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Office of Minority Health and Health Disparities

North Carolina

January 2003

“From Disparity to Parity in Health”

Eliminating Health Disparities Call to Action

North Carolina Department of Health and Human Services

Emmanuel Ngui, MS., Editor

Office of Minority Health and Health Disparities

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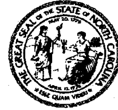
Message from Secretary Carmen Hooker Odom



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Michael F. Easley, Governor | Carmen Hooker Odom, Secretary

January 17, 2003

Message from Secretary Carmen Hooker Odom

In 2001, I established the elimination of health disparities as one of the top four priorities for the Department. This declaration signaled a new era for the Department, and challenged fourteen Divisions and Offices to identify solutions to the persistent health and service disparities in the state. During the initial phase, the Divisions and Offices assessed their programs/services to determine current activities aimed at addressing disparities. This baseline information was used by the programs to outline practical strategies to reduce health and service barriers for historically underserved communities, particularly racial/ethnic minorities and people with disabilities.

The resulting document is the "DHHS Call to Action to Eliminate Health Disparities". This Call To Action provides an operational framework to help guide the Divisions and Offices in their efforts to:

- increase awareness about the significant health disparities that exist between racial/ethnic minorities and White populations,
- expand the capacity of the programs in the Department to identify and eliminate health and service disparities, and
- build the community, state and national partnerships necessary to achieve the vision of a state where all North Carolinians enjoy good health, regardless of their race/ethnicity, disability, or socio-economic status.

We recognize that one Department alone can not eliminate the significant and complex factors that contribute to health disparities. This Call to Action represents one Department's efforts to implement a comprehensive and systematic approach to an urgent problem. It reinforces a philosophical position that health disparities are not acceptable. It is a commitment and a strategic effort to identify and correct system failures, remove barriers to services, and embrace change with new strategies and new community partners. That is a major first step in the systems change process.

While this a daunting task that is set before us, I have confidence that my staff in the Department and our other partners will be able to achieve this vision.

Sincerely,

Carmen Hooker Odom

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Acknowledgements

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Executive Summary

Shortly after Governor Mike Easley appointed her as Secretary of the Department of Health and Human Services, Carmen Hooker Odom declared eliminating health disparities a priority for the department. The Secretary charged the Office of Minority Health and Health Disparities with lead responsibility for developing the DHHS Call to Action to Eliminate Health Disparities. A Steering Committee on the Elimination of Health Disparities was also established. The committee, which guides the work of the department in building the department's capacity to identify and address disparities in each division, is made up of representatives from fourteen divisions and offices in DHHS.

The DHHS Call to Action to Eliminate Health Disparities represents the work of the Office of Minority Health and Health Disparities and the DHHS Steering Committee of Eliminating Health Disparities. The Call to Action provides an overview of North Carolina demographics and health disparities. Although the health status of North Carolinians has continued to improve over the last decade, the health status of a large segment of North Carolinians continues to lag behind that of the general population. Recent reports from the North Carolina State Center for Health Statistics document persisting racial and ethnic disparities in health status for almost all conditions. The reports show that African Americans, American Indians and Hispanics in North Carolina are more likely to be in poorer health than the White population in the state.

The Call to Action reviews the Healthy People 2010 conceptual framework to help understand the determinants of health status and health disparities. Healthy People 2010 suggests that population health is determined by a complex interaction of multiple factors including individual behaviors, biological factors, physical and social factors, environmental factors, policies, interventions and access to health care services. Healthy People 2010 also suggests that the development of comprehensive strategies to eliminate health disparities in North Carolina will require close collaboration and linkages with community assets, workforce diversity, economic development, and a more responsive, accessible and efficient health care delivery system.

N.C. DHHS used a multi-faceted process to develop recommendations and an action plan to advance the Call to Action to Eliminate Health Disparities. The process included OMHHD focus groups and regional meetings focusing on identifying key health disparity issues and a DHHS Disparity Program Assessment. The OMHHD focus groups and regional meetings helped to identify external perspectives for the department to consider in formulating its Call to Action. The Disparities Program Assessment focused on developing a DHHS internal perspective on the Call to Action approach.

Key external perspectives include:

1. Lack of grassroots involvement in the decision-making process in the development, implementation, and evaluation of programs, policies, and funding to address disparities.
2. Lack of inclusion of communities affected most by disparities at state and local "tables" where discussions on policies, interventions, programs, or research and evaluation decisions are made.
3. Limited ownership and lack of accountability for the elimination of health disparities.
4. Failure to have a diverse workforce that is representative of the communities served in the state.
5. Socio-cultural differences such as lack of trust, language differences, and differences in attitudes, values, beliefs, and myths.

Key internal perspectives included:

1. Lack of, or limited common understanding of, disparities across state programs. This includes the lack of a uniform definition of disparities and clear programmatic strategies to address these disparities individually and collectively.
2. Lack of communication across the different divisions and programs on health disparities.
3. Restriction of services by socio-economic status or other state and federal mandated requirements.
4. Failure to have a diverse workforce that is representative of the communities served in the state.

5. Socio-cultural differences such as lack of trust, language differences, and differences in attitudes, values, beliefs and myths.

The OMHHD and the DHHS Steering Committee work collaboratively to develop specific strategies for each recommendation that DHHS offices and divisions could consider in formulating office- and division-specific initiatives to address health disparities. Each participating DHHS division and office developed an action plan as part of the overall DHHS Eliminating Health Disparities Call to Action. The essential elements of each division or office plan included: program specific action steps for each relevant key recommendation; a division/office time frame for achieving each specific action step; an evaluation approach to measure progress towards meeting the recommendation/action step; data that are available to measure the action step; and identification of the resources that are available to meet the recommendation.

The following nine recommendations were formulated based on the input from the regional forums, health disparities focus group, and DHHS Steering Committee.

KEY RECOMMENDATIONS

1. **Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability, and socioeconomic status.**
2. **Communicate, document, and champion best practices in eliminating health disparities.**
3. **Promote, develop, and enhance communities' capacity to engage in healthy living and elimination of disparities in health status.**
4. **Monitor progress towards the elimination of health disparities.**
5. **Promote customer-friendly services that meet the needs of underserved populations (i.e., the poor and minority groups).**
6. **Increase resources and investments to eliminate health status gaps.**
7. **Build, support, and fully utilize a diverse workforce capable of working in cross-cultural settings.**
8. **Identify and advocate for public policies that aid in closing the health status gap.**
9. **Demonstrate accountability and ownership for health outcomes.**

Purpose and Vision

Purpose: The purpose of this Call to Action to Eliminate Health Disparities is to provide a framework for understanding the magnitude of racial and ethnic disparities in North Carolina and some of the social determinants of these disparities. The Call to Action focuses on the role of Department of Health and Human Services in addressing these issues and provides specific action steps proposed by each division and office in the Department to address these issues. The ultimate goal is to reduce service barriers and provide health and human services in a way that ensures that all North Carolinians enjoy good health regardless of race/ethnicity, disability, or socioeconomic status.

The Health Parity Vision:

"ALL NORTH CAROLINIANS WILL ENJOY GOOD HEALTH REGARDLESS OF THEIR RACE/ETHNICITY, DISABILITY OR SOCIOECONOMIC STATUS"

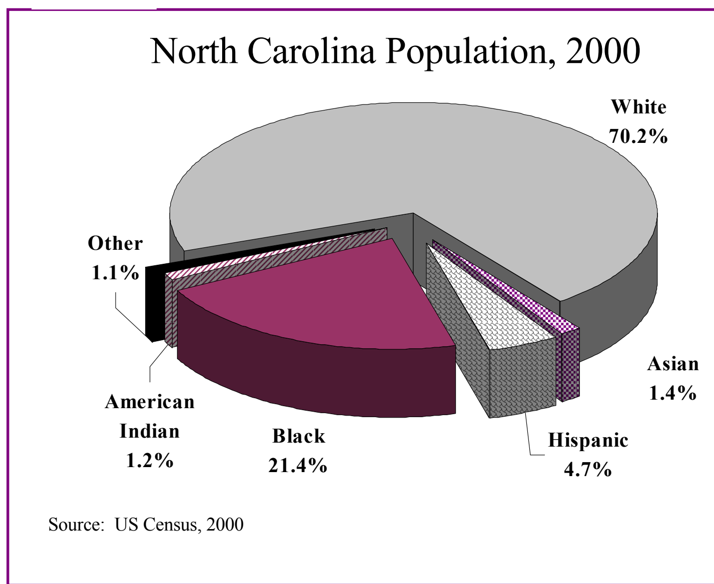
Achieving this vision will require concerted efforts by all sectors and individuals in North Carolina. Eliminating health disparities transcends the public health and the health care industry. It is an individual, community, state, and national issue. This vision requires reorientation of our individual and collective thinking, policies, programs, and resource allocations towards the goal of healthy living for all North Carolinians. Adoption of this vision indicates a desire to make North Carolina a state in which health status is not distributed by race/ethnicity, gender, disability, economic resources, or geographical location.

The Department of Health and Human Services is taking a leadership role in promoting and collaborating with other departments, agencies, policy makers, and communities to make the vision of health parity a reality for all North Carolinians regardless of their socioeconomic, race/ethnicity, gender, or disability status. The department is also building its internal capacity to address and eliminate health disparities.

North Carolina Demographics

According to the 2000 US Census, the population of North Carolina grew by 21.4 percent since 1990 to about 8,049,313 in 2000. African Americans, American Indians, Asians, and Hispanics now account for about 30 percent of the state's population.

Figure 1



As shown in Figure 1, in 2000:

- ❖ Whites made up about 70 percent of the North Carolina or about 5.6 million people.
- ❖ Blacks or African Americans account for about 21.4 percent of the population or about 1.7 million people.
- ❖ American Indians made up about 1.2 percent of the state's population or about 95 thousand people.
- ❖ Asians made up about 1.4 percent or about 112 thousand people. The Asian population in North Carolina consists mainly of Asian Indians, Chinese, Filipino, Japanese, Korean, and Vietnamese.
- ❖ Hispanics made up about 4.7 percent of the North Carolina population or about 379 thousand people, and accounted for about one-fifth of the 1.4 million people added to the state between 1990 and 2000. Most of the Hispanics in North Carolina were Mexican (246,545), Puerto Rican (31,117), Cuban (7,389), and other Hispanics or Latinos (93,912).

Overview: Health Disparities

The National Institutes of Health defines disparities as "the differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States."[2] Most of the health disparities are usually noted in terms of race/ethnicity, income, and gender. However, disparities also exist in other dimensions such as geographical location, age, disability status, and sexual orientation. Minorities and other underserved populations living in urban and rural communities continue to experience limited access to quality health care services, economic resources, and continue to experience poorer health than the general population.

Over the past few decades, enormous strides have been made in improving the health status and quality of life of all North Carolinians. However, in spite of these improvements, a large segment of the state's racial and ethnic minorities, particularly African Americans, American Indians, and Hispanics, continue to experience a disproportionate burden of poor health and premature mortality compared to their White counterparts.

The health status gap between racial/ethnic minorities and the White population continues to persist and appears to be widening in some conditions, such as asthma, diabetes, HIV/STD, and several forms of cancer. According to a recent report,[3] racial and ethnic disparities in health status continue to persist in almost all major health conditions and causes of death. The report shows African Americans, American Indians, and Hispanics in North Carolina are more likely to have a poorer health status than the White population in the state. These inequalities are not limited to health status but also involve the type and quality of services minorities and underserved populations continue to receive (i.e., access to life saving technologies, insurance coverage, and specialty care)[4,5,6].

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[2] National Institutes of Health, Addressing Health Disparities: The NIH Program of Action. What are health disparities. Available at: http://healthdisparities.nih.gov/whatare.html. Accessed December 9, 2002

[3] Buescher, P. Racial and ethnic differences in health in North Carolina. A Special report from the Center for Health Informatics and Statistics and the Office of Minority Health, November 2000. www.schs.nc.us/SCHS/pubs/

[4] Institute of Medicine. Unequal Treatment: Confronting racial and ethnic disparities in healthcare. National Academy Press, 2002.

[5] See: Medical Care Research and Review Volume 57, Supplement1, 2000

[6] Lillie-Blanton, M., Rushing, O.E. & Ruiz, S. Racial /ethnic differences in Cardiac Care: The weight of the evidence. The Henry J. Kaiser Family Foundation , Menlo Park, CA. Publication # 6041

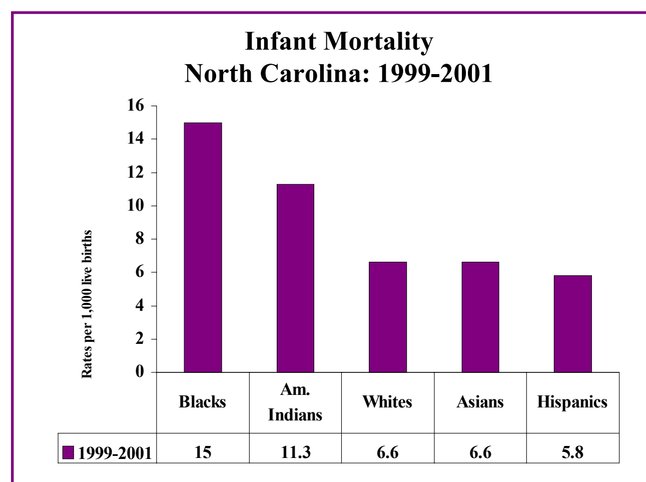
Key Areas of Disparities in Health Status

The disproportionate burden of poor health status and premature mortality is well documented. Many studies document widespread racial and ethnic differences in health status, access to care, and quality of care. The following section highlights some of the racial and ethnic disparities in North Carolina. Although these disparities can be examined from different perspectives, this overview and call to action will focus on racial and ethnic differences in health.

1. Infant mortality

According to the North Carolina State Center for Health Statistics, the overall infant mortality rate declined to 8.5 deaths per 1,000 live births in 2001 (1,035 in 1999 to 1,005 in 2000), a decrease of 1.2 percent from the 2000 rate of 8.6 (Figure2). However, as shown in Figure 2, the infant mortality for African Americans increased to 15 deaths per 1,000 live births during the same period.

Figure 2



- The infant mortality rate for African Americans continues to be over 2 times higher than that of Whites.
- Among American Indians, the infant mortality rate was about 1.7 times higher than that of Whites.
- The infant mortality rate for Hispanics was the lowest (5.8) followed by Whites and Asians with a rate of 6.6 each.

2. Cancer

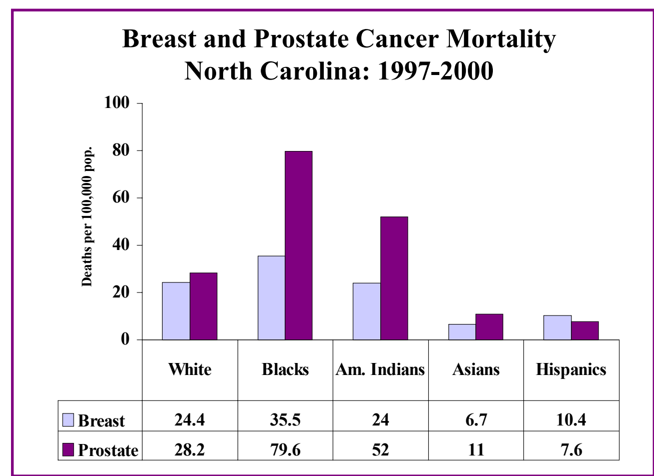
In 2001, over 37,300 new cases of cancer were diagnosed in North Carolina. In the same year, there were about 16,300 reported cancer related deaths in the state.[7] With the exception of prostate cancer, the general patterns of cancer incidence appear to be very similar among White and African American populations in the state. However, clear racial and ethnic differences exist in cancer related mortality rates, especially among African Americans. For example:

A. Prostate Cancer

In North Carolina:

- African American males are almost 3 times more likely to die of prostate cancer than White males.
- American Indian males are about 2 times more likely to die of prostate cancer than Whites are.
- Hispanics and Asians have lower prostate cancer mortality rates than all the other racial and ethnic groups (Figure 3).

Figure 3



	White	Blacks	Am. Indians	Asians	Hispanics
Breast	24.4	35.5	24	6.7	10.4
Prostate	28.2	79.6	52	11	7.6

[7] Source: American Cancer Society facts and Figures, 2001. Estimates exclude more than a million cases of basal and squamous cell skin cancers and in situ cancers, except urinary bladder, that will be diagnosed in 2001. Lung cancer rates include bronchus cancer. State death totals rounded to nearest 100.

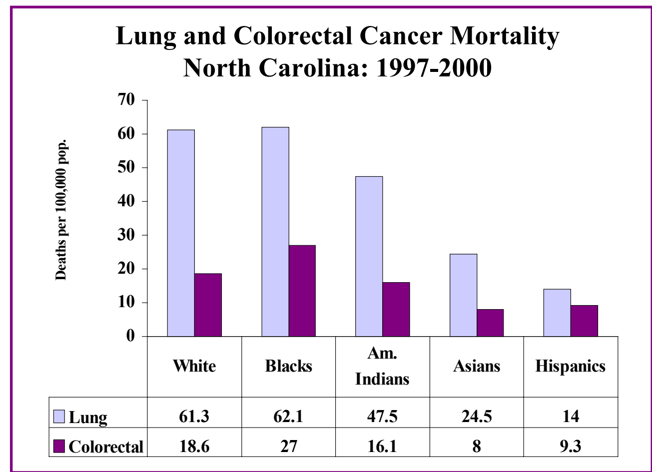
B. Breast Cancer

Similarly, African American females are about 1.5 times more likely to die due to breast cancer than their White counterparts. Breast cancer mortality rate for American Indians were similar to those of White females. The mortality rate for Hispanics and Asians is lower than that of the other racial and ethnic groups (Figure 3).

C. Lung Cancer

As shown in Figure 4, the rate of death due to lung cancer is about the same for African Americans and Whites and almost 30 percent lower among American Indians than Whites. Hispanics and Asians have the lowest death rates associated with lung cancer.

Figure 4



	White	Blacks	Am. Indians	Asians	Hispanics
Lung	61.3	62.1	47.5	24.5	14
Colorectal	18.6	27	16.1	8	9.3

D. Colorectal Cancer

Deaths due to colorectal cancer are about 45 percent higher among African Americans than Whites (Figure 4). Conversely, colorectal death rates among American Indians, Hispanics, and Asians are lower than those of Whites and African Americans.

