300	300
	Number of participants provided HIV education and screening	325	750
	Number of participants provided Sexually Transmitted Disease (STD) education and screening	425	743
	Number of partnership agreements maintained between provider organization and other partnering agencies.	5	5
	Number of unduplicated participants receiving preventive and self-management education on cancer, diabetes, HIV/AIDS/STDs, obesity, heart disease, stroke, and clinical encounters.	2,015	3,464
	Number of unduplicated participants that shall be converted from emergency department usage to the	280	850

	Opportunities Industrialization Center Family Medical Centers medical home.		
	Percent of asthma participants who shall experience a decrease in their hospital emergency department visits	35%	40%
	Percent of Contractor staff that received cultural competency training who report an increased knowledge of cultural competency principles.	100%	100%
	Percent of diabetes education participants who improve at least one diabetes health indicator (e.g. decrease blood pressure, weight, BMI).	75%	100%
	Percent of diabetes education participants who shall increase their knowledge of diabetes.	70%	100%
	Percent of heart disease and stroke education participants who shall increase their knowledge of risk factors for heart disease and stroke.	75%	100%
	Percent of HIV and STD education participants who shall increase their knowledge of HIV and STDs.	80%	100%
	Percent of HIV and STD screening participants who shall become aware of their STD and HIV status.	92%	100%
	Percent of participants receiving a higher quality of care as a result of conversion from emergency departments to a medical home.	100%	100%
	Percentage participants receiving prostate cancer outreach who improve their knowledge of prostate cancer.	75%	100%
Agency Name	**Performance Measure**	**Projected**	**Actual**
RAIN, Inc.	Number of action plans that shall be maintained to guide the implementation of prevention/disease management education workshops, insurance options for Medicaid and Medicare, education, evaluation and data collection, media campaigns, and marketing	4	4
	Number of Chronic Disease Self-Management Program (CDSMP) workshops that shall be conducted	2	3
	Number of partnership agreements that shall be maintained	6	6
	Number of unduplicated HIV at-risk and positive youth referrals to community services to increase retention in medical homes	466	500
	Percent of HIV at risk and positive youth enrolled in Empowering Positive Youth (EPY) who shall report an increase in condom use.	75%	100%
	Percent of participants referred to a medical home who shall have increased knowledge on how to access health services	75%	100%

	Percent of youth who are at risk for HIV or HIV positive enrolled in Empowering Positive Youth (EPY) who shall access, receive case management/referrals, maintain medical care and other clinical services.	75%	100%
Agency Name	**Performance Measure**	**Projected**	**Actual**
Scotland Community Health Clinic	Number of at-risk or diabetic participants attending 3 diabetic healthy cooking lessons	100	100
	Number of CDSMP Healthy Lifestyle workshops provided to participants	2	2
	Number of medical homes participants shall be referred to for management of diabetes and secondary condition prevention	1	3
	Number of partnership agreements maintained between provider organization and other partnering agencies.	4	12
	Number of unduplicated at-risk and diabetic participants attending American Diabetes Association (ADA) education workshops.	75	75
	Number of unduplicated clients receiving lab coverage for diabetes and secondary related conditions such as heart disease, obesity, and hypertension.	200	340
	Number of unduplicated participants receiving diabetic eye exams.	75	100
	Number of unduplicated persons with or at-risk for diabetes that shall attend a diabetes health symposium	100	100
	Percentage of at risk and diabetic participants that received healthier cooking classes and/or CDSMP workshops who shall report an increased knowledge and awareness of the onset of diabetes.	50%	50%
	Percentage of participants who report lower HbA1C levels within normal range at the project end.	55%	80%
	Percentage of participants who shall identify the Contractor as the medical home or service provider.	100%	100%
	Percentage of participants who shall increase their knowledge of diabetes through workshops, cooking classes, and the diabetic health symposium.	75%	65%
Agency Name	**Performance Measure**	**Projected**	**Actual**
Wake Medical Society Community Health Foundation, Inc.	Number of participants who received chronic disease self-management workshops using Stanford University's Chronic Disease Self-Management Program (CDSMP) and Living Healthy with Diabetes training (DSMP) in Wake and Johnston Counties.	375	400

	Number of partnership agreements maintained with community-based organizations and local health departments.	5	6
	Number of uninsured individuals receiving Patient Navigation services	750	825
	The number of minority residents of Wake and Johnston Counties trained on the "Tomando Control de su Salud" and "Chronic Pain Self-Management" programs.	400	525
	Percent of participants attending informational workshops who show an increase in knowledge regarding Medicaid and Medicare accessibility.	85%	100%
	Percent of participants receiving Patient Navigation services who shall increase their preventive care, including preventive health screenings.	60%	85%
	Percent of training participants who demonstrate an increased level of activation in self-managing their health conditions. Trainings include Chronic Disease Self-Management, Diabetes Self-Management, Chronic Pain Self-Management, and "Tomando Control de su Salud."	85%	100%
	Percentage of communities with increased awareness of disease self-management, Medicaid/Medicare education opportunities, and health ambassadors recruited as a result of Faith Community partnerships.	100%	100%
Agency Name	**Performance Measure**	**Projected**	**Actual**
Western NC AIDS Project	Number of action plans that shall be maintained to guide the implementation of prevention/disease management education workshops, insurance options for Medicaid and Medicare, education, evaluation and data collection, media campaigns, and marketing	5	5
	Number of partnership agreements that shall be maintained.	5	5
	Number of unduplicated participants who shall be screened for HIV/AIDS	270	300
	Number of unduplicated participants who shall receive case management	140	140
	Number of unduplicated participants who shall receive SISTA training	40	50
	Number of unduplicated participants who shall receive VOCES/VOICES training	40	45
	The number of unduplicated participants attending Positive Self-Management Program (PSMP) workshops across the service area	18	15
	The number of unduplicated participants that shall receive a referral to a medical home that requires additional follow up or services.	50	50

	Percent of participants identified as at risk who shall receive case management/referral for additional services or medical care	100%	100%
	Percent of participants receiving SISTA education services who will report a positive change in health knowledge or awareness as it relates to HIV/AIDS.	100%	100%
	Percent of participants receiving VOCES/VOICES education services who will report a positive change in health knowledge or awareness as it relates to HIV/AIDS.	100%	100%
	Percent of participants referred to a medical home who will have increased knowledge on how to access health services.	90%	100%
	Percent of participants who shall receive support needed to remain in care for their HIV/AIDS diagnosis.	85%	100%
	Percent of participants who will receive education services and will report a positive change in health knowledge or awareness as it relates to HIV/AIDS	100%	100%
Agency Name	**Performance Measure**	**Projected**	**Actual**
Buncombe County Health Department	Provide screenings and conduct preventive and self-management education on obesity, diabetes, heart disease, stroke, asthma, cancer and HIV/AIDS/STDs for 1,300 unduplicated minority individuals throughout the county.	1,300	2,037
	Provide 14 Chronic Disease Self-Management (CDSMP) Living Healthy Workshops	14	13
	Provide 14 Chronic Disease Self-Management (CDSMP) Living Healthy Workshops to 140 unduplicated individuals.	140	88
	Provide Project EMPOWER Teen Pregnancy Prevention classes focusing on Asheville City School students with 20 students served each semester, for a total of 40 students per school year.	40	26
	Maintain 8 to 10 CDSMP lay health advisors from local churches and community organizations.	10	16
	Provide the Diabetes Wellness Program to 80 participants and the Diabetes Prevention Program to 40 participants.	80	51
	Provide the Diabetes Wellness Program to 80 participants and the Diabetes Prevention Program to 40 participants.	40	44
	Provide the monthly Ladies Night Out Program to a minimum of 240 women total, serving an average of 20 women each month.	240	173
	Provide Body & Soul, Diabetes Wellness Program and Diabetes Prevention workshops to 5 churches, with a minimum of 10 people participating from each church.	50	30
Agency Name	**Performance Measure**	**Projected**	**Actual**