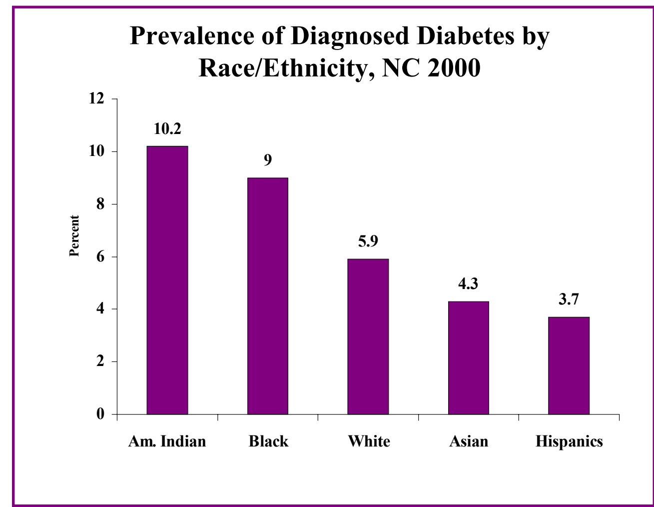
3. Diabetes

Diabetes is the sixth leading cause of death in North Carolina. It is estimated that over 584,000 North Carolinians are living with diabetes, with one third of them unaware that they have the disease. A large proportion of people living with diabetes in the state are American Indians and African Americans.

Diabetes Prevalence

As shown in Figure 5,

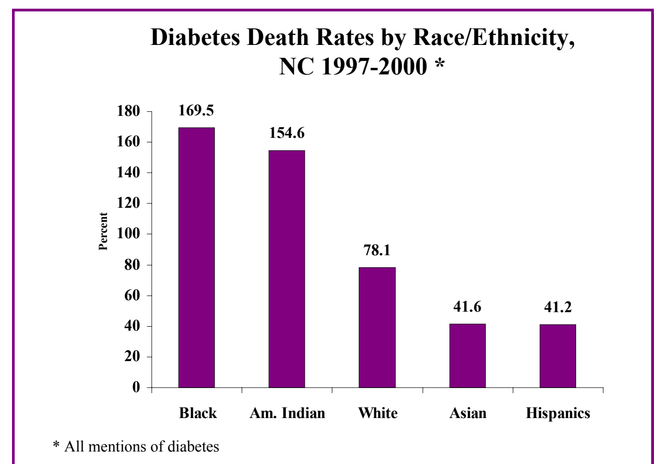
Figure 5



- The prevalence of diabetes among American Indians in North Carolina is about 1.7 times higher than Whites (10.2% vs. 5.9%).
- Similarly, the prevalence of the diabetes among African Americans is about 1.5 times higher than Whites (9% vs. 5.9%).
- The prevalence of diabetes is about 72 percent lower among Asians, and 62 percent lower among Hispanics in North Carolina.
- The prevalence of diabetes also appears to vary by socioeconomic status, with rates in households with incomes of less than $15,000 being over 3 times higher (11%) than households with an income of over $50,000.[8]

Diabetes Mortality

Figure 6



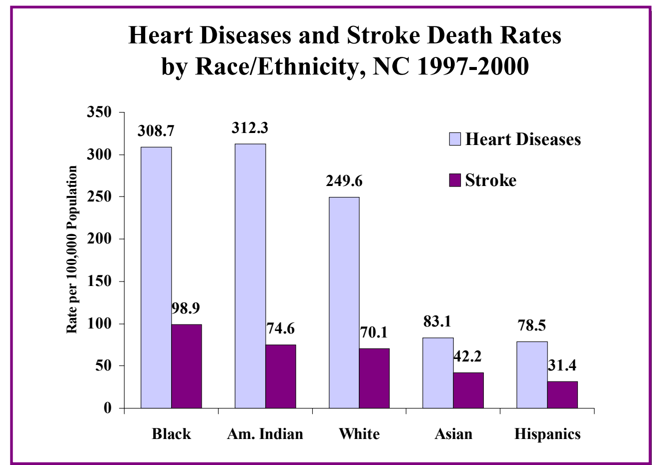
- African Americans and American Indians in North Carolina are both 2 times more likely to die of diabetes than Whites (Figure 6).
- Death rates among Asians and Hispanics are the same and about 50 percent lower than those of Whites.

4. Cardiovascular Diseases

Heart diseases remain the leading cause of death in North Carolina, accounting for over 20,000 deaths in 2000. In 1997-2000, African Americans and American Indians were about 25 percent more likely to die due to heart diseases than Whites (Figure 7).

The distribution of heart diseases in North Carolina also appears to vary by gender, education status, and disability status.[8]

Figure 7



- ❖ Males are 70 percent more likely to have a history of heart diseases than females (11.4% vs. 6.7%).
- ❖ Adults with less than a high school education have over 2 times higher prevalence of heart diseases than adults with more than a high school education.
- ❖ Among adults with a disability, the rate of cardiovascular disease is 5 times higher (24.2%) than that of adults without disability (4.6%).

[8] Gizlice, Z., Herrick, H., Buescher, P., Huston, S., Roth, M. & Scandlin, D. *Health Risks among North Carolina Adults: 1999. With a special section on persons with disabilities.* A report from the Behavioral Risk Factor Surveillance System. Division of Public Health & State Center for Health Statistics, Raleigh, NC. May 2001.

5. Stroke

As shown in Figure 7,

- African Americans are over 40 percent more likely to die due to stroke than their White counterparts.
- The death rate among American Indians is about the same as that of Whites (74.6 vs. 70.1).
- Hispanics have the lowest death rate associated with stroke (31.4).
- The risk of stroke is about 7 times higher among adults with disabilities than those without disabilities (10% vs. 1.4%)[8]

6. Asthma

African American and American Indian children in North Carolina are almost 2.8 times more likely to be hospitalized due to asthma than White children. Similarly, African American adults are over 2.5 times more likely to be hospitalized and 4 times more likely to die due to asthma than White adults.

7. Homicide

American Indians in North Carolina have higher homicide related deaths than all the other racial and ethnic groups.

- In 1997-2000, the homicide rate for American Indians was about 4.6 times higher than that of Whites (21.9 vs. 4.8).
- African Americans and Hispanics had the second and third highest homicide related deaths rates during the same period (18.4 and 11.5, respectively).

8. Sexually Transmitted Diseases[9]

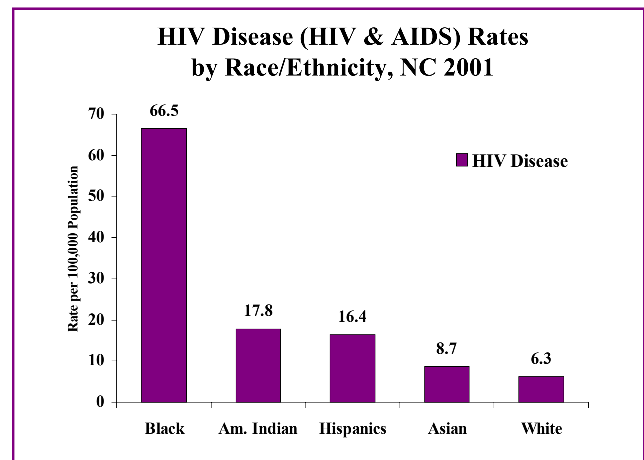
Racial and ethnic minorities in North Carolina continue to experience a disproportionate burden of sexually transmitted diseases.

A. HIV Disease

In 2001, African Americans in North Carolina bore a greater burden of HIV/AIDS than all other racial and ethnic groups. This burden is evidenced by the fact that although African American make up less than 22 percent of the state's population, they account for 75 percent of all new HIV infections in the state.

As shown in Figure 8, African Americans are over 10 times more likely to have HIV disease (HIV and AIDS) than Whites (66.5 vs. 6.3). Among American Indian population, the rate of HIV disease is about 3 times higher than that of Whites. Similarly, the rate of HIV disease among Hispanics is over two and half times higher than that of Whites (16.4 vs. 6.3). Overall, Asians in North Carolina have the lowest rate among all minority groups (8.7)

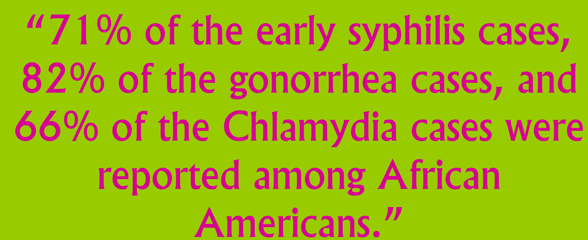
Figure 8



[9] North Carolina 2001 STD Surveillance Report. HIV/STD Prevention and Care Branch, Epidemiology and special studies unit. Division of Public Health, NC Department of Health and Human Services

B. Other Sexually Transmitted Diseases

Racial and ethnic minorities in North Carolina also share a disproportionate and persisting burden of sexually transmitted diseases, such as syphilis, gonorrhea, and chlamydia. The burden is especially great in the African American community where in 2001, "71% of the early syphilis cases, 82% of the gonorrhea cases, and 66% of the chlamydia cases were reported among African Americans."[9]

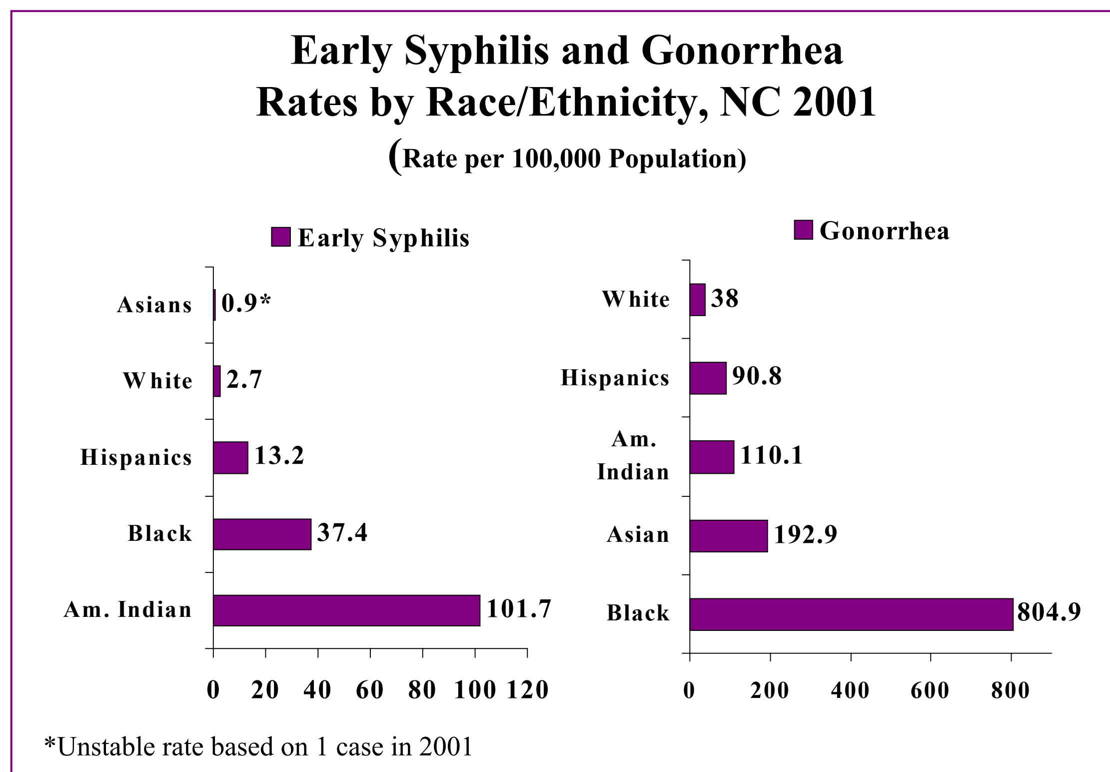


1. Early Syphilis

Figure 9 shows the rate of early syphilis and gonorrhea in North Carolina in 2001.

- ❖ American Indians had the highest rate (38 times higher than Whites) of early syphilis (primary, secondary, and early latent) in the state in 2001.
- ❖ Similarly, the rate of early syphilis among African Americans is about 14 times higher than that of Whites (37.4 vs. 2.7).
- ❖ Among Hispanics, the rate of early syphilis is almost 5 times higher than that of Whites (13.2 vs. 2.7).

Figure 9



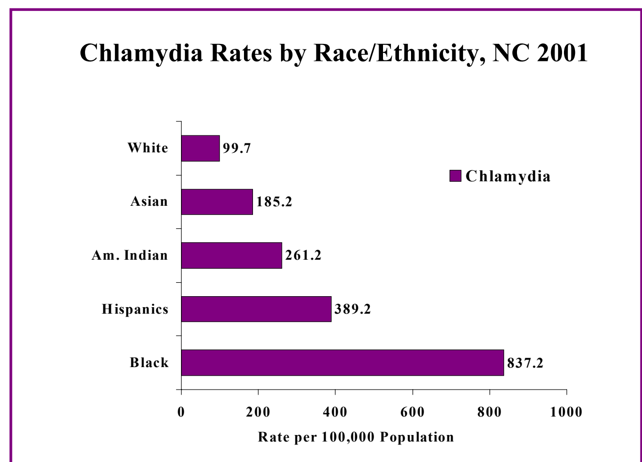
2. Gonorrhea

In 2001:

- African Americans were 21 times more likely to have gonorrhea than Whites (804.9 vs. 38).
- The rate among Asians was 5 times higher than Whites (192.9 vs. 38).
- American Indians had a rate 3 times higher than that of Whites (261 vs. 38).
- The rate of gonorrhea among Hispanics was over 2 times higher (90.8 vs. 38) than that of the White population.

3. Chlamydia

Figure 10



Just as for gonorrhea, in 2001, most of the cases of chlamydia were reported among African Americans (Figure 10). The rate of chlamydia in the African American population was about 8 times higher than in the White population (837.2 vs. 99.7).

Hispanics had the second highest number of cases of chlamydia with a rate of about 4 times higher than that of Whites (389.2 vs. 99.7). The rate for American Indians was about 3 times higher than that of Whites (261.2 vs. 99.7) while Asians had a rate of almost 2 times higher than that of their White counterparts (185.2 vs. 99.7).

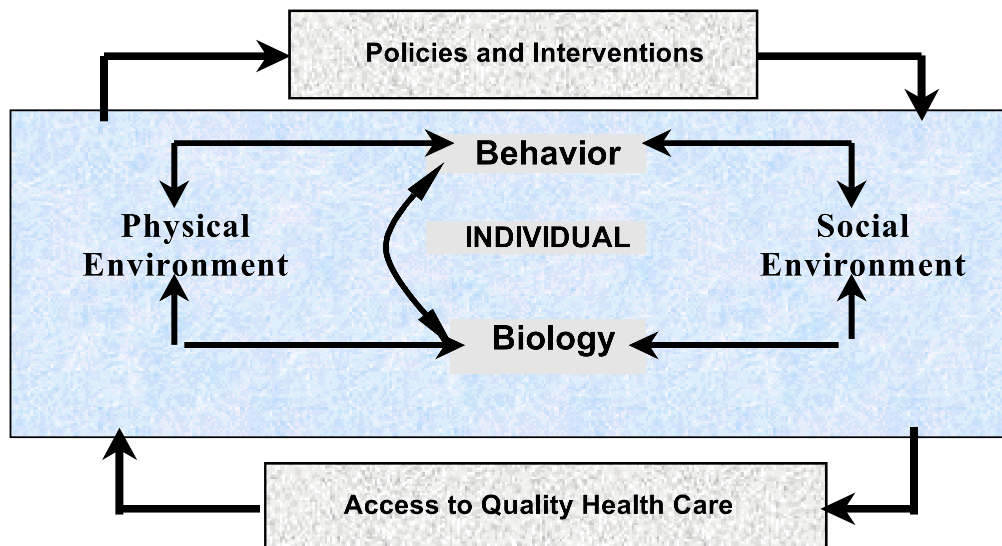
Determinants of Health

Population health is determined by a complex interaction of many factors including individual behaviors, biological factors, physical, social environmental factors, policies/interventions, and access to health care services (Figure 11). Individual factors include early childhood environment and development, biological predisposition, personal health practices, individual capacity, and coping skills. Individual health practices (i.e. smoking, physical activity, or sexual activity) and coping skills also greatly influence an individual's health. Personal health practices contribute significantly to most of the health conditions associated with health disparities.

The complex web of poverty and poor health have far reaching effects on individuals and communities which make it almost impossible to address one without the other.

Although individual factors such as health practices are important determinants of health status differences, there is growing consensus indicating that the underlying main causes of these disparities are social and economic inequalities.

Figure 11: **Determinants of Health**



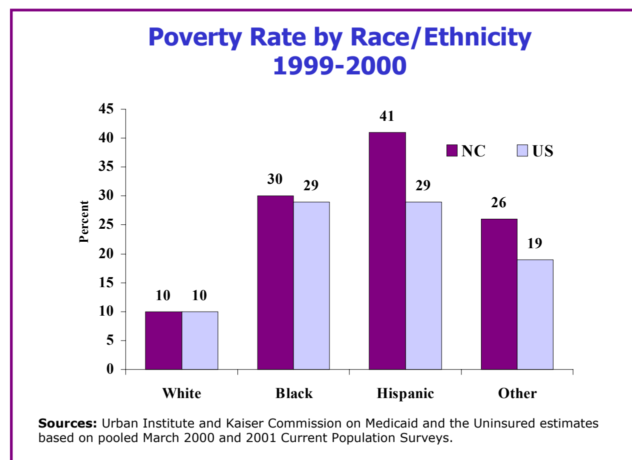
Source: Healthy People 2010: Understanding and Improving Health. (2000)
http://www.health.gov/healthypeople

Mikkelsen and colleagues contend that, "the chief underlying cause of health disparities is increasingly understood to be social and economic inequality; i.e., social bias and institutional racism, limited education, poverty, and related environmental conditions that either directly produce ill health or promote unhealthy behaviors that lead to poor health." P.3.[10]

Because of the narrow focus of medical interventions and other individually focused interventions, the use of such interventions, while critical, is not comprehensive enough to eliminate health disparities. Elimination of these disparities will require broad prevention interventions at the systems level that focus on changing conditions at the community level rather than individual level. Some of the most effective public health strategies have focused on policy level interventions rather than individual interventions. For example, the introduction of nationwide laws on minimum drinking age, seat belt use, lead, and non-flammable materials in children's sleepwear have all been credited with significant decline premature mortality[11,12,13].

To eliminate health disparities, fundamental changes and actions will need to be made to eliminate poverty and promote economic development opportunities in rural and poor communities in North Carolina. The complex web of poverty, race, and poor health have far reaching effects on individuals and community well-being which make it almost impossible to address one without the other.

Figure 12



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[10] Mikkelsen L, Cohen L, Bhattacharyya K, Valenzuela I, Davis R, & Gantz T. Eliminating health disparities: The Role of Primary Prevention. Oakland, Calif: Prevention Institute; 2002. http://www.preventioninstitute.org

[11] National Center for Statistics and Analysis. Traffic Safety Facts 1999: Young Drivers. Washington, DC: National Highway Traffic Safety Administration, US Dept of Transportation; 1999. Publication DOT HS 809 099.

[12] Trauma Foundation. Sleepwear fact sheet. Available at: http://www.tf.org//tf/injuries/sleep3.html

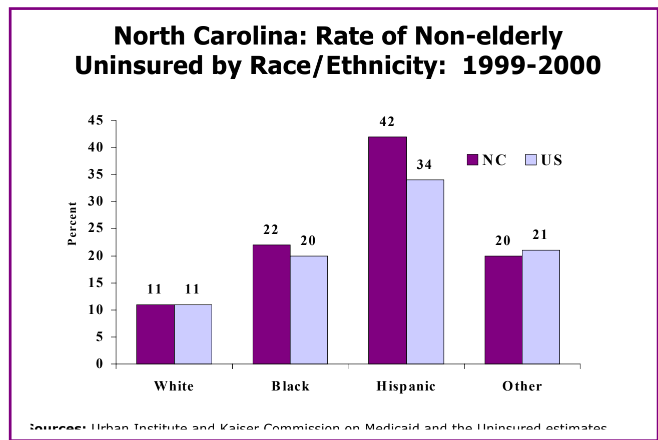
[13] National Safe Kids Campaign. Injury facts: poisoning. Available at: http://www.safekids.org. Accessed January 14, 2002.

A recent World Health Organization (WHO)[14] report states that "poverty is a cause, an associated factor, a catalyst, and a result of ill-health" (p89)…and that "good health is a way out of poverty [since] it results in a greater sense of well-being and contributes to increased social and economic productivity" (p84). The poor regardless of race or ethnicity or geographical location share a disproportionate burden of poor health.

> ***Poverty can affect health in a number of ways. Income provides the prerequisites for health, such as shelter, food, warmth, and the ability to participate in society: living in poverty can cause stress and anxiety which can damage people's health; and low income limits peoples' choices and militates against desirable changes in behavior. (Benzeval, Judge, & Whitehead, 1995, p.xxi)*** [ϕ]

As shown in Figure 12, racial and ethnic minorities are over represented among the poor in North Carolina. In 1999-2000 Hispanics and blacks were 4 and 3 times, respectively, more likely to be poor than Whites. Although only 10 percent of the White non-elderly population in North Carolina lived in poverty in 1999-2000, over 30 percent of non-elderly African American population, and 41 percent of the non-elderly Hispanic population in state lived in poverty.

Figure 13



Access and quality of health care services, especially services that are designed to promote and maintain good health, contribute to improved population health status. As shown in Figure 13, although only 11 percent of the White non-elderly population in North Carolina is uninsured, over 22 percent of non-elderly African American population and 42 percent of the Hispanic non-elderly population are uninsured in North Carolina. The high rate of the uninsured

[14] Global Forum for Health Research. *The 10/90 Report on Health Research 1999.* Global Forum For Health Research, WHO, Geneva, Switzerland. March, 1999.

[ϕ] *Benzaval, M. Judge, K., & Whitehead, M. (1995). Tackling inequalities in health: An* agenda for action. London: Kings Fund.

closely mirrors the distribution of poverty in the state (see Figure13).[15] The development of comprehensive strategies to eliminate health disparities in North Carolina will require close collaboration and linkage of community assets, workforce diversity, economic development, and more responsive, accessible and efficient health delivery systems.

> ***"…given access to economic opportunity, poor people will have the wherewithal to find or create their own health communities. The only way to get rid of poor places and poverty is to ensure that poor people become fully functioning participants in the mainstream economy. In order to improve economic opportunities for poor people, we have to build bridges between poor places and the regional and metropolitan economy."***
>
> *- William Julius Wilson*

[15] **Sources:** Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys. *http://www.statehealthfacts.kff.org/*

DHHS Disparities Program Assessment
Overview of Key Challenges

Disparity Program Assessment: The Disparity Program Assessment was developed by the OMHHD in collaboration with the North Carolina Department of Health and Human Services Eliminating Health Disparities (EHD) Steering Committee. The main purpose of the assessment was to examine divisions' and offices' key health disparities priority conditions or issues, service delivery and socio-cultural challenges, and health disparities focus areas. The survey was disseminated to the 14 divisions in the Department of Health and Human Services. The Department of Public Instruction and Department of Environmental Health also responded to the survey.

The assessment results show a great diversity in the issues each division/office sees as priorities. The Division of Public Health (DPH) had the largest number of programs focusing on health and also the broadest array of focus areas (i.e., disability, immunization, reproductive health, communicable diseases, and chronic conditions).

Service Delivery Challenges: The most frequently cited service delivery challenges include:

- ❖ Health education
  - ➥ Examples of health education and training needs include: "convincing families to feel empowered to use the system at the first sign of illness rather than as a last resort and for wellness", "educating local health and aging service providers about diseases and helping them develop the skills to educate the citizens in their communities."
- ❖ Access and coordination of services
- ❖ Staff and resource shortage (i.e. funding)

- Physical and social access barriers
    - Examples include: lack of transportation and lack of services and service providers in rural communities.
- Lack of or limited collaboration and partnerships between DHHS and:
    - divisions and agencies
    - programs and communities of color.

Socio-Cultural Barriers: The most frequently cited socio-cultural challenges identified by divisions and offices include:

- Language and communication barriers - particularly in delivery of services to linguistically different clientele.
    - The lack of interpreters and translation services emerged as a growing and persisting problem in the delivery of health and human services in North Carolina. For example, most programs indicated their need to serve the growing Hispanic population in the state and the lack of resources (i.e. bilingual staff and interpreter services) to provide such services. Programs also indicated barriers related to communicating with people from other cultural heritages. Many programs also indicated that the lack of bilingual providers was a major barrier.
- Lack of workforce diversity: Several programs cited the lack of diversity in the departments' workforce as barriers to serving the increasingly diverse population of the state.
- The lack of education, awareness, and knowledge of health problems or the health care system were also cited as additional socio-cultural barriers to service delivery.

- In addition, many programs cited attitudes, beliefs, values, trust, and stigma associated with both providers and clients as challenges to the delivery of services.
    - Some of the attitudes mentioned include provider attitudes towards minority patients, Medicaid clients, the poor, or people with disabilities. One program observed there is need for the "elimination of provider and provider/staff attitudes that discourage Medicaid recipients from seeking or obtaining medical care."
    - Trust issues between providers and clients or health care organizations and clients emerged as a critical socio-cultural challenge. Several programs cited mistrust of the health care delivery system by racial and ethnic minorities and other underserved groups as major challenges.

Areas of Disparity Focus: Of the eight disparities focus areas (age, gender, race/ethnicity, education, socioeconomic status, disability, geographical location, and sexual orientation) identified by Healthy People 2010, most of the programs indicated that their services focused on income, disability, race/ethnicity, and age. For many programs, their focus is largely determined by income criteria and disability eligibility requirements. Overall, most programs indicated that they focus directly or indirectly on racial and ethnic minorities as a result of these federal and state eligibility requirements through which minorities tend to be over-represented.

Current Gaps in Eliminating Health Disparities

Internal Perspective

(DHHS Steering Committee)

- Lack of or limited understanding of disparities across state programs and agencies. This includes the lack of a uniform definition of disparities and clear programmatic strategies to address these disparities individually or collectively.
- Lack of communication on health disparities across the different divisions and programs.
- Restriction of services by socioeconomic status or other state and federal mandated requirements.
- Failure to have a diverse workforce that is representative of the communities served in the state.
- Socio-cultural differences, such as: lack of trust, language differences, and differences in attitudes, values, beliefs, and myths.

External Perspective

(Focus Group)

- Lack of grassroots involvement in decision-making process in the development, implementation, and evaluation of programs, policies, and funding to address these disparities.
- Lack of inclusion of racial and ethnic minority communities affected most by health disparities on state and local entities where discussions on policies, interventions, programs, or research, and evaluation decisions are made.
- Limited ownership and lack of accountability for the elimination of health disparities.
- Lack of a diverse workforce that is representative of the communities served.
- Socio-cultural differences such as lack of trust, language differences, and differences in attitudes, values, beliefs, and myths

DHHS Divisions' and Offices'

Health Disparities

Implementation Plans

Implementation Plans

Division of Public Health

Mission: Protect, promote, and preserve the health of North Carolinians through ethical, compassionate, and evidence-based public health practice. http://www.dhhs.state.nc.us/dph/

Sections/Programs: Nineteen programs in the Division of Public Health responded to the survey. Response from the Division of Public Health included:

- Women and Children Section: Women's Health; Newborn Hearing Screening; Immunization Branch; WIC; Specialized Services Unit Programs for Children with Special Health Care Needs; Health Check/Health Choice; Office of Disability and Health
- Epidemiology: HIV/STD Prevention and Care Branch and TB Control
- Dental Health Section: Oral Health
- Health Promotion/Disease Prevention Section: Diabetes Branch; Cardiovascular Health; Cancer Prevention and Control Branch; Tobacco Prevention and Control Branch; Physical Activity and Nutrition Unit; Injury and Violence Prevention Unit; Statewide Health Promotion Program; Refugee Health Program; and Older Adult Health

Socio-cultural Challenges: Results from the survey responses indicate a need to examine and address several socio-cultural challenges faced by numerous programs in the Division of Public Health. The most frequently cited socio-cultural challenges in DPH include language and communication difficulties, attitudes, and values of providers and clients, and the need to improve health education/knowledge and awareness. Specifically, the lack of capacity to deliver linguistically appropriate services to clients, especially Hispanics, due to lack of bilingual staff and interpreters was considered a major challenge. In addition, programs cited both attitudes of providers to clients as well as clients' attitudes towards their health and health promoting activities (i.e., nutrition, physical activities and other preventive measures) as key challenges.

Most of the attitudes and language issues were described within the context of cultural differences between professionals and clients or communities they serve. Some of the programs also mentioned perceived differences in beliefs, myths, and social norms to be key socio-cultural challenges in the delivery of services. Several programs mentioned cultural differences and workforce diversity as socio-cultural barriers.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability, and socioeconomic status.	The NC Office on Disability and Health (NCODH) will publicize HP2010 goals for people with disabilities and NC and national progress in achieving these goals and objectives through reports and web to professional audiences.	Compile annually and report biannually	Documents available in hard copy and via websites	BRFSS, Core Indicators, YRBSS	NCODH and State Center for Health Statistics (SCHS).
	NCODH will identify and monitor health disparities among persons with disabilities as compared to North Carolinians without disabilities and identify priority areas for health interventions.	Annually	Compare to Healthy People 2010 and Healthy Carolinian objectives	BRFSS, Core Indicators, and YRBSS	NCODH
	NCODH will promote an awareness of the interrelationship between health and disability in efforts addressing employment, independent living, and community integration, to other DHHS Divisions.	On-going	Integration of health access and health promotion in DHHS initiatives such as Olmstead Transition to Work		
	Health Choice/Health Check (HC/HC) will promote HP 2010 goal to "increase the proportion of children, ages birth to 18 years, with health insurance" by: sharing demographic data / information re: uninsured, # enrolled and utilization rates through the State Outreach Coalition to Key Stakeholders, Child Advocates, Local Coalitions and others.	As data becomes available.	Written materials, meeting minutes and other documents that verify this effort	Data Needed on an ongoing basis: Reliable numbers of uninsured and enrolled by race/ethnicity, disability, and socioeconomic status. Utilization data by race/ethnicity, disability, and socioeconomic status. Geographic list of providers that accept Medicaid and State Child Health Insurance Program (SCHIP)	State Outreach Coalition State Staff, NCHSF Staff Key Stakeholders, Child Advocates, Local Coalitions Seek financial support from Robert Woods Johnson (RWJ) *Covering Kids and Families (CKF)* and Rex Foundation to support computer-programming costs.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status – continued.	The Women's Health Branch (WHB) data & partnership teams will review and analyze existing data sources and prepare a maternal health/family planning fact sheet on the health status inequities in North Carolina to assist CBOs and other contractors to identify priority areas for health interventions.	7/01/02-06/30/02	The development of 1-2 health status fact sheets for African American, Hispanic/Latino, and American Indian/Native American populations.	BRFSS, PRAMS, SCHS, Healthy Carolinians, Healthy People 2010, SHEPS center, Vital Statistics, March of Dimes, Child Advocacy Inst	WHB staff
	As the Children and Youth Branch (C&YB) develops and expands programs, there will be an increased focus on identifying and addressing health and service disparities, with an emphasis on improving access to health care for children and adolescents.	October 2002 - July 1, 2003	Planning Documents	Income Disability Medicaid eligibility Health Choice Enrollment data Medicaid (EPSDT) Participation data Health Choice Utilization data NCBRFSS and Youth Risk Behavior Survey (YRBS) data on youth with disabilities/ Chronic conditions Annual School Health Services Report for Public Schools Child Fatality Data Asthma hospitalizations NC School Asthma Survey HSIS Clinical Fusion	Office of Minority Health and Health Disparities (OMHHD) C&Y Branch Staff (central and regional offices) Family Participation NC Office on Disability and Health Division of Medical Assistance (DMA), Department of Public Instruction (DPI), Mental Health NC Pediatric Society Women's and Children's Health (WCH) Liaison Committee of Local Health Directors' Association State Child Fatality Prevention Team Asthma Alliance

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status – continued.	**Early Intervention Branch** Increase the number of minorities served in the NC Early Intervention Program by 10%	July 1, 2003	NC Early Intervention Data Base will be reviewed 10/1/02, 1/1/03, 3/1/03, and 7/1/03	Existing Early Intervention statewide data base	Early Intervention Branch regional and state staff NC Interagency Coordinating Council Cultural Diversity Committee
	The Immunization Branch (IB) will develop communication tools and disseminate to newspapers, television, and radio media outlets, highlighting HP 2010 disparities in childhood and adult immunization rates and effective strategies directed at reducing identified disparities.	Yearly	Number of communication tools created and submitted compared to disseminated tools. # of children, by race/ethnicity age-appropriately immunized by age two # of older adults, by race/ethnicity receiving flu and pneumococcal vaccines # of pregnant women, by race/ethnicity being tested for HbsAg % of infants born to HbsAG+ women - % of those infants prophylaxed at birth	North Carolina Immunization Registry (NCIR), NIS, CMS and BRFSS data, Hep B tracking information, Assessment, Feedback, Incentive, and Exchange (AFIX) assessments	IB staff, Office of Public Affairs, NIS, CMS and BRFSS staff

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status – continued.	The SCHS will publish and disseminate Minority Health Fact Sheets, including a new updated one on Latino Health. The SCHS will publish at least one special study highlighting health disparity issues.	Latino health, 2-1-2003. O Ongoing	Actual publication and dissemination of fact sheets	Existing secondary data from statistics kept at the SCHS	SCHS Statisticians
	By June 2003, the Health Promotion Disease Prevention (HPDP) Section will partner with the NC Commission of Indian Affairs, American Indian communities, the SCHS, and programs within DPH to measure burden of diabetes, cardiovascular disease (CVD), and other chronic illnesses in the American Indian population. HPDP will also disseminate arthritis and osteoporosis educational materials for working with American Indian populations.	FY 2003 - FY 2004	Annual data collected, published, and widely disseminated Number of educational materials distributed and number of persons receiving training	BRFSS data Hospital data 2000 Six County Cardiovascular Health (CVH) Survey Data Hospital discharge data on hip fractures	Led by CVH Epidemiologist, CDC funds and state matched funds. Diabetes Program funds, BRFSS Coordinator, Tribal leaders
	The Diabetes branch will utilize various targeted messages for African Americans, American Indians, and Hispanic/Latinos developed by the National Diabetes Education Program (NDEP) for controlling blood sugar levels and encouraging flu and Pneumococcal vaccines to promote awareness among policy makers, health care providers, and the public.	July 2002 - June 2003 and on going.	Number of times aired and estimated reach of target audience.	Demographic info needed on target audience for the various communication mediums. Info. Also needed on the best medium to reach the individual target groups.	NDEP, CDC Partnerships with state or community-based organizations (CBOs) of each target population

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status – continued.	Through June 30, 2003, the Diabetes Branch will partner with NC newspapers that reach a large percentage of ethnic minority populations and spread the Diabetes Advisory Council's news magazine model to these media.	July 2002-June 2003 and ongoing	Publication in additional newspapers and documentation of reach to the target population.	Diabetes Advisory Council (DAC) membership	DAC membership and other partners will be used to identify opportunities and appropriate media
	The Cancer Prevention and Control Branch (CPCB) will promote the achievement of the goals, objectives and strategies of the North Carolina Cancer Plan, 2001-06 specific to disparities.	FY 2003 – FY 2004	Analysis of objectives met	Demographic data for race, ethnicity	SCHS/CCR
	The Osteoporosis and Arthritis programs will promote the achievement of HP2010 goals for NC, with emphasis on the objectives for populations experiencing health disparities	FY 2003 - 2004		Need data on populations experiencing health disparities	Financial resources dependent on FY02-03 legislative budget CDC Funding
	The HPDP Section will develop partnerships with General Baptist Convention of NC to disseminate osteoporosis and arthritis education materials for working in African American communities.	June 30, 2003 Completed by 7/02	Number of educational materials distributed and number of persons receiving training and/or information	BRFSS survey data	CDC Funding HPDP staff

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status – continued.	The Tobacco Prevention & Control Branch (TPCB) will disseminate data and goals from the TPCB & diversity workgroup's strategic plan to identify and eliminate disparities via web site and culturally appropriate media channels.	January 2003 – July 2003	Track number of people & channels used to disseminate plan and number of health officials and directors reached		CDC funding Diversity/Disparities Director Media/Communications Director
	The TPCB will provide data to all local health officials and leaders within the local coalition counties and TPCB Youth Centers on the statewide cost impact due to lack of services, such as Medicaid coverage for cessation benefits and smoke-free workplaces for blue-collar and service industries.	June 2003 - June 2004		Number of health officials and leaders who receive information	
	The Forensic Tests for Alcohol (FTA) Branch will work to reduce the number of death and injuries caused by drinking drivers by increasing media attention to the general public and young drivers through highway safety events and assisting with community programs	July 2002, and on-going	Reviewing Governor's Highway Safety Program (GHSP) yearly reports and state DWI statistic	State intoxilyzer data	FTA Receipts and GHSP reports
	The Tuberculosis Control Branch (TBCB) will publish and distribute county case rates of tuberculosis (TB) by race and ethnicity, to local health jurisdictions.	Annually	Increased rate of TB treatment completion in high-risk minority populations.	Local Health Department (LHD) data from TB nurse consultant annual assessment	TB program staff, LHD staff.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status – continued.	The Oral Health Section (OHS) will provide data regarding oral health preventive efforts that strive to reduce the number of dental disease and untreated dental decay in low-income populations to decision-makers.	Conduct the kindergarten and fifth grade dental assessment every other year. Conduct a statewide dental survey of children in 2003-2004 and repeat in 2010.	Increase in the proportion of children with sealants. Decrease the proportion of children with high levels of dental disease and untreated dental disease. Information shared with decision-makers.	Average number of sealants per child. Average number of decayed, missing, and filled teeth per grade level per school. Demographic information	Oral Health Section staff funded by State appropriations and Federal Financial Participation (FFP). CDC funds for statewide survey of dental decay in school children.
	The TBCB will utilize avenues of Social Marketing to educate the public about TB transmission and prevention.	Within 2 years.	Targeted marketing to high-risk groups.	Monitoring of Social Marketing projects.	TB Health Educator DHHS Social Marketing Matrix team
	The HIV/STD Prevention & Care Branch will hold town meetings/forums across NC to assess need and increase awareness about HIV/STD, esp. disparities related to race/ethnicity, disability, and socioeconomic status.	On-going	Document number of town meetings/forums held, attendance, etc	Reports produced by HIV/STD Branch	Funding from CDC, HRSA, HIV/STD Branch staff

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
2. Communicate, document, and champion best-practices in eliminating health disparities	The NCODH will serve as a point of contact for best practices in addressing health promotion needs for persons with disabilities in DHHS initiatives and programs by providing technical assistance on adopting and adapting these strategies and interventions. The NCODH will work with DHHS on how to include a disability perspective in the design and implementation of health initiatives.	Ongoing	Document requests for technical assistance, distribution of publications and participation in work groups Document disability component of health initiatives		NCODH staff and Eliminating Health Disparities (EHD) Steering Committee
	HC/HC will work with the State Outreach Coalition, Key Stakeholders, Child Advocates & Local Coalitions to: ❖ share "lessons learned" from targeted outreach efforts through *Covering Kids* (CK) and State efforts. ❖ share best practices from *CKF* Grantees and local coalitions through state coalition letters.	Planned release of *CK* Final Report delayed due to pending freeze on Health Choice. Date TBD Local coalition letters are published at least quarterly.	Published *CK* Final Report & coalition letters.		*CK* Final Report. Approximately 3 FTEs at the State level. State Outreach Coalition. NC Commission on Children with Special Health Care Needs. RWJ/*CKF* and Rex Foundation Partners.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
2. Communicate, document, and champion best practices in eliminating health disparities – continued.	The Nutrition Services Branch (NSB) will select WIC local agencies to survey and to document best practices in serving the Hispanic/Latino community	7/02 – 10/02	Report of findings by 10/02	Qualitative survey data obtained 07/02 & 08/02	Federal WIC grant funding.
	The WHB will identify and document effective state or national strategies in addressing specific disparities by supporting the implementation, evaluation, and dissemination of results from the following pilot projects: ❖ Centering Pregnancy Model ❖ Healthy Start Baby Love Plus (BLP) -Family Violence Grant ❖ BLP Continuity Care conferences ❖ Smoking Cessation for Pregnant Women ❖ Sickle Cell ❖ Perinatal HIV	7/1/02-6/30/04	By the implementation, evaluation, and dissemination of results from the proposed pilot projects	PRAMS, BRFSS, Newborn Screening data, SHEPS Center, SCHS, Vital Statistics, HIV/STD Surveillance data.	Federal Healthy Start funds for the Family Violence grant and Continuity Care conferences; Health and Wellness Trust Fund Commission for Smoking Cessation for Pregnant Women; State Funds HIV/STD Prevention and Care Staff
	The IB will enlist all NC immunization providers to participate in the Universal Childhood Distribution Program (UCVDP), NCIR, AFIX and Government Performance Regulatory Act (GPRA) service delivery programs.	Ongoing	Efforts result in an increased number of immunization providers participating service delivery programs	Total number immunization providers *Baseline data* = total number of immunization providers participating in each service delivery program	IB staff, AFIX coordinators, Regional Consultants Registry

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
2. Communicate, document, and champion best-practices in eliminating health disparities – continued.	Through Vacunas Para Todos Pilot Projects, the IB will identify and promote effective strategies to increase MMR immunizations among women of childbearing years, and susceptible immigrants at the earliest point of entry and increasing up-to-date age appropriate immunizations in children by age two.	By July 2003 identify effective strategies By July 2004 replicate in local health departments January 1, 2003 Publish results from survey	Number of replicable identified strategies	Pilot Project Results # of opportunities to promote project	IB staff, LHD staff, Registry, Mary Easley, one time private funding Needed – continued funding
	The HIV/STD branch will work with OMHHD to obtain information about practices that promote access and quality of care. The HIV/STD branch will work on survey to measure minority staff presence, after hour services, and community-based organizations (CBOs).	Publish results from survey.	Development and distribution of survey Analysis of survey results Publish results	HIV/STD Branch survey.	Cooperative venture between OMH and HIV/STD branch. Statisticians from SCHS will complete analysis and report.
	The HP Branch will work on two specific national projects with UNC Health Promotion/Disease Prevention Research Center and NIH/National Cancer Institute to identify tools, such as CDC's Community Prevention Guidelines, to disseminate best practices on delivering and sharing information to LHDs and CBOs.	FY 2002-2002 and ongoing.	Document training opportunities, participation, and participant's evaluation.	Data from logs and evaluations.	HP Branch Staff.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
2. Communicate, document, and champion best-practices in eliminating health disparities – continued.	The CP&C Branch will participate in a conference with other community partners to determine use of best practices in disseminating cancer information.	January – July 2003	Summary of conference evaluation responses.	Conference evaluations	
	The TPCB will share information or deliver workshops state-wide for health departments, community-based and faith organizations, schools and universities (e.g. Historically Black Colleges & Universities, Title IX) that serve diverse population groups to promote best practices on tobacco prevention and control in African American, American Indian and Latino priority populations.	FY 2003 – FY 2004	Pre and Post-training surveys . Development of "lists of services" material.	Number of agencies that receive training.	CDC funding TPCB staff
	The Forensic Tests for Alcohol Branch will work with the Governor's Highway Safety Program during the statewide *Booze It & Lose It* campaign in an effort to reduce drinking and driving and enhance public awareness, particularly among the Hispanic population.	July 2002 and on-going	State DWI statistics and GHSP reports.	Number of events conducted statewide, GHSP reports	FTA receipts and GHSP support.
	The OHS will continue best practices, such as providing dental sealants for high-risk elementary schoolchildren in collaboration with the private dental sector and promoting fluoride varnish for high-risk preschool children.	Provide 20,000 sealants per school year – Ongoing	Report the number of sealants provided due to state efforts.	5th Grace dental assessment: number of sealants provided semiannually	State appropriations and FFP funds. OHS staff. Funding for sealants replacement uncertain. Funding for community fluoridation uncertain.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
2. Communicate, document, and champion best-practices in eliminating health disparities – continued.	The Bioterrorism Branch will develop and maintain a compendium/inventory of "best practices" related to responding to potential bioterrorism attacks for diverse populations.	FY 03,04	To be determined	To be determined	Funding provided by CDC.HRSA
	The HIV/STD Branch will include as part of the "Request for Applications/ Proposals" processes a requirement for applicants to include specific action steps as to how the proposed project will address disparities related to HIV/STD.	Limited to the availability of new funds.	Review of all RFA/Ps for concurrence.	Copy of RFA/Ps developed by Branch.	HIV/STD staff.
	The TBCB will focus targeted skin testing for Latent Tuberculosis Infection (LTBI) toward high risk minority populations through community outreach.	Within one year.	Increases proportion of skin tests positive.	Data from LHDs TB Nurse consultant annual assessments.	TB Program staff, LHD staff
	The OHC/HE will sponsor an annual conference, regional meetings, and other training offerings to provide opportunities to learn about best practices in identifying and eliminating disparities.	Annually	Document training opportunities, participant evaluations	Reports and participants evaluations.	Registration fees and Sponsors fund all Health Carolinians activities
	The Occupational and Environmental Epidemiology Branch (OEEB) will promote evidence-based programs and interventions to address health disparities by conducting an Antibiotic Resistance Study.	January, 2003	Results reported by HAB program at least semiannually	HAB program Environmental and Health data.	6 CDC funded positions.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
2. Communicate, document, and champion best-practices in eliminating health disparities – continued.	The IB will enhance provider and client targeted health education strategies by promoting best practices information for specific racial/ethnic groups, which include Asian Pacific Islanders, Older African American adults, and Hispanic/Latino.	Yearly	Assess availability of audience specific educational materials and opportunities	Number of site visits for the exchange of best practices Number of audience specific educational materials disseminated	IB staff, social marketing contract for adult immunization
	LHS will utilize resources from North Carolina's Turning Point to provide social marketing training, capacity development, and specific presentations/workshops on eliminating health disparities for NC's public health system.	FY 2002 – FY 2003	The development of formal steps and procedures to ensure culturally appropriate interventions for targeted communities	Copies of Social Marketing plans, Record of or agendas for events	OHC/HE Staff

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	The C&YB will reassess priorities and resource allocation to community partners with the elimination of disparities as a key consideration.	Fall 2002			
	The NCODH will identify disability organizations and groups at the state and community level that can ❖ be linked with health initiatives; ❖ promote inclusive approaches to community interventions; ❖ promote policies around healthy living to ensure responsiveness to issues and concerns of people with disabilities.	Ongoing	Documented requests from state or local agencies for assistance in disability representation.		EHD Steering Committee, NCODH, DHHS divisions
	HC/HC will promote HP 2010 goal to "increase the proportion of children, ages birth to 18 years, with health insurance" as the state budget allows by: ♦ Working with State Outreach Coalition and other Key Stakeholders to develop a strategy for targeted outreach. ♦ Partnering with *CKF* Grantee & Project Counties. ♦ Partnering with ACCESS II/III Initiative to link families to a medical home. ♦ Targeting media and print materials to local community-based coalitions.	Quarterly meetings. Pending funding decision from RWJ Ongoing Ongoing. Ongoing. Fall 2002.	Meeting minutes, written communications, annual reports, etc.		Approximately 3 FTEs at the State level State Outreach Coalition, Key Stakeholders NC Commission on Children with Special Health Care Needs, RWJ/*CKF* and Rex Foundation Partners, Local community coalitions

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status – continued.	The NSB WIC staff will participate in coordinated, comprehensive, monitoring of WCHS programs in local health departments.	Ongoing	Local agency corrective action plans	Local agency performance objectives from WCHS Agreement Addenda	Federal WIC administrative funding/regional and central office staff.
	The WHB will engage different communities early in research, programmatic and intervention efforts by sharing the facts sheets developed by the Branch to assist the various communities in determining the most effective intervention efforts and also to establish shared values and purpose and build on mutually beneficial relationships.	7/1/02 – 6/30/02	Partnering with various community coalitions or consortiums through the Minority Infant Mortality Reduction Program (MIMRP), BLP, and Teen Pregnancy Prevention Initiative (TPPI) projects	WHB Fact Sheets	WHB Staff
	Through state-level collaboration with DMA and GPRA, the IB will support and provide technical assistance for county-based collaborative efforts to promote and implement a web-based immunization registry.	Ongoing	Assessment of county readiness levels for registry implementation	County readiness evaluations.	IB, DMA, GPRA and LHD staff.
	The IB will collaborate with Division of Facility Services (DFS) to reach Long Term Care Facilities (LTCF) and Nursing Homes to institutionalize standing orders for and provision of immunizations for long term care residents and staff.	Yearly	Documentation and implementation of plan Increase in immunization rates among residents and staff	Deployment strategies determined by state-level partners. CMS and BRFSS adult immunization data.	Federal funds matched with state funds.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status – continued.	Through a collaborative relationship with OMH, & WCHS, the SCHS will develop a survey to obtain data about working relationships between LHDs and CBOs.	June 1, 2003	By carrying out, completing, entering, and analyzing data, and publishing report. Enhanced working relationship between LHDs and CBOs.	Data will be collected to obtain perspective from minority CBOs.	The SCHS will support the initiative by the HIV/STD branch and OMH to find ways to promote LHD work with CBOs, which are minority led.
	The HP Branch will continue the "Start with Your Heart: and "Strike Out Stroke" awareness campaigns that target counties with the highest CVD death rates, African Americans, and food stamp eligible populations. The HP Branch will link local CVH s with American Indians	Ongoing	Number of impressions in targeted populations.	Media campaign data collected through social marketing contract	State appropriations for two campaigns plus matching federal dollars through NC Nutrition Network
	The HP Branch will disseminate new State Blueprints focusing on healthy eating and increased physical activity by kicking off the state initiative "Eat Smart and Move More…NC".	Ongoing	Progress Check Integrated HP Evaluation System	Reports from LHD & other funded provided.	Federal funds matched with state funds.
	The HP Branch will install smoke alarms and provide fire safety education in 2.000 low-income homes annually in NC communities with population with < 50K	Sept 2002 – Sept 2006	Follow-up on phone surveys to 15% of recipients one year post interventions.	Data collected when service provided and in post intervention. Phone survey.	CDC cooperative agreement for residential fire safety – Injury and Violence Prevention Unit.
	The HP Branch will require that objectives to address health disparities be included in the local health departments' agreement addenda.	Ongoing	Progress Check reporting system	Quarterly and year end reports.	State revenue and Preventive Health Services Block Grant.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status – continued.	The Diabetes program will work with the General Baptist State Convention – African Americans, Commission of Indian Affairs, El Centro Hispano of Durham and local health departments to build capacity through implementation of the Diabetes today community model.	July 2002 through June 2003 and ongoing with specific target groups.	Progress Check Reporting System	Data is needed that addresses policy and environmental changes that occur with the interventions. Progress Check Reporting system	These organizations are funded through the Diabetes program grant from the CDC for implementation of Diabetes Today.
	The Diabetes program will leverage the influence of the statewide Diabetes Advisory Council and continue to advocate for the needs of the uninsured and underinsured in obtaining diabetes medications, testing strips and self management education.	July 2002 and ongoing	Progress Check Reporting System	Relevant legislation or reimbursement policy must be documented. Data is needed on the number of uninsured and other demographics describing this population.	In kind support of council membership to advocate for relevant legislation/policies that impact the uninsured with diabetes. State prescription drug program. Indigent test strip programs are needed that mirror the indigent medication programs now available.
	The CP&C Branch will develop public information messages on cancer risk and screening opportunities for publication in media used by diverse populations. The CP&P Branch will provide specific training on cancer risk and preventive measures at meetings conducted by diverse communities.	January – July, 2003	Number of articles published	Listing of media that reaches specific population groups.	Community media partners.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status – continued.	In coordination with OMHHD, the TPCB will provide a training workshop on tobacco use prevention and cessation at the Health Trust kickoff event for the community and schools grantees and to the 3 agencies that receive Health Trust funding for disparities.	FY 2002 – FY 2004	Survey to determine training and technical assistance needs. Program Tracking System with modifications.	Survey of state-level health promotion agencies. Number of diverse community leaders involved in local coalitions.	Limited funding for training and technical assistance for Health Trust recipients (depending on availability of Health and Wellness Trust Funds. TPCB staff, 1 part-time consultant to aid in the development and programming of PTS.
	The TPCB will enhance collaborative efforts with diverse community leaders, local contractors, agencies and non-traditional venues that serve low SES and other at-risk for tobacco use population (i.e. Social Services, Social Security Intake Offices, Shelters, Public Housing Agencies) to improve service delivery for smoking cessation and to develop appropriate interventions for their communities.	FY 2002 – 2004		Number of low SES collaborating with TPCB	
	The FTA will assist local communities to schedule highway safety events to reach populations with high rates of alcohol crashes	July 2002 and ongoing	Reports from communities GHSP and state statistics.	State data, GHSP report.	GHSP grant funds and FTA funding.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status – continued.	The OHS will collaborate with and promote partnerships at the county level with elementary school staff and administration, school nurses, local health organizations, and other community-based organizations that wish to start dental clinics to serve low-income populations.	Ongoing	Count the number of collaborations or partnerships developed.	Survey of OMS staff.	State and FFP funding or Oral Health staff at the state, regional and local level.
	The OHS will continue to work with the public-private partnership to develop coordinated strategies for the "Into the Mouths of Babes" program, an innovative new program that integrates preventive dental services in the offices of private physicians and health departments to reduce dental disease in the low-income populations.	Ongoing	Report the number of young children receiving the preventive procedure in a medical setting.	Medicaid data.	State and FFP funding for Oral Health staff at the state, regional, and local level.
	The Bio-terrorism Branch will facilitate networking among researchers with expertise in eliminating health disparities among bio-terrorism responders.	Ongoing	Documentation of efforts, request, and development of technical assistance plan.	Contract monitoring plans .Routine Branch activity reports.	Funding from the CDC, HRSA
	The HIV/STD Branch will identify key areas of need for technical assistance related the elimination of health disparities for all Branch funded CBOs, LHDs, and Ryan White Title II providers engaged in HIV/STD prevention/care efforts/	Ongoing	Documentation of key and development of plan to provide technical assistance.	Contract monitoring plans and reports.	Funding from the CDC, HRSA, HUD, HIV/STD Prevention and Care staff.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status – continued.	The TBCB will foster local partnerships with the American Lung Association, CDC, and regional academic medical centers to enhance the community's capacity to address health disparities.	3 Years	Increased number of educational symposia, grants, and funded projects.	Number of partnerships and projects developed.	TB program staff, LHD staff and target agencies.
	The OH/HE will provide consultation and technical assistance to Healthy Carolinian Partnerships I over 800 counties to assist them in implementing action plans to address health disparities.	Ongoing	Monthly reports, Partnership evaluations, and progress reports.		OHC/HE staff, Healthy Carolina Partnership staff.
	The HIV/STD Prevention and Care Branch will facilitate networking among researchers with expertise in eliminating health disparities and those providing HIV/STD prevention and cares services.	Ongoing	Documentation of efforts, requests and development of technical assistance plans.		HIV/STD Prevention and Care staff.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
4. Monitor progress towards the elimination of health disparities.	The NCODH will garner consensus within DHHS of the importance to consistently capture disability status for measuring health and service disparities by including screening questions in surveillance and program data systems.	By March, 2003	Develop consistent definition and screening questions.		C&Y and NCOHD staff, EDH Steering Committee, DHHS Division Chiefs, and OMHHD.
	HC/HC will continue to conduct ongoing data analysis and share information with the State Outreach Coalition, local coalitions, stakeholders, and advocates.	As data becomes available.			RWJ CKF and Rex Foundation Projects for funding support.
	The WHB will collaborate with at least 2 NC counties to utilize the Perinatal Periods of Risk Model to monitor and identify health gaps. Which will enable the communities to target resources for prevention activities.	7/1/02 – 6/30/04	Actual results for the PPOR review and targeting resources to address the identified gap.	HP 2010, PRAMS, SCHS, Vital Statistics.	WHB staff time.
	The IB will implement a statewide web based immunization registry.	5 years total implementation. Yearly assessment of readiness levels.	Progress towards implementation of defined deployment strategies. Interim assessment of available data.	County readiness level results NIS, CMS, and BRFSS data.	IB, LHD, CMS, and BRFSS staff. Needed – Continued federal and state funding.
	The SCHS will continue to monitor trends in yearly figures, regarding al aspects of infant mortality, and other outcomes including indexes of access and quality.	Ongoing, Yearly reports by October.	After closing out calendar year statistics, prepare report for release.	Vital Statistics Birth Defect Registry.	SCHS cooperates with SCHS and Public Affairs in DHHS to disseminate data.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
4. Monitor progress towards the elimination of health disparities – continued.	The HP Branch will continue surveillance of trends in CVD deaths and risks in order to publicize the trends in disparities, particularly to decision-makers.	Ongoing	Number of annual reports and presentations.	CVD Deaths, BRFSS and 6 county survey data.	CVH Epidemiologist and Data Manager.
	The HP Branch will use the integrated Progress Check reporting system to evaluate and assess progress and outcomes of local programs addressing health disparities.	Ongoing	Progress Check reporting system.	Quarterly and year end reports.	Health Promotion staff.
	The Diabetes Branch will develop capacity at the state level to monitor the burden of diabetes and other chronic disease in the American Indian and Hispanic/Latino communities.	July, 2002 – June, 2003	Data will be generated and reported by the SCHS on an n annual basis for these two populations addressing diabetes and other chronic diseases. Each program will compile data, track trends over time and present data to stakeholders and the public.	BRFSS data and specific modules (diabetes and other chronic diseases). For the American Indian population, will require access to phone number of the American Indians in the state.	Funds for BRFSS are included in the diabetes program grant to the CDC annually. Division partners have pledged support to work collaboratively to obtain data for other health indicators and chronic diseases.
	The CP&C Branch will monitor breast and cervical cancer screening rates among diverse populations.	FY 2002-03 and ongoing.	Analyze screening rates for changes in usage patterns.	Breast and Cervical Cancer and Control Program (BCCCP) data.	BCCCP and SCHS

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
4. Monitor progress towards the elimination of health disparities – continued.	The TPCP will examine the feasibility of expanding existing or developing a new system to collect information on: GLBT; high school smoking rates for NC American Indians, and Asian Americans.	July, 2003 – December, 2004	Review of existing data systems. Feasibility of developing/improving data systems.	YTS data BFRSS Qualitative data collection (i.e. Key informant interviews), PTS	SCHS
	The TCPB will explore the opportunity of working with partners who provide health services to Spanish-speaking migrant workers to address Green Tobacco Sickness.	FY 2002-2004	Feasibility plans developed.	Expanding sample size for YTS & BRFSS would require additional funding.	NC TBCB Surveillance and Evaluation Team.
	The OHS will conduct a statewide dental survey on the oral health status of children and to evaluate the effectiveness of the state's dental preventive programs. The OHS will utilize the bi-annual dental assessment of grades K and 5 to monitor progress toward the elimination of health disparities.	Statewide survey of children conducted in FY 2003-2004. Assessments conducted on grades K and 5 every other year.	Decrease the number of children with tooth decay, reducing disparities in the underserved population.	Data on the number of decayed, filled, and missing teeth by school, age, race, ethnicity, SES geographic region, language and limitations in activity and disabilities.	State appropriations and FFP to fund staff, CDC grant to fund expenses for the statewide survey. State appropriations and FFP to fund the dental assessments in schools.
	The OEEB will implement and enforce state and local policies, the collection and reporting of complete and consistent data by race, ethnicity, socioeconomic status, and primary language in research and programs.	December 1, 2002	Review data collection and report forms for appropriate use of language.	Health Directors and Healthy Carolinians Annual reports.	None
	The state Lab will support the state's data on diverse populations to identify gaps in populations seeking testing services at LHDs.	12-14 months.	Ability to generate report of demographic indices.		Resources at present not available.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
4. Monitor progress towards the elimination of health disparities – continued.	The Bio-terrorism Branch will include in all statewide needs assessment questions to measure the impact of bio-terrorism on health disparities.	To be developed.	The development and inclusion of questions on needs assessment.	To be developed.	
	The HIV/STD Prevention & Care Branch will review surveillance reports for changes in disease trends for populations disproportionately impacted by HIV/STDs.	Current/Ongoing			HIV/STD Prevention and Care Branch
	The TBCB will monitor progress towards elimination of health disparities by collecting annual data on TB cases using CDC's collection forms, which allow for classification by race and ethnicity.	Annually	CDC Report Form	Data from collection forms.	TB staff, LHD staff, CDC
	LHS and the Governor's Task Force (GTF) for Healthy Carolinians will monitor progress towards the elimination of health disparities by utilizing the NC Objectives for 2010 and the certification process for each Healthy Carolinians (HC) Partnership, which requires an emphasis on identifying and addressing health disparities.	Ongoing review of 2010 objectives; Certification process every 4 years.	Review of data from SCHS and other data sources; the review of activities implemented within the HC Partnerships that address eliminating health disparities	Annual report	State funds, local Healthy Carolinians Partnership resources.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
5. Promote customer friendly services that meet the needs of underserved populations (i.e. low-income and minority groups.	The C&YB, using their own materials from the NC Healthy Start Foundation (NCHSF) , will continue to support and implement new outreach strategies for reaching Hispanic/Latino populations.	FY 2003-2004	Increased number of outreach strategies and improved visibility in Hispanic/Latino populations.		C&YB staff, NC Healthy Start Resource Line (NCFHRL). Special Needs Hotline, RWJ Covering Kids Grant, NCODH, OMHHD
	The NCODH will develop clear policies and strategies for serving people with disabilities including removal of architectural, communication, and program barriers.	Preliminary review of existing DHHS policies by May, 2003	Completion of document for serving people with disabilities.		EHD Steering Committee, NCODH staff, Division representatives.
	HC/HC will work with the NCHSF to develop a family-friendly web site and continue the development and distribution of targeted media and outreach materials (i.e. Ana Marie Campaign).	Ongoing Fall 2002 for web site.	Web site and print materials; TV/Radio marketing schedules and ads.	Number of hits on web site. Reports of material distribution.	NCHSF staff, state, local staff, and stakeholders involved in material development
	The NSBs WIC program policy will continue to promote and support the use of non-traditional hours of service.	Ongoing	Results of WIC local agency program review findings.		State/federal funs. WIC staff
	The WHB will promote and coordinate at least 3 trainings to local health departments, community-based organizations, and private providers to improve their capacity to provide customer friendly services.	6/30/02	The number of actual trainings held and the evaluation comments from participants.	N/A	The WHB Training Title X funds, Emory University Trainers, Baby Love Plus Program

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KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
5. Promote customer friendly services that meet the needs of underserved populations (i.e. low-income and minority groups - continued	The IB will support and assist local health departments to implement Sixth-grade School Site Hepatitis B initiatives and extended hours of service.	Yearly	Sixth-grade county summary reports.	Number of counties participating in sixth grade initiative and completion rates. Number of LHDs with extended hours of service.	IB staff, LHD staff,, Annual sixth grade total county summary database.
	The SCHS will, in addition to its extensive web site, have persons on call to provide information about public health to any citizen or interested party upon request.	Ongoing	Customer satisfaction measured by complaints made to SCHS and Division Directors.	Existing data	Although this designated position was RIS last year, the SCHS has continued to maintain this service by reassigning staff.
	The HP Branch will continue to develop and disseminate culturally appropriate education materials, such as the United for Better Health Black Churches intervention materials.	FY 2003	The development and dissemination of materials.		State and federal funds for CVH and CDC funds for Injury Prevention Branch.
	The HP Branch will work to translate educational materials or resources into Spanish, such as elements on the CVH web site, the Color Me Healthy family newsletter, and classroom posters.	Ongoing	Web site elements available in Spanish – three learning sessions attended linkages made.	Number of hits specifically for Spanish materials on web site.	State matched funds with USDA.
	The CP&C Branch will incorporate customer service and culturally sensitive materials into program procedure manual for BCCCP	February 2003 and May 2003			
	The TPCB will continue to provide grantees (customers) culturally appropriate resources (i.e. provide Spanish speaking tobacco prevention training expert to Latino health conference).	FY 2003-Fy2004	Agencies surveyed and strategies developed.	Culturally appropriate resources needed.	TPCB staff, Diversity Workgroup Coalition Partners

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KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
5. Promote customer friendly services that meet the needs of underserved populations (i.e. low-income and minority groups - continued	The TPCB will actively reach out and recruit young smokers to serve on coalition action teams to encourage peers to quit smoking.	January, 2003 – July, 2003	Completed manual and evaluation from Clinical Updates.	YTS	TPCB staff.
	The OHS will promote customer friendly services by developing age and reading-level materials and presentation; and translating dental screening reports and educational materials into Spanish to serve Limited English Proficiency (LEP) clients.	Revise two pieces of educational material per year. Translate 2 pieces of educational materials into Spanish per year. Continue to provide dental referral reports in Spanish.	Get feedback from representatives of a variety of cultures and income levels on appropriateness of educational materials.	Feedback from a diverse group.	State appropriations and FFP. Funds uncertain for translation services.
	The HIV/STD Prevention and Car Branch will provide training for staff and contractors that support the tenets of need based customer friendly service provision.	Ongoing	Number of staff and contractors in attendance at the training, number of sessions offered.	Training Rosters Training Agendas	Funding from CDC, HRSA, HUD, Foundations, HIV/STD Prevention and Care Staff.
	The TBCB will increase accessibility to health education materials available in more than 10 foreign languages to decrease language barriers.	Ongoing	Education materials are available in various languages upon request.	Log of requests by site and language requested.	TB Health Educator

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KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
5. Promote customer friendly services that meet the needs of underserved populations (i.e. low-income and minority groups - continued					
	The Bio-terrorism Branch will make efforts to include representatives from various racial/ethnicity group on the Branch Advisory Committee	Ongoing	Number of racial/ethnic minorities serving on Committees	Committee Roster	Bio-terrorism staff time. Funds provided by CDC and HRSA.
	LHS will assure that the Consolidated Agreement with LHDs require interpreter services to be provided at no cost to the client regardless of immigration status.	Annually	Review of Consolidated Agreement to assure language is included.	Copy of Consolidated Agreement	Chief of Local Health Services (LHS)
6. Increase resources/ investments to eliminate health status gaps.	The programs within DPH will incorporate health disparity objectives in LHD agreement addenda, contractual scopes of work, and memorandums of understanding (MOU), when applicable.	FY 2003-FY2004	Program managers will ensure that scopes of work and/or MOUs include health disparity objectives. Child Health Agreement Addenda Process Outcome Objective (POO).	C&YB and WHB contracts, MOUs, etc. To develop outcome measures: HP2010, PRAMS, BRFSS, Title X, Sickle Cell data, Healthy Carolinians, Baby Love Plus, vital Statistics, SCHS.	DPH program staff. State and federal funds.
	The NCODH will provide support to DHHS agencies and programs in developing and responding to grants and RFPs targeted toward eliminating health disparities among people with disabilities.	Ongoing			NCODH staff.

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KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
6. Increase resources/ investments to eliminate health status gaps - continued	Pending grant funding through RWJ/CKF, HC/HC and the NC Pediatric Society will provide leadership in pursuing matching funds from Foundations and private resources, including a. Partnering with Rex Foundation Project in Wake County b. Continuing to cultivate partnerships with key stakeholders to reach out to target populations.	Pending grant funding, must have matching funds by 3rd year of grant cycle..	Budge with matching funds. Membership in state and local coalitions. Other evidence of stakeholder involvement.		NCPS, Rex Foundation, State, NCHSF staff, Local Project staff, Key Stakeholders.
	The NSB will continue to participate in the WCHS initiative to promote folic acid consumption by Latino women.	Ongoing	Completion of Spanish folic acid outreach campaign.	Tracing the incidence of Neural Tube Defect.	SCHS
	The NSB will increase the awareness of breastfeeding, WIC dangers of lead ingestion, the importance of folate, and the risk of listeriosis in the Hispanic/Latino community through the broadcast of PSAs on Spanish language radio.	8/02 – 10/02	Production of PSAs and purchase of broadcast time. Call back impressions of focus group participants.	Tracking or broadcast schedule.	Federal WIC grant funding.
	The IB will continue to support all childhood immunization providers through the UCVDP to ensure North Carolina continues to provide vaccine for all children.	Ongoing	Number of immunization providers enrolling in UCVDP. Monitor continued legislative support . Assure maximum level of Federal Vaccines for Children Funding is allocated to NC	Total number of immunization providers compared to the number participating in UCVDP. Number of VFC eligible children compared to the number of VFC eligible children receiving vaccines.	IB staff, CMS data, registry state and federal funding.

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KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
6. Increase resources/ investments to eliminate health status gaps - continued	The HP Branch will identify federal carry-over funds to supplement current funding to two counties focusing on CVH efforts in African American communities and continue to support and link services with the American Indian Rural Health Outreach Project in eastern NC.	FY 2003	Supplemental funds and resources to Disparities counties.	Documentation of supplemental resources.	Federal (CDC) carry-over funds for CVH Proposal funded.
	The CP&C Branch will promote the need to be screened for breast, cervical, colorectal and prostate cancer by increasing the publicity of local BCCCP screening sites to outreach among diverse populations.	FY 2002-03 and ongoing as openings occur.	An increase in the number of individuals screened at sites.	Participant data at the sites.	BCCCP Cancer Plan community partners. SCHS
	The Diabetes program will establish a state-based diabetes collaborative to improve the quality of diabetes care provided by primary care providers serving underserved populations.	12/02 – 6/30/04	Proposal submitted to grantor in August 2002 and will be awarded November 2002. An electronic registry the CV/DEMS (Cardiovascular/Diabetes Electronic Monitoring System) will be utilized. Data from medical records are abstracted in the registry following each provider visit.	Targeted diabetes indicators are: A1x Testes 2/yr.; Average A1c Level; registry Size; Self-Management Goal Setting; VC Risk Reduction; Foot Exams; Dilated Eye Exam; Flu and Pneumococcal Vaccines.	Application submitted for a $100,000 grant from RWJF. Additionally, over $87K was pledged as in-kind time from five state and Division partners. Diabetes Unit staff time will also be utilized. Integrate coordinator position into the diabetes program under the CDC grant. Support for staff positions will be e noted and approved in CDC grant for 04-05.

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KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
6. Increase resources/investments to eliminate health status gaps - continued	The TBCB will use federal funds through the NC American Lung Association to provide greater housing stability for patients.	Annually	Annual Budget Budget report		Funds provided by CDC. TB program staff, LHD staff.
	The TPCB will support diverse community-based organizations to increase partnerships and the sharing tobacco use prevention and cessation (i.e. Gay Pride, Indian Health Conference, etc.).	January 2003 – December, 2004	Bi-annual evaluation of grants. Increase network and resources to community-based organizations.		Local coalition coordinators.
	The OHS will increase the focus of resources on sealant provision for the low-income population, dental referrals and follow-up for low-income students, and fluoridation of community waster supplies, based on need and evidence.	FY 2002-2004	Proportion of children with sealants, proportion of children with untreated decay. Proportion of the population receiving community fluoridation.	Dental assessment/surveillance system, Fluoridation Census.	State appropriations and FFP for staff, unsure other funds.
	The Bio-terrorism and HIV/STD Branches will fund evidenced-based community interventions focusing n bio-terrorism or HIV/STD prevention.	As funding permits	Number of funded community interventions.	Annual reports, CDC, HRSA	Funding provided by CDC and HRSA, DPT=I
	LHS will continue to increase resources available to Healthy Carolinian Taskforces through grant-writing in order to generate funding to encourage activity toward addressing health disparities.	Ongoing	Grant awards received and distributed to local taskforces.	Review of Healthy Carolinians budget.	LHS staff.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings.	The B&YB and WHB will promote diversity in the decision making processes and policy development by increasing the proportion of racial and ethnic minorities or person with disabilities in interview teams and in recruiting/hiring of new staff; on advisory boards, commissions and task forces.	Ongoing	Successful recruitment and hiring of racial and ethnic minorities.	N/A	WCHS staff
	The NCODH will continue to support the development and provision of in-services and continuing education opportunities to increase capacity to work effectively with people with disabilities.	Ongoing	Training, curricula, agendas for training and workshops.		NCODH staff
	NCODH will provide assistance in recruiting individuals with disabilities to serve on advisory boards and committees.	Ongoing	An increase in the number of individuals with disabilities serving on boards and committees.		EHD Steering Committee and Division representatives.
	HC/HC will ensure that members of the State Outreach Coalition and the local coalitions are representative of leaders from the target populations.	Ongoing	Lists of State and local coalition members.		State and local staff. Key stakeholders.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings. - continued	The NSBs WIC nutritionist recruitment letters will be targeted to colleges and universities in states with a higher proportion of Spanish speaking students in order to increase diversity among WIC nutritionists.	Ongoing	Special survey of local health departments – 9/02	Roster of schools with Spanish speaking students.	NSB staff.
	The NSB will incorporate cultural diversity training into the Preschool Nutrition Conference sponsored by the NSB.	October, 2002	Completion of the conference.	Evaluations from conference participants.	NSB staff.
	The WHB management will support and offer at least two training opportunities, such as lunch-n-learns, for staff to increase knowledge of cultural/ethnic groups in order to enhance the staff's capacity to work with people from diverse cultural backgrounds.	7/1/02 – 6/30/02	The number of training opportunities provided and feedback from staff who participate.		
	The C&YB will encourage participation and provide educational programs and resources on cultural competency and diversity to staff in the Branch	Objective implemented in FY2003	Programs reflect outreach to minority and special populations.		
	The SCHS will work with Human Resources to recruit and retain a larger number of minority staff, particularly among statisticians and other professionals. The Center will continue its vigorous pursuit of diversity in the work place.	Ongoing	An increase in the number of minorities working at SCHS.	Data already available	Human Resources SCHS Management.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings - continued	The HP Branch will build on the collaborative work of the cross-cultural Public Health Institute/Faith Collaboration Team.	Ongoing	Strategic Plan, Shared lessons learned.		Executive Director or Tri-State Stroke Network and HP staff.
	The HPDP section will establish hiring practices that encourage applications from persons in diverse populations.	FY 2002-03 and ongoing as openings occur.	Tracking of staff hired.	Track hiring process.	Human Resources, HPDP management.
	The PHDP Section will work to increase the proportion of under-represented racial and ethnic minorities and person with disabilities on community based coalitions and advisory committees.	Ongoing	An increase in minority representation.	Coalition or Advisory Committee rosters.	
	The OHS will support a diverse workforce by providing cross-cultural education and disability awareness training for staff and by adding Hispanic representative to the Committee for Dental Health	May, 2003	Document that training occurred and that a Hispanic representative was added to the Committee.	Attendance roster from training and membership list of Committee.	Funding for training uncertain. Additional Committee members.
	The Bio-terrorism and HIV/STD Branch will create experiential opportunities for students from underserved or high impact communities to work on bio-terrorism projects or HIV/STD Branch funded agencies.	One year.	Number of student internships created for underrepresented populations.	Personnel demographics.	Funding provided by CDC,, HRSA, NC General Assembly, and Foundations.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings - continued	The OEEB hiring committee will review the proportion of employees for under representation of minorities and staff with disabilities prior to the interview process and document that careful consideration is given to the above groups when positions are available.	Ongoing		OEEB Personnel roster	Hiring committee.
	The Epidemiology Section will create opportunities for staff to enhance their capacity to work with people from diverse cultures.	Ongoing	Number of trainings offered and number of staff in attendance.		Funding provided by CDC, HRSA, NC General Assembly, Foundations.
	LHS will provide a mechanism for all new Public Health Nurses at the local level to receive training on cultural issues.	Twice per year (January and August)	Review of syllabus for the "Introduction to Public Health Nursing" course.	Number of participants	Staff from DPH and UNC-CH.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
8. Identify and advocate for public policies that aid in closing the health status gap.	The Division of Public Health will incorporate eliminating health and/or service disparities into each employee's work plan.	FY 2003	Review of individual DPH employee work plans.		
	The NCODH will provide technical assistance and training to DHHS staff on the American's with Disabilities Act (ADA) and approaches to improve environmental, communication, and programmatic access for people with disabilities.	Ongoing			NCODH staff, EHD Steering Committee, NCOADA, NCDBTAC, DD Council, NC State Center for Universal Design.
	The NCODH will participate in DHHS efforts to assess ADA compliance among Divisions and community service providers and assist with in the development of compliance plans.	Fy 2002-2004			NCOHD staff
	HC/HC will continue to encourage and promote elimination of disparities by providing guidance in the composition of state and local coalitions, policies, strategies for targeting outreach, and developing materials.	Ongoing	Meeting minutes; documentation of state and local efforts.	Number of providers in underserved communities.	State and local staff and key stakeholders.
	The WHB will continue to advocate for a Family Planning Medicaid Waiver, which will provide reimbursement for men and women at or below 185% of the federal poverty level and assist in Branch efforts to reduce the number of unintended pregnancies in populations of greatest risk.	Ongoing	The award of the Medicaid waiver.	DMA Y SCHS	No financial resources needed to advocate for waiver. Human resources required.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
8. Identify and advocate for public policies that aid in closing the health status gap - continued	The IB will continue to advocate for policy development to ensure long-term care residents and staff are offered and receives influenza and pneumoccocal vaccinations as recommended.	5year – assess yearly progress	Stages of policy development and implementation.	Needed: number of long term residents and staff and those being offered and receiving vaccinations.	IB staff, Medical Review of NC and DFS staff.
	The CP&C Branch will promote policy initiatives that provide for access to cancer and end-of-life care for diverse populations.	FY 2003-2006	Adopted laws or new regulations.	Qualitative data on specific issues.	Advisory committee on Cancer control and Coordination. Community cancer control partners.
	The IB will advocate for coordinated strategies to prevent the spread of hepatitis B through systematic identification and prevention strategies.		Development and implementation of a NC Hepatitis Prevention Strategy Policy.	Birthing Hospital Infant Prophylaxis Surveys, Communicable Disease statistics on # of acute and chronic hepatitis B infections, # of hepatitis vaccinations provided through LHD STD clinics.	IB staff, LHD staff, General Communicable Disease Branch.
	The SCHS will work with other agencies, such as; March of Dimes, Child Fatality Task Force, and other advocacy groups to ensure they have the necessary data to effectively advocate for reducing health disparities.	Ongoing	Feedback from advocacy groups.	Data currently available in the various data sources accessible to the SCHS.	Statisticians at SCHS
	The TPCB will provide support to coalition partners to increase public advocacy for medical providers to include smoking cessation counseling services to underserved clients as the most basic part of the benefits package.	January, 2003 – December, 2004	Monitor medical providers' policies and practice.	Current policy data: Public and private agencies that provide counseling.	Diversity/Disparities Director; Director of Communications and Media; Prevention Partners; Coalition Partners; Diversity Workgroup

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
8. Identify and advocate for public policies that aid in closing the health status gap - continued	The OHS will support policies at the state and national level that provide loan repayment for dentists, who serve in minority or underserved communities. The OHS will work with the Office of Rural Health and Development to recruit dentists to underserved areas.	Ongoing	Document where policies reference disparities.	Documentation where policies reference disparities and efforts to recruit dentists to underserved areas.	State appropriations.
	The TBCB will pursue a public health rule change that mandates the submission of TB isolates to State TB lab for confirmation, susceptibility testing and genotyping for epidemiological evaluation.	One year	Number of isolates submitted to State Lab.	LHD data, State Lab data.	State Lab, LHD staff, TB program staff.
	The State Lab will comply with new CDC and HIPAA requirements for coding of race/ethnicity on lab requisition forms.	12-18 months	Quality assurance review of Lab Information Management System (LIMS).		Resources at present not available.
	LHS will assure that the Problem Oriented Health Record (POHR) clinical record forms included race and ethnicity codes per OMB standards.	Ongoing	Review of forms in manual.	Copy of manual or all forms.	DPH, LHD staff.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
9. Demonstrate Accountability and Ownership for Health Outcomes.	The C&YB will pursue grant and state funding to enhance access and availability of health care to populations of children experiencing health disparities.	Objectives implemented FY 03	Increased funding and ultimately increased access to services.		C&Y staff
	The NCODH will participate in establishing an accountability network on eliminating health disparities by assisting in the setting of benchmarks; collecting and disseminating baseline and subsequent data.	Ongoing	DHHS and SCHS reports		NCODH staff, EHD Steering Committee and SCHS staff.
	The WHB will translate national, state, and county data pertaining to minority health and health disparities into information the Women's Health Nurse and Social Work Consultants can use with local health departments as agreement addenda are developed.	7/1/02 – 6/30/04	The inclusion of targeted activities and health outcomes to address minority health disparities in local health departments' agreement addenda.	Healthy People 2010, PRAMS, SCHS, HSIS, Vital Statistics	Healthy Mothers, Healthy Children's fund, MCC/MOW program.
	In addition to the POO data on the Agreement Addenda, the WHB will explore/investigate using 5-year maternal health and family planning data by race and ethnicity to assist local health departments in implementing appropriate interventions to address the disparities.		The inclusion of 5-year data by race and ethnicity on the Local Health Department Agreement Addenda.		

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
9. Demonstrate Accountability and Ownership for Health Outcomes. -continued	The IB will institutionalize effective assessment strategies to ensure accurate immunization assessments of practice and geographic based immunization coverage rates.	5 years – assess yearly progress.	AFIX and site visit assessment results, increased LHD compliance rates, and progress towards a fully implemented registry.	LHD Compliance rates, AFIX summaries.	IB and LHD staff.
	The SCHS will monitor the production of Minority Health fact sheets and work done on behalf of OMHHD and other instances of disseminating information about health disparities.	This is an ongoing process but at least one Minority Health Fact Sheet per year will be published.	Publication of Fact Sheet and feedback from customers.	Existing data.	SCHS and OMHHD staff.0
	The HPDP Section will translate national and state data on health promotion related disparities into information communities can use to promote evidence-based public and private policy.	FY 2003-2004	Information evaluated for cultural appropriateness and disseminated to local community organizations.	Morbidity and mortality, BRFSS data, SCHS	
	The OHS will translate information on methods to reduce early childhood caries into 2 brochures and 2 educational exhibits in a form of information that communities can use.	Ongoing	Produce educational materials, newspaper articles and articles for local dissemination.	Data from assessments and surveys.	State appropriations, FFP, CDC grant for statewide survey.

DIVISION OF PUBLIC HEALTH – HEALTH DISPARITY IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
9. Demonstrate Accountability and Ownership for Health Outcomes. -continued	The OHS will continue to use effective evaluation systems (surveillance system and statewide survey) and best practices in service delivery (sealant, community fluoridation, and fluoride varnish for high-risk infants).	Immediate	Levels of dental disease and sealant presence by school and county (surveillance/assessment) and by age, race, sex, income level and geographic region (statewide survey).	Bi-annual K/5 surveillance system. Statewide children's dental survey.	
	The Bio-terrorism and HIV/STD Branches will develop and internal review process to evaluate bio-terrorism response plan and HIV/STD interventions for cultural and linguistic appropriateness.	Ongoing	Documentation of annual reports to CDC, HRSA and the Advisory Council		CDC, HRSA, HIV/STD Prevention and Care staff, Bio-terrorism staff
	The TBCB will report the annual TB statistics from each LHD that will reflect incidences of TB cases by race and ethnicity.	Annually	Review of records maintained at the local level.		LHD staff, TB Program.
	The HIV/STD Branch will collect data on HIV/STD disease incidence as well as document service utilization in a manner that will allow for measuring progress towards the elimination of disparities.	Ongoing	Documentation in annual reports to HRSA, CDC, HUD, and the Advisory Council.	HIV/STD Surveillance Reports	HIV/STD Prevention and Care, Epidemiology and Special Studies Unit
	The OHC/HE requires all Healthy Carolinians Partnerships to include objectives for addressing health disparities in their plans.	Every 4 years	Number of new or renewed plans with health disparity objectives.		GTF – DHHS OHC/HE

Division of Medical Assistance

Mission: The Division of Medical Assistance manages Medicaid and NC Health Choice for Children for the state of North Carolina. Medicaid is a health insurance program for certain low-income and needy people paid with federal, state, and county dollars. It covers more than 1 million people in our state, including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. http://www.dhhs.state.nc.us/dma/

Sections/Programs: Five programs/sections in the Division of Medical Assistance (DMA) responded to the disparity assessment survey. These programs/sections include: North Carolina Health Choice for Children; Medical Policy; Managed Care; Medicaid Eligibility; and Medicaid.

Priority Conditions/Issues: The top priority conditions for the Division of Medical Assistance included developmental disabilities, newborns or neonatal conditions (poor birth outcomes, pregnancy, and childbirth) and chronic conditions (i.e. asthma, heart diseases, diabetes, mental health, and disabilities).

Service Delivery Challenges: The three most cited service delivery challenges for the programs in the Division of Medical Assistance (DMA) were access and coordination of health services, cost containment, and reimbursement for services, and health education and training needs for educating consumers on appropriate use of services. For example, one section mentioned the need to develop after business hour alternatives to reduce emergency department use as service delivery challenge, while another cited the need to improve the appropriate use of Medicaid covered services by African Americans and other minority Medicaid recipients. Curtailing health care costs was a common theme emerging from almost all the Medical Assistance sections. In terms of health education and training,

programs such as the NC Health Choice for Children cited "convincing families to feel empowered to use the system at the first sign of illness rather than as a last resort for wellness" as a primary challenge.

Socio-Cultural Challenges: The main socio-cultural challenges faced by the division are summarized in the figure below. The most frequently cited socio-cultural challenge was language, communication and attitudes and conflicting, values systems of clients and providers. Examples of language related challenges include "lack of Spanish speakers and those sensitive to Hispanic/Latino culture among professional community". Other socio-cultural challenges mentioned include "need for after hours clinics staffed with Spanish speakers", "educating cross-cultural families about how to use and trust the health system here", "elimination of beliefs that keep people from seeking medical care" and elimination of provider and provider/staff attitudes that discourage Medicaid recipients, particularly minority Medicaid recipients from seeking or obtaining medical care. Some of the sections also indicated that beliefs or myths related to the health care system were also important socio-cultural challenges.

Disparity Focus Areas: The main disparity focus areas for DMA include income, disability, age, and race/ethnicity. According to the division, these focus areas are largely determined by state and federal mandates, which determine income eligibility to programs such as Medicaid or State Children Health Insurance Programs (SCHIP). Eligibility is usually based on income, age, and disability status.

DIVISION OF MEDICAL ASSISTANCE – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status.	Examine Medicaid paid claims data and Medicaid eligibility data for patterns of disparity among race/ethnic groups.	November 1, 2002	Report of data analysis Report to DMA Health Disparities Committee	Medicaid eligibility information by race/ethnicity Medicaid recipient information by race/ethnicity Medicaid expenditures and utilization by race/ethnicity Primary Care and ER visits by race/ethnicity Eligibility Categories by race/ethnicity	Medicaid paid claims data DMA Decision Support Staff DRIVE reports DMA Medical Policy Staff DMA Health Disparities Committee
	Examine Medicaid paid claims data and statewide data for similarities in health disparities.	April 1, 2003	Report of data analysis Report to DMA Health Disparities Committee	Leading causes of death and morbidity in NC Various statewide studies and reports	DMA Health Disparities Committee Reports/Studies from State Center for Health Statistics Data from N.C. Primary Health Care Association Information from Office of Minority Health Data from HBCU Health Promotion Alliance Information from National Healthy People 2010 Office of Rural Health Information from members of DHHS Health Disparities Steering Committee
	Measure, analyze and document health status inequities to identify priority areas for health interventions.	April 1, 2003	Report of data analysis Report to DMA Health Disparities Committee	Medicaid paid claims data analysis of diagnoses billed Correlation of diagnoses billed and leading causes of death	See immediately above.

DIVISION OF MEDICAL ASSISTANCE – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
2. Explore the possibility of working with identified groups of providers and other resource groups to communicate, document, and champion best practices in eliminating health disparities	Approach organized groups of providers to assist in promoting evidence based programs and interventions to address health disparities.	May 1, 2003	Evidence of partnerships with identified providers	Results of data analysis in 1 above Identification of target provider Groups	Medicaid Carolina Access ACCESS II & III Office of Rural Health HBCU N.C. Primary Health Care Association NC PAG DSS Directors Association NC Council (MH/DD/SAS) Assoc. of Public Health Directors Faith Community Old North State Medical Society
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Increase the appropriate use of medically necessary services by Medicaid eligible recipients in racial/ethnic groups at greatest risk of targeted health status inequities	June 30, 2003 – have plan established for this objective	Evidence of plan to increase appropriate use	Data similar to that analyzed in 1 above and additional data identified during process Identification of targeted health status inequities	See immediately above DMA health Disparities Committee
4. Monitor progress towards the elimination of health disparities	Collect and analyze data from Medicaid paid claims and other available statewide data on a regular basis.	June 30, 2003 – have regular monitoring schedule established	Evidence of regular monitoring schedule	Data similar to that analyzed in 1 above and additional data identified during process	DMA Health Disparities Committee
5. Promote customer friendly services that meet the needs of under served populations	Promote the hiring of bilingual Medicaid staff.	December 1, 2002 – have recruitment plan established	DMA employment statistics	Employment statistics relative to numbers/types of bilingual Medicaid staff hired	DMA Personnel Office DMA Supervisors and Managers
6. Demonstrate accountability and ownership for health outcomes	Identify an area of focus for improving health outcomes for a health indicator that indicates disparity	June 30, 2003 – have focus identified	Evidence of identified focus area	Analysis of data in 1 above	DMA Health Disparities Committee Other pertinent stake holders from 1 above

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Mission: "North Carolina will provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice."

Sections/Programs: Four sections (Adult Mental Health, Child and Family Services, Developmental Disability, and Substance Abuse Services) from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) responded to the survey.

Service Delivery Challenges: Access and coordination of services, shortage of mental health workers and the need for housing for clients with mental health and substance abuse needs were cited as the top service delivery challenges. The sections also identified transportation, geographical variations in services, lack of insurance coverage, and the need for community outreach and support as additional service delivery challenges in the delivery of mental health and substance abuse services in the state.

Socio-Cultural Challenges: The most frequently cited socio-cultural challenges by the Division of Mental Health, Developmental Disabilities, and Substance Abuse include: issues related to client and provider attitudes; trust and stigma; cultural differences and lack of diversity in the workforce; language and communication problems; limited education, knowledge or awareness of mental health issues and discrimination of people with mental health conditions.

DIVISION OF MENTAL HEALTH – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability, and socioeconomic status	Develop consensus on key indicators for measuring MH/DD/SA health status	June 2003	Reports of State Plan Implementation Committees.	N/A	State Plan Implementation workgroup staff
	Measure, analyze and document inequities in access to MH/DD/SA treatment to identify priority areas for MH/DD/SA	Ongoing	Annual report care and other statistical reports.	CDW, Client Outcomes, IPRS. Data, waiting list data, NCSNAP, core indicators, CMHS funded projects	IT Division staff and existing databases
	Engage and use different mediums of communication (print, radio, TV, etc) to promote increased awareness among policy makers, service providers and the public.	Ongoing	Evidence of media campaign efforts and reports form LME's Local Business Plans for general awareness and specific to underserved communities.	Web sites, local media products, local business plans.	Communications and Training staff, State and LME web sites, existing communications.
	Identify characteristics and trends relative to the local population and train staff in relevant cultural competencies.	Ongoing	Core competencies, evidence of training.	Documentation of core competencies and training.	Staff development and existing supervisory staff representatives from minority groups, OMHHD and Program Evaluation staff.
	Identify and address the determinants of disparities MH/DD/SA health that impact individuals in the MH/DD/SA	Ongoing	Decrease in barriers to services	Waiting lists, training, outcome reports, client satisfaction data.	Staff to maintain waiting lists, client outcome, and satisfaction reports. CDW, IPRS, and special projects.
2. Communicate, document, and champion best practices in eliminating health disparities.	Adopt, adapt, highlight, and promote best practice strategies and interventions to address disparities. Promote evidence based programs and interventions to address health disparities through funding incentives.	Ongoing	Evidence of a CQI effort targeting the elimination of health disparities. Progress on implementation of a UR/UM system.	Local Business Plan and periodic progress reports.	Division and LME staff.