Columbus County Health Department	Estimate the percentage of your staff that has demonstrated improvements in cultural competency knowledge.	4	12
	Number of partnership agreement that shall be developed and/or maintain	3	17
	Number of African Americans, Hispanic/Latinos and American Indians participants who shall receive preventive services	750	871
	Number of educational workshops that shall be provided congregational and community members	72	62
	Number of Heart Wellness Centers that shall be established.	6	13
	Maintain seven (7) and enroll one (1) church into the LIGHT Project, a health education program that focuses on the prevention and management of diabetes, stroke, heart disease and obesity.	8	11
	Maintain at least one lay health advisor per church for a total of twelve (12) trained advisors to become CDSMP and/or DSMP certified lay leaders. The lay leaders will attend sessions to learn how to engage in chronic diseases risk reduction conversations with people in their own social networks utilizing role model stories.	12	9
	Provide referral and information for Medicaid and Medicare to 120 participants attending workshops, health fairs, or outreach activities that are held during normal business hours, no-traditional hours, evenings and	120	818
Agency Name	**Performance Measure**	**Projected**	**Actual**
Wayne County Health Department	Number of staff and subcontractors trained with CDCSMP and Culturally Competency training	3	6
	Number of Staff, subcontractors and partners trained with CDSMP training	3	5
	Maintain a Plan of Action with local partners to educate on the 7 focus areas	5	8
	Maintain a Plan of Action with local partners to educate African American and/or Hispanic Latinos on Medicaid and Medicare enrollment and eligibility	5	4
	Maintain wellness facilitators from each church on establishing a ministry of health program - Faithful Families	16	1615
	Ensure each of the churches provide 5 training sessions to their congregations	40	15
	Ensure that churches conduct monthly pastor-lead preventive messages during their Sunday Sermons	64	7819
	Provide a 5 week fitness program twice a year totaling 10 weeks	50	19

	Provide medical home services to uninsured minorities for the treatment and management of all focus areas	180	99

Policy Issues or Other Relevant Information:

None

Other

Recommendations for Change (Statutory, Budgetary, or Administrative):

- CFEHDI has never been formally evaluated for its effectiveness and consistency with national practices and standards of other State' Offices of Minority Health. Grant-making, however, is not a best practice consistent with other states' Offices of Minority Health (see *Recommendations for Improving Services, or Reducing Costs or Duplication*). DHHS recommends that the existing CFEHDI grant program be eliminated.
- The consequence of not implementing change would be continued investment in a stand-alone minority health initiative (CFEHDI) that is:
  - Limited to a few community organizations and local health departments (unlike other statewide DHHS Division of Public Health programs that address minority health disparities);
  - Is not consistent with practices of other states' Offices of Minority Health; and
  - Has never been evaluated for its effectiveness.

Consequences of Discontinuing Funding:

The consequence of discontinuing funding to CFEHDI is that there may be less access for screening services currently being provided by CFEHDI grantees. Additional recommendations (see *Recommendations for Improving Services, or Reducing Costs or Duplication*), however, are likely to result in additional service delivery opportunities to minority populations in North Carolina.

Recommendations for Improving Services, or Reducing Costs or Duplication:

In 2014, the DHHS Office of Minority Health and Health Disparities (OMHHD) surveyed other states' Offices of Minority Health practices and programs, and found the following:

- Nationwide, states' Offices of Minority Health do not generally serve as "grant making" entities like North Carolina's OMHHD. State Offices of Minority Health (OMH) are not formally ranked, as many are at different stages of development. However:
  - Oregon, Colorado, Washington, Massachusetts, and Texas are examples of states that use data-driven strategies and work with other systems such as education, juvenile justice,

criminal justice, child welfare and public health to develop policies that address the social determinants of health, the interrelation of systems and the ultimate impact on health.
    - It appears that in many states' Offices of Minority Health, there is less focus on program development and implementation (although there are some programs that are supported) and more emphasis on advancing health equity and systems transformation.
- Two existing initiatives in the OMHHD (CFEHDI and the former Interpreters Services) do not seem consistent with current national practice and standards.