DIVISION OF MENTAL HEALTH – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Collaborate and promote community partnership across agencies, sectors, and levels.	Ongoing	By progress in implementing the community collaborative.	Community Collaborative surveys.	Current Division and LME staff.
	Develop coordinated strategies, multifaceted programs, and intervention approaches to address health disparities.	Ongoing	Success of the State Plan implementation and the Division reorganization.	Reports on the progress of the State Plan implementation and the Division reorganization.	Division and LME staff.
	Enhance health education to increase knowledge skills, and attitudes among providers and clients on MH/DD/SA issues.	Ongoing	Evidence of training.	Training evaluation, numbers of trainings, and records of attendance.	Training contractors, AHEC, Division staff, LME, Training and communication staff.
	Engage different communities (i.e. faith, tribes, people with disabilities) early in research, programmatic and intervention effort and promote and advocate for self-determination, consumer input respect and recognition of diversity.	Consistent with timeline for implementa tion of the State Plan.	State Plan implementation reports.	Reports on the progress of the State Plan implementation and the Division reorganization.	Community Collaborative, Interagency Councils, Division, and LME staff. Minority groups, advocacy, faith-based, and other community groups.
	Identify tools, policies, and approaches that more effectively engage community members and community groups in MH/DD/SA improvement; identify and act on obstacles to broad implementation of these tools, policies, and approaches.	Ongoing	State Implementation reports.	Director's Advisory Committee report on input from stakeholders.	Division staff, LME staff, State Plan local advisory groups.
	Invest in community capacity building and accountability.	Ongoing	State Plan Implementation and Olmstead reports.	Reports on Olmstead and State Plan	Division and LME staff.

DIVISION OF MENTAL HEALTH – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
4. Monitor progress towards the elimination of health disparities.	Strengthen state's capacity to collect reliable data on minority populations (including racial and ethnic minorities and persons living with disabilities) and conduct surveillance in gaps in health status.	Ongoing	Implementation of the State Plan	CDW data, other databases, and reports on State Plan implementation.	Division and LME staff.
	Implementation and enforce state and local policies requiring the collection and reporting of complete and consistent data by race, ethnicity, and socioeconomic status.	Ongoing	Through data gathered by the Division's Data Operations Branch.	Performance agreement report.	LME staff and Data Operations Branch staff.
5. Promote customer friendly services that meet the needs of underserved populations (i.e. low-income and minority groups).	Support non-traditional hours of service.	Ongoing	Reports of LMEs	Clinic operating hours.	Division and LME staff.
	Increase, strengthen, and support bilingual services where needed through the hiring and training of interpreters and bilingual staff.	Ongoing	By evaluations of local business plans.	Local business plans.	Division and LME staff.
	Develop clear policies and strategies for serving Limited English proficiency (LEP) clients and providing interpreter services.	Ongoing	By evaluations of local business plans.	Local business plans.	Division and LME staff.

DIVISION OF MENTAL HEALTH – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
6. Increase resources/ investments to eliminate health status gaps.	Base funding and programmatic decisions on needs and evidence.	Ongoing, with shift to serving target populations	Implementation of the State Plan.	UM/UR data, State Plan implementation progress reports..	Division, LME staff and private providers.
	Include health disparity objectives in programmatic and contractual scopes of work and Memorandums of Understanding (MOUs).	Ongoing with implementation of the State Plan.	Through assessment of the State Plan implementation.	Local business plans and LME contact reports.	
7. Build, support, and fully utilize a diverse workforce capable of working in cross-cultural settings.	Ensure that the provider network	Ongoing	Through evaluations of local business plans.	Local business plans, HR data at the area programs.	Division and LME staff.
	Integrate cross-cultural education and disability awareness training of all present and future (medical schools, public health, graduate, residency) health professionals.	Ongoing	Through evaluations of trainings.	Training evaluations.	Division staff.
	Require employees to increase their ability to work with people from diverse cultural backgrounds and with mobility, sensory, cognitive, and psychiatric disabilities.	Ongoing	Through results of training on cultural competencies.	Records of staff competencies.	Division staff and LME staff.
	Increase proportion of underrepresented racial and ethnic minorities and persons with disabilities on all major advisory boards.	Ongoing	Through State Plan implementation.	Database of consumers/family on advisory groups.	Division staff.
	Build eliminating disparities into state and local policies, procedures, and practices.	Ongoing with implementation of the State Plan.	Through submission of Local Business Plans and development of a quality mgt. Structure.	Reviews of State Plan implementation reports and Local business plans.	Division and LME staff, consumer, and family volunteers.

DIVISION OF MENTAL HEALTH – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
8. Identify and advocate for public policies that aid in closing the health status gap.	Support policies that provide incentives to providers serving or working in minority and under-served communities.	Ongoing	Through State Implementation Plan.	State Plan reports.	Division staff
	Ensure state and local compliance with the Americans with Disabilities Act.	Ongoing	Compliance monitoring	Consumer compliant data.	
	Incorporate eliminating health disparities into work plans of employees in the Advocacy and Customer Service Sections and the Community Policy Implementation and Management Section	January 1, 2003	Examination of employee work plans	Employee work plans.	
9. Demonstrate accountability and ownership for health outcomes.	Set measurable targets for MH/DD/SA improvement.	June, 2003	System report card, and consumer outcome reports.	Consumer outcome data.	Division staff
	Develop and mandate effective evaluation systems and best practices in service delivery.	July, 2003	Evaluations of Local Business Plans. Progress on State Plan Implementation.	Local Business Plans.	Division and LME staff.
	Publicly report results on progress towards the elimination of health status disparities.	Annually	Client Statistical Reports.	Client Data Warehouse and outcome data.	Division and LME staff.

Division of Facility Services

Mission: The Division of Facility Services regulates medical, mental health and group care facilities, emergency medical services, and local jails. We ensure that people are safe, and that the care in these facilities is adequate. We make certain that medical facilities are built only when there is a need for them. http://facility-services.state.nc.us/

Sections/Programs: Seven sections (Emergency Medical Services, Adult Care Licensure, NC Medical Care Commission Bond Program, Mental Health Licensure and Certification, HCPR, Human Resources, and Construction) in the Division of Facility Services responded to the survey.

Priority Conditions/Issues: Priority conditions or issues for the Division of Facility Services varied by section. Overall, geographical factors such as distribution of health resources were cited as a priority. These resources include, the need to increase the number of Level III training centers with proper geographical distribution, need for competent mental health residential providers, recruitment, and retention of qualified Nurse's Aides and training for county DSS staff and providers. The Construction Section mentioned the need for more staff to monitor adult care homes. The section mentioned that it is unable to inspect physical plant facilities on a routine basis because of lack of adequate staff.

Although some of the questions did not seem to apply directly to some of the sections in this division, the following service challenges were mentioned: health education and training; physical and social access barriers; lack of infrastructure; resources (i.e. funding, staff). For example, the Adult Care Licensure section indicated that "committing time for state staff to provide training" and the need for training materials and locations were key challenges. Another section indicated that the "lack of residential mental health facilities" was also a service delivery challenge. Shortage of staff was cited as a challenge to timely inspections of facilities and safety (i.e., fire inspections).

Socio-cultural Challenges: The Emergency Medical Services mentioned language barriers between the Hispanic population and Emergency Management Services personnel as a socio-cultural challenge.

Disparity Focus Areas: The key focus areas for the division were geographical location, education, disability, and race/ethnicity. These key focus areas were identified based on state laws, regulations, and examination of the geographical distribution of existing trauma centers. Identification of these areas of focus was based on the Medical Facilities Plan statute.

DIVISION OF FACILITY SERVICES – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status.	**Mental Health Licensure and Certification** Provide "New Provider Orientation Class" for potential providers of community behavioral healthcare.	Class is provided twice/month – once in Mecklenburg County and once in Wake County	Providers are better prepared for licensure	Number of participants and number of classes conducted each year	Need more survey consultants to conduct education for potential and existing providers
	Medical Care Commission Communicate to potential borrowers of NCMCC desire to promote providing of community benefits as part of services provided by borrower.	Ongoing	Annual Reports to Medical Care Commission (MCC)		
	Certificate of Need Section Conduct certificate of need reviews by assuring applicants demonstrate their proposals will meet the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, HIV/AIDS persons, and handicapped persons.	Ongoing	Certificate of Need Decision findings to show applicant's conformity.	Medicare and Medicaid data from DMA cost report; d DFS license renewals. There is no data collected for racial or ethnic groups	Existing staff resources and databases. Enhance databases to provide licensure information in a summary format.
	Medical Facilities Planning Development of State Medical Facilities Plan (SMFP) which addresses geographic distribution and access to health service facilities and services that are identified in NCGS 131E-176.	Annual	Governor signing SMFP to be effective January 1 of each year.	Population, utilization and inventory information.	Governor's Office, State Health Coordinating Council (SHCC) (appointed by the Governor), and Medical Facilities Planning Section (MFPS).

DIVISION OF FACILITY SERVICES – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
	Human Resources Utilize different mediums of communication.	Periodic reviews with EEO Officer for the Division and assessment with hiring managers throughout the organization.	Analyze new hires and demographics of organization against the annual EEO plan.	Race/gender data extracted from the Personnel Management Information System (PMIS).	Advertising in various mediums to "target" specific groups; attend job fairs where appropriate to focus on groups with required
2. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups)	**Licensure and Certification** Identify and document effective state and national strategies for quality of care in ESRD service providers by working collaboratively with the Southeastern Kidney Council.	1 year	Dialogue with the Southeastern Kidney Council	Deficiency reports; national publications	Southeastern Kidney Council; Internet; DFS staff
	EMS Actively encourage smaller hospitals to become Level III Trauma Centers	April 1, 2004	Number of new Level III Trauma Centers	State Trauma Registry	Continue financial support to trauma program.
	Adult Care Licensure Section Identify and utilize, if applicable, effective programs from other organizations to address disparities.	Ongoing	Monitoring of training activity	Identification of training content	Internet
	Human Resources Identify and utilize effective programs for recruitment	Ongoing based on current needs	Weekly analysis of organization vacancy report and coordination with hiring managers	PMIS and close monitoring of paperwork for new hires	Coordination with other units to benchmark best practices (e.g. contact with Dix Hospital nurse recruiters)

DIVISION OF FACILITY SERVICES – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	**ACTION STEPS**	**TIME FRAME**	**EVALUATION**	**DATA NEEDS**	**AVAILABLE RESOURCES**
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	**EMS** Provide technical assistance to hospitals desiring Level III Trauma Center designation that do not meet criteria.	April 1, 2004	Number of new Level III Trauma Centers	State Trauma Registry	Continue financial support to trauma program.
	Human Resources Involve people of different religions, race, disabilities.	As needed based on opportunities via job fairs, etc.	Hiring rates of target groups and EEO goals being met via periodic evaluation of annual EEO plan.	EEO plan and recruiting efforts and mediums.	Assigned staff who can assist in these efforts
	Construction Involve other agencies/programs as local DSS (adult home specialists) building inspectors, fire marshals.	Ongoing	Number of times local officials alert Construction Section of problems in licensed facilities	Keep track of local reporting	Staff already assigned
4. Monitor progress towards the elimination of health disparities	**Human Resources** Develop and utilize data base	In place	Periodic review of goals	PMIS	Advertising in appropriate mediums and monitor data base3
5. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups)	**North Carolina Medical Care Commission** Encourage continuing care retirement center that borrow through the Healthcare Facilities Finance Act to develop and implement plans to increase the diversity of the population they serve	Ongoing	Annual reports are filed with MCC	Racial breakdown of persons who qualify by age and income for admission to facility	Population data from OSBM
	Construction Provide consultation and training to providers, DSS, local authority when possible (in conjunction with other sections).	Ongoing	Annual reports	Keep track of training and consultations	No additional resources available

DIVISION OF FACILITY SERVICES – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	**ACTION STEPS**	**TIME FRAME**	**EVALUATION**	**DATA NEEDS**	**AVAILABLE RESOURCES**
5. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups) - continued	**Licensure and Certification** Provide ESRD patients with toll free complaint hotline telephone number for filing of complaints.	6 months and ongoing due to the continual increasing number of ESRD patients	Assessing trends in complaints filed; Dialogue with Southeastern Kidney Council	Computer Complaints tracking program	DFS Staff; Southeastern Kidney Council members; existing complaint tracking computer system
	Adult Care Licensure Section Develop protocol to follow when people in under served populations bring disparities to state or county's attention	6 months to 1 year	Has a written protocol been developed?		
	Mental Health Licensure Section Regulate providers fairly and objectively with State licensing and client rights requirements	Ongoing	Number of deficiencies cited and number of providers inspected	Deficiency writing program (already in use)	Need more survey consultants to better regulate behavioral health providers
	Human Resources Develop procedure for serving people with disabilities/limited language proficiency	Limited somewhat by nature of all but administrative and clerical duties Ongoing acceptance of applicants	Periodic review of EEO Plan	Knowledge of new hires and any accommodations made for them	Physical accommodations in place such as ramp and elevator for easy access
6. Increase resources/ investments to eliminate health status gaps	**Human Resources** Targeted recruiting efforts through various mediums based on needs and results of previous efforts	Ongoing based on current needs	Evaluation of EEO Plan goals and data base demographics	Annual EEO Plan	Advertising and job fairs

DIVISION OF FACILITY SERVICES – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	**ACTION STEPS**	**TIME FRAME**	**EVALUATION**	**DATA NEEDS**	**AVAILABLE RESOURCES**
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings.	**Human Resources** Second language training and cross cultural education	Varied – Language would require training or money to compete for limited resources	Periodic evaluation of established goals	Recruitment goals	Money to have staff trained or staff to conduct training
	EMS Offer Medical Spanish courses thorough EMS continuing education programs.	August 1, 2004	Number of courses offered.	Track through local continuing education records.	OEMS system monitoring.
8. Identify and advocate for public policies that aid in closing the health status gap.	**EMS** Assure diversity in state planning groups (task forces, workgroups, etc.) for EMS issues.	Ongoing	Track composition of planning groups.	N/A	State EMS Advisory Council; EMS Special Interest Groups
	Human Resources Promote compliance with ADA and EEOC	Ongoing – Ensure we are always in compliance with existing guidelines	Advising management as necessary as to compliance issues	Info on affected employees	Educate and train staff on compliance issues and ensure standards are maintained
9. Demonstrate Accountability and Ownership for Health Outcomes	**Human Resources** Report and coordinate results of objectives with senior management and DHHS staff	Ongoing based on demographics	Review of EEO Plan and PMIS data base	EEO Plan and PMIS	Collection of data by Personnel staff and EEO Officer

Division of Vocational Rehabilitation

Mission: To promote employment and independence for persons with disabilities through customer partnerships and community leadership.

Priority Condition/Issues: The priority condition for the Office of Vocational Rehabilitation is disabilities. The Office stated that they could not prioritize according to disability. However, the Office indicated that whenever a condition reaches a point of impediment to employment, then that condition becomes a priority for the Office. http://dvr.dhhs.state.nc.us/

Service Delivery Challenges: The Office cited equalized distribution of services, delivery of quality services in the most cost effective manner to the largest number of people and transportation for persons with disabilities to be some of their top service delivery challenges. Other service delivery challenges include the need for routine medical needs while participating in a rehabilitation program and overcoming disincentives to employment, especially related to the lack of health insurance for people who want to move from welfare or social security disability to work.

Socio-cultural Challenges: The main socio-cultural challenges include language, stigma, and attitudes.

Disparity Focus Area: The top priority focus areas include disability, income, and education based on federal mandates and determination of rehabilitation plans.

DIVISION OF VOCATIONAL REHABILITATION – HEALTH DISPARITIES IMPLEMENATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status.	Communicate to Management Staff the 9 key recommendations for eliminating health disparities	10/02	Feedback from managers	Copy of staff notes/agenda	VR and Office of Minority Health (power point presentation
2. Communicate, document, and champion best-practices in eliminating health disparities	Communicate & advocate with other DHHS agencies the need to implement the Medicaid Buy In for NC citizens with disabilities	Ongoing	Apply for Medicaid infrastructure grant	Cost information, models from other states	Resources from grant Staff from DHHS agencies
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Local interagency collaboration to review community systems in health care and identify gaps in health care and potential solutions	Ongoing, Interagency groups functional by 7/1/03	List of identified gaps, quarterly reports, functional interagency group by 7/1/03	Number of individuals who access services	VR/ILStaff/Managers
4. Monitor progress towards the elimination of health disparities	Improve data collection system to identify disparity within populations	4/03	Analysis of data	Demographics & statistics	Planning & Program Evaluation
5. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups)	Staff training on customer service and outreach, advocacy and communication with school system and students (including unidentified) at a younger age	Ongoing	Increase of number of underserved population served by agency	Demographics of individuals presently served by agency	Staff, data system
6. Increase resources/ investments to eliminate health status gaps	Seek grants to provide services to targeted groups, seek support from General Assembly, set aside basic funds to provide services to underserved populations	Ongoing	Receipt of grants, increase in resources	VR data files	Staff, data system
7. Build, support and fully utilize a diverse workforce capable of working in cross- cultural settings.	Early recruitment of bilingual & bicultural students (high school) Organized recruitment effort, sponsor Spanish classes for interested staff	Ongoing	Evaluate marketing recruitment efforts – brochures, career day attendance	5 year comparison of diversity workforce, EEO report	Staff
8. Identify and advocate for public policies that aid in closing the health status gap.	Partner with other agencies & organizations for policy changes	Ongoing	Public policies adopted	Public policies	Dedicated staff
9. Demonstrate Accountability and Ownership for Health Outcomes	Successful rehabilitation and independent living outcomes to ensure comparable benefits are maintained	Ongoing	VR & IL outcome data	VR data base	Staff, data system

Division of Social Services

Mission: To assist and provide opportunities for individuals and families in need of basic economic support and services to become self-supporting and self reliant. The Division advocates for and encourages individuals to seek actions appropriate to their needs. In cooperation with county departments of social services, and other public and private entities, the Division also seeks to identify needs, devise and focus resources, and deliver services responsively and compassionately. http://www.dhhs.state.nc.us/dss/

Sections/Programs: Four sections: 1) Child Support Enforcement, 2) Work First, 3) Food Stamps, and 4) Children's Service responded to the disparity survey.

Priority Conditions/Issues: All the sections indicated that they did not have a priority disease, condition, or issue. The Child Support Enforcement section stated that "NC Child Support Enforcement does not deal with disease or health problems" while the other sections, indicated that this question was not applicable to their work.

Service Delivery Challenges: According to the *Child Support Enforcement* (CSE) section, some of the main service delivery challenges they face include lack of sufficient staff, court time, sheriff deputy time to process child support orders, and paternity establishments to meet the needs of our clients; resources to provide "state of the art" training to local offices as needed and program outreach to the citizens of our state; and interaction/coordination with other state programs.

The *Work First section* identified availability of service provision during non-traditional hours, internet based application/eligibility assessment, addressing issues of Limited English Proficiency, economy and job losses, and the lack of two-parent participation in the home, as their main service delivery challenges.

The *Food Stamps Section,* the main service delivery challenges include: increasing participation of eligible households; improving services for eligible working families;

addressing nutritional assistance needs of elderly; addressing issues of Limited English Proficiency and program simplification. The *Children's Services Section* reported their main service delivery challenges to be identification of high-risk families: provision of effective; family-centered prevention services; stopping child maltreatment without removing children whenever possible; finding safe; permanent homes for children who cannot be safely reunited with their families and provision of effective post-adoption support services.

Socio-cultural Challenges: Common socio-cultural challenges for the four social services sections included language barriers, attitudes, trust, and cultural competency issues. The *Child Support Enforcement* (CSE) section mentioned Program awareness with clientele population, trust/confidence in CSE to deliver financial support to clients, new sense of personal responsibility among non-custodial population, communicating to teenagers the mental, physical, and financial costs of parental responsibility, and overcoming the increasing problem of language barriers in NC as their top five socio-cultural challenges.

The *Work First Section* identified staff understanding of program goals and culture, language, and barriers such as substance abuse, family violence, stigma, and public perception as their socio-cultural challenges. The *Food Stamps Section*, the main socio-cultural challenges include welfare stigma associated with the program, language barriers, and outreach to non-participating households. The *Children's Services Section* reported issues related to their transition from an incident-oriented, investigative approach to an assessment –oriented, family-centered approach in child protection work, the need for culturally competent of service providers, bi-lingual service providers, and public recognition of the effects of poverty on child maltreatment as their main socio-cultural challenges.

Disparity Focus Areas: The top disparity focus areas for most of the Social Services sections were income, education, disability, and race/ethnicity.

DIVISION OF SOCIAL SERVICES – ADULT – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status.	A public awareness/public education campaign will be developed to inform the general public about domestic violence – the nature and causes of domestic violence as well as community resources for seeking help. Under served populations such as the elderly and Hispanics will be included in this initiative.	Will begin in SFY02-03.	Reports from local service providers on whether utilization of services by underserved population increases.	Data reported by local service providers.	Coordinated effort and staff resources from the participating DHHS Divisions, the Commission of Domestic Violence, the Governor's Crime Commission. & others.
2. Communicate, document, and champion best-practices in eliminating health disparities	The Family Violence Program Coordinator in the Division of Social Services provides consultation and technical assistance to local domestic violence programs on best practices for serving under served populations.	On-going	Reports from local service providers on increases in utilization of services by under served populations	Data reported by local service providers.	Staff at the Division of Social Services.
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	County departments of social services and local domestic violence programs are working jointly to develop plans for how they will serve Work First families who are experiencing domestic violence.	SFY02-03 and beyond, depending on availability of funding from the General Assembly.	County plans submitted by the departments of social services and local domestic violence programs.	Data reported by local service providers.	Local staff in service provider agencies and Division of Social Services staff.
4. Monitor progress towards the elimination of health disparities	Monitor accomplishments in items 1, 2, and 3 above.	On-going or as long as funding is available.	Monitoring of reports and county plans submitted by local agencies.	Data reported by local service providers	Local staff in service provider agencies and Division of Social Services staff & others.
5. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups)	The Family Violence Program Coordinator in the Division of Social Services provides consultation and technical assistance to local domestic violence programs on best practices for serving under served populations.	On-going	Reports from local service providers on increases in utilization of services by under served populations	Data reported by local service providers.	Staff at the Division of Social Services.

DIVISION OF SOCIAL SERVICES – ADULT – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
6. Increase resources/ investments to eliminate health status gaps	The Division of Social Services is seeking a U. S. Department of Justice grant to improve services to elderly adults who are victims of domestic violence.	SFY03-04 and beyond depending upon availability of grant funds.	Reports from local service providers on increased use of services by elderly	Data reported by local service providers.	Local staff in service provider agencies and Division of Social Services staffs.
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings.	The Family Violence Program Coordinator in the Division of Social Services provides consultation and technical assistance to local domestic violence programs on workforce issues, including need for culturally diverse staff.	On-going	Reports from local service providers on composition of work force.	Data reported by local service providers.	Staff at the Division of Social Services.
8. Identify and advocate for public policies that aid in closing the health status gap.	The Division of Social Services will continue efforts to identify federal and state laws or rules that need amending in order to improve services to under served populations.	On-going	Proposals and input for changes in federal and state laws and rules.		Staff at the Division of Social Services
9. Demonstrate Accountability and Ownership for Health Outcomes	Monitor accomplishments in items 1 - 8 above.	On-going or as long as funding is available.	Monitoring of reports and county plans submitted by local agencies.	Data reported by local service providers	Local staff in service provider agencies and Division of Social Services staff & others.

DIVISION OF SOCIAL SERVICES – CHILDREN'S SECTION – HEALTH DISPARITIES IMPLEMENATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	RESOURCES AVAILALBE
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status.	Continue to communicate to child welfare professionals and advocates the importance of reducing the disproportionate representation of African-American children in the child welfare system.	On-going	Number of county DSS agencies that participate in Challenge for Children; system performance measures	Number/proportion of children in public child welfare system who are African-American	Resources are adequate to conduct awareness within public social services system; inadequate to conduct on a broader scale
2. Communicate, document, and champion best-practices in eliminating health disparities	Demonstrate impact of Multiple Response System (MRS) in 10 counties	August, 2002 thru June, 2003	Evaluation of impact of MRS demo on disproportionate representation issue	Demographic data on children in child welfare system	Existing data resources will enable us to do this
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Implement MRS statewide	To be determined	Statewide implementation when achieved	Data indicating number of counties that implement MRS	Existing data resources will enable us to do this
4. Monitor progress towards the elimination of health disparities	Continue to use longitudinal, entry cohort analysis to measure change in number/proportion of African-American children in child welfare system	On-going	Number and proportion of children in system who are A-A	Demographic data on children in system	Existing data resources will enable us to do this if UNC contract remains intact
5. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups)	Same as #3 above	Same as #3	Same as #3	Same as #3	Same as #3
6. Increase resources/ investments to eliminate health status gaps	Obtain federal approval for 5-year extension and statewide expansion of IV-E Waiver	By April, 2003	Federal approval	None needed	Need to continue UNC contract to evaluate impact of the Waiver

DIVISION OF SOCIAL SERVICES – CHILDREN'S SECTION – HEALTH DISPARITIES IMPLEMENATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	RESOURCES AVAILALBE
7. Build, support and fully utilize a diverse workforce capable of working in cross- cultural settings.	Provide comprehensive training to all DSS child welfare staff as part of MRS implementation	Same as #3	Number of county DSS agencies with all child welfare staff fully trained	Training database	Continue contract to manage training database
8. Identify and advocate for public policies that aid in closing the health status gap.	Prepare and present statutory changes necessary for statewide implementation of MRS	2003 Legislative Session	Legislative changes	Progress of proposed changes	Legislative liaison
9. Demonstrate Accountability and Ownership for Health Outcomes	Continue to make disproportionate representation of African-American children an issue	On-going	No./proportion of children in child welfare system who are A-A	Demographic data - children in child welfare system	Existing data resources will enable us to do this

DIVISION OF SOCIAL SERVICES – ECONOMIC INDEPENDENCE – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status.	A public awareness/public education campaign will be developed to inform the general public of efforts to end hunger by improving access to food stamp benefits, nutrition education, as well as community resources. Under served populations such as the elderly and Hispanics will be included in this initiative.	Will begin in SFY02-03.	Reports from local service providers on whether utilization of services by under served populations increase.	Data reported by local service providers.	Coordinated effort and staff resources from the participating DHHS Divisions, County D.S.S. agencies, USDA, Food Policy Council, Food Security Work Group and others.
2. Communicate, document, and champion best-practices in eliminating health disparities	The Program Integrity Representatives and Policy Consultants in the Economic Independence Section provide consultation and technical assistance to local D.S.S. agencies on best practices for serving under served populations.	On-going	Reports from local service providers on increases in utilization of services by under served populations	Data reported by local service providers.	Staff at the Division of Social Services/Economic Independence Section.
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	The Economic Independence Section, county departments of social services, and local community partners are working jointly to develop plans for serving the nutrition needs of under served populations. Special emphasis will be placed on the elderly and Hispanics.	SFY02-03 and beyond, depending on availability of funding from the General Assembly.	County plans submitted by the departments of social services and their partners.	Data reported by local service providers.	County DSS staff, community partners, and Division of Social Services/Economic Independence staff.
4. Monitor progress towards the elimination of health disparities	Monitor accomplishments in items 1, 2, and 3 above.	On-going or as long as funding is available.	Monitoring of reports and county plans submitted by local agencies.	Data reported by local service providers	County DSS staff, community partners, and Division of Social Services staff.

DIVISION OF SOCIAL SERVICES – ECONOMIC INDEPENDENCE – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	**ACTION STEPS**	**TIME LINE**	**EVALUATION**	**DATA NEEDS**	**AVAILABLE RESOURCES**
5. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups)	The Program Integrity Representatives in the Division of Social Services provide consultation and technical assistance to local DSS agencies on best practices for serving under served populations.	On-going	Reports from local service providers on increases in utilization of services by under served populations	Data reported by local service providers.	Staff at the Division of Social Services and community partners.
6. Increase resources/ investments to eliminate health status gaps	Local DSS agencies and their community partners seek grants from the United States Department of Agriculture to implement programs to improve outreach and nutrition for families. Emphasis is placed on under served and vulnerable populations.	SFY02-04 and beyond depending upon availability of grant funds.	Reports from local service providers on increased use of services by under served and vulnerable populations.	Data reported by local service providers.	Local DSS staff, community partners, and Division of Social Services staff.
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings.	The Program Integrity Representatives provide consultation and technical assistance to DSS agencies on workforce issues, including the need for culturally diverse staff. The E.I. Section also has an ESL Coordinator to assist with issues involving the Hispanic population.	On-going	Reports from local service providers on composition of work force.	Data reported by local service providers.	Staff at the Division of Social Services.
8. Identify and advocate for public policies that aid in closing the health status gap.	The Division of Social Services will continue efforts to identify federal and state laws or rules that need amending in order to improve services to under served populations.	On-going	Proposals and input for changes in federal and state laws and rules.		Staff at the Division of Social Services
9. Demonstrate Accountability and Ownership for Health Outcomes	Monitor accomplishments in items 1 - 8 above.	On-going or as long as funding is available.	Monitoring of reports and county plans submitted by local agencies.	Data reported by local service providers	Local staff, community partners, Division of Social Services staff & others.

Division of Services for the Blind

Mission: The top priority conditions or issues for the Division of Services for the Blind include: deafness; hard of hearing; deaf-blind; elderly with hearing loss; and hard of hearing with multiple disabilities. http://www.dhhs.state.nc.us/dsb/

The main priority conditions or issues for the Division of Services for the Blind (DSB) are blindness and visual impairment.

Service Delivery Challenges: According to the division, the top service delivery challenges include: inadequate funding to meet service delivery needs; inadequate transportation resources for clients and; public awareness of services offered by the Division

Socio-cultural Challenges: Language barriers and public attitudes and misconceptions about blindness, and vision loss and language barrier were identified as the main socio-cultural challenges faced by the division.

Disparity Focus Areas: In terms of disparity focus areas, the Division has "not identified significant health disparities with respect to the health related services it delivers in any of the focus areas. Even so, DSB does outreach activities to ethnic minorities and individuals in rural areas. DSB has not identified significant health disparities in the focus areas. However, eligibility for certain services is contingent on the client's visual acuity or income as determined by law and/or policy."

DIVISION OF SERVICES FOR THE BLIND – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability, and socioeconomic status.	Collect data and share with staff on race/ethnicity, disability status and eye diseases	1/2003	Our current data will be reviewed from our Electronic Services System.	Data is available on age, eye disease, low income status, and race/ethnic status.	Medical Eye Care Program; Nursing Eye Care Consultants; Social Workers for the Blind; other DSB staff.
	Share information as opportunities allow with providers, DSS, and other agencies in an effort to prevent vision loss.		Increase goal of more "sharing opportunities" on employee work plans	Collect data from designated work plans on number of "sharing opportunities".	
2. Communicate, document and champion best-practices in eliminating health disparities.	Our Medical Eye Care Program is our best program to eliminate health disparities to persons needing eye care. To be eligible, one must be low income, a North Carolina resident, and not eligible for Medicaid.	Medical Eye Care Program is in effect now.	Measure hits on DSB web site.	Substantial data will be available from DSB web site.	Medical Eye Care Program is all State funds that could not be reduced.
	DSB will share information about Program via web site.	1/2003		1/2003	Social Workers for the Blind, Nursing Eye Care Consultants, and other DSB staff.
3. Promote, develop, and enhance community's capacity to engage in healthy living, eliminating of disparities in health status.	Nursing Eye Care Consultants and Social Workers for the Blind are involved in health fairs, public education at Club meetings, senior centers, employment sites, etc. They educate about eye diseases. They offer eye exams, glasses, and/or treatment to persons who meet eligibility requirements for Medical Eye Care Programs.	Ongoing 1/2003	Collect data on public education regarding eye diseases and awareness of Medical Eye Care Program Services.	Data will be needed from designated staff work plans after mid-year evaluations.	State funds for Medical Eye Care Program and Nursing Eye Care Consultant positions. Block grant funds for Social Worker for the Blind positions and services; DSB staff and their funding source.

DIVISION OF SERVICES FOR THE BLIND – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
4. Monitor progress towards the elimination of health disparities.	Identify needed improvements in our data collection so we can identify any health disparity issues in our Medical Eye Care Program. Develop goals to reduce any identified disparities	1/2003	Carefully review/analyze data.	Data available from our Electronic Services System.	Our Computing Support Technician and other DSB staff.
5. Promote customer friendly services that meet the needs of underserved populations (i.e. low income and minority groups).	DSB provides interpreter services for persons who are deaf and/or who speak a foreign language.	1/2003	Control file on use of Agency purchased interpreter services.	Number who received Agency paid interpreter services.	DSB has limited funds but we have staff available to arrange service by various means.
	Supervisors will encourage staff to provide services after regular working hours if/when this is the only way to meet a specific need.		Data will be collected from staff at work plan evaluations.	Number of occasions when staff provided services and education after regular hours.	Stat is available and funded from several resources to meet this need.
6. Build, support, and fully utilize a diverse workforce capable of working in cross-cultural settings.	Promote and integrate cross-cultural education and disability awareness.	6/2003	Review training log and review EEO report.	Training log.	DHHS employees are available to address cross-cultural and disability awareness issues.
	Work to increase proportion of underrepresented persons with disabilities on all major governing boards to promote diversity in decision making process, policymaking, and program design.		Review of data will identify underrepresented groups. Encourage appointment of underrepresented people.	Electronic Services System headcount/observation of Board composition.	Limited funds restrict travel.
7. Identify and advocate for public policies that aid in closing the health status gap.	Incorporate eliminating health disparities into employee work plans and promote compliance with ADA	7/2003	Review of work plans by Field Services Manager.	Number of work plans that address eliminating health disparities.	Staff already available.

Division of Services for the Deaf and Hard of Hearing

Mission: The division provides a broad range of services for children and adults, their families and the professionals who serve them. The division also provides interpreter services, advocacy, access to technology and coordination of human services for the deaf and hard of hearing. http://www.dhhs.state.nc.us/docs/divinfo/dsdhh.htm

Service Delivery Challenges: The top service delivery challenges for the division include advocacy, consumer skills development, outreach, consultation, and training. Advocacy challenges include eliminating resistance among service providers to provide effective communication in medical/health settings. This includes both public and private healthcare providers. The Consumer Skills Development challenge includes many individuals not seeking additional information regarding health issues because of communication barriers. Outreach challenges relate to reaching deaf, deaf-blind, and hard of hearing individuals in rural areas and reaching minority deaf, deaf-blind, and hard of hearing citizens. Another challenge involves collaborating with other agencies to identify options for achieving equal access and providing educational opportunities to agencies.

Socio-cultural Challenges: Socio-cultural challenges for the division include misconceptions about deafness, language barriers, stigma, and consumers not trusting the system. The division's top three focus areas include disability, education, and income. Regarding resources to address disparities, the division observed that "qualified specialists focus on primary conditions of deafness, hearing loss and deaf-blindness to eliminate disparities. The Telecommunications Equipment Distribution Program eliminates some communication barriers. Grants have been secured to help purchase hearing aids as well."

DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	**ACTION STEPS**	**TIME LINE**	**EVALUATION**	**DATA NEEDS**	**AVAILABLE RESOURCES**
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability, and socioeconomic status.	Refer all DHHS "health focused" divisions to the DHHS Communication Access Provision policy. Provide in service training; "Orientation to Deafness to all health care divisions within DHHS to assist in initiating equal access. Continue outreach to private health care facilities in regards to equal access to effective communication	January 2003	Response from the original request for support Documentation of the number of agencies that received training	Resource Center daily documentation or quarterly Reports.	Existing collaboration efforts from the Department Resource Centers employ specialists in each of the critical areas of its focus.
2. Communicate, document, and champion best-practices in eliminating health disparities	Partner with health care agencies and provide input on promoting best practices to support access for the deaf, hard of hearing and deaf/blind	July 2003	Survey area health care providers about contact with RRC	Survey development	Existing staff
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Conduct consumer education series to inform citizens of available health services. Partner with consumer organizations to disseminate information on eliminating disparities.	March 2003	Biannual evaluation through consumer surveys and one on one interviews.	DSDHH recently developed a consumer satisfaction survey. They have not been used yet.	RRC specialist could conduct education series with the support of health agency experts and consumer organization representatives
4. Monitor progress towards the elimination of health disparities	Advocate for equal access to health services for deaf, deaf/blind and hard of hearing citizens	July 2003	Quarterly evaluation could be done based on consumer requests for support by way of advocacy	Current documentation kept by RRC staff via quarterly report	RRC staff

DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
5. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups)	Partner with health care agencies to reach the minority communities of the deaf, hard of hearing and deaf/blind.	July 2003	Consumer satisfaction surveys		Existing staff and volunteers
6. Increase resources/ investments to eliminate health status gaps	Seek grant (s) to promote awareness of health issues within the deaf, deaf/blind and hard of hearing communities to eliminate health status gaps	July 2003	Review of such grants	Information on funding sources	Collaboration has already begun with grant writers with knowledge of deafness and health issues.
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings.	Promote