The Interpreters Services program has already been aligned with the Culturally and Linguistically Appropriate Services (CLAS) training to promote statewide implementation of a best practice in service delivery (versus supporting only 10 counties in the state through the Interpreters Services program).

DHHS recommends the repurposing of the approximately $2.6 million in funds currently dedicated to CFEHDI to reform the OMHHD and to enhance existing DHHS Division of Public Health Open Window Services which target the health disparities impacting racial/ethnic groups in North Carolina.
For SFY 15-16, CFEHDI funds total $2,597,345 (appropriations of $49,490; federal Preventive Health Block Grant of $2,547,855). For SFY 16-17, CFEHDI funds total $2,597,355 (all appropriations). For SFY 16-17, DHHS would recommend:

- Repurpose $2,547,355 in current CFEHDI funds to enhance and expand, not duplicate, the following three existing DHHS Open Window Services:

    - HIV – Sexually Transmitted Diseases (STD) Prevention Activities
    - Community Focused Infant Mortality
    - Heart Disease and Stroke Prevention

    In these 3 Open Window Services, repurposed funds would be targeted to areas of health disparities to include (1) African-American infant mortality, and HIV/STD, cancer and diabetes incidence; and (2) American Indian diabetes and heart disease incidence. These focus areas are consistent with documented disparate disease incidence and mortality rates for racial/ethnic groups in North Carolina. Funding would be directed to non-governmental agencies that address health programming in these focus areas.

    Such a repurposing of funds would also enhance subject matter expertise which already exists in these 3 DHHS Open Window Services (but does not currently exist in the OMHHD) and would allow for enhanced monitoring capability of funds utilization.

- Repurpose the remaining $50,000 in CFEHDI funds to provide operating funds for the OMHHD (travel, supplies, and workshop and conference expenses) to deliver statewide health equity and CLAS training, to ensure appropriate monitoring of the CLAS initiative, and to provide operating support to the Minority Health Advisory Council (MHAC), which had not convened for several years until calendar year 2015.

Research Methodology

No further research will be conducted. The DHHS OMHHD has researched evidence-based interventions and best practices, as well as other states' Office of Minority Health programs, and has included its recommendations in this interim report.

Resources

General

Improving North Carolina's Health: Applying Evidence for Success (2012). Report of the North Carolina Institute of Medicine Task Force on Implementing Evidence-Based Strategies in Public Health.

SAMSHA's National Registry of Evidence-Based Programs and Practices. http://www.nrepp.samhsa.gov/. Accessed October 28, 2015.

World Health Organization (WHO) Evidence-Informed Policy-Making. http://www.who.int/evidence/about/en/. Accessed October 28, 2015.

Bowen, S, Zwi AB (2005). Pathways to "evidence-informed" policy and practice: A framework for action. PLoS Med 2(7):e166.

Evidence for Office of Minority Health Program Interventions

Culturally and Linguistically Appropriate Services (CLAS) Training

U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Committee for Quality Assurance, and the National Institutes of Health.

Community Focused Eliminating Health Disparities Initiative (CFEHDI) Grantees' Interventions

Stanford University School of Medicine's Patient Education Research Center programs (Chronic Disease Self-Management Program, Positive Self-Management Program, Diabetes Self-Management Program, and Tomando Control de su Salud Self-Management Program)
http://patienteducation.stanford.edu/programs/

KidShape 2.0 curricula
American Academy of Pediatrics' "Recommendations for Treatment of Child and Adolescent Overweight and Obesity" (Pediatrics 2007; 120; S254-288)
U.S. Preventative Services Task Force recommendations on screening for obesity in children and adolescents. (Pediatrics 2010; 125;e396).

http://www.kidshape.net/

Faithful Families Eating Smart Moving More, a derivative of Eat Smart, Move More North Carolina, is a practice-tested intervention by the University of North Carolina at Chapel Hill's Center of Excellence for Training and Research Translation, in collaboration with the Centers for Disease Control and Prevention's (CDC) Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases.
http://www.faithfulfamiliesesmm.org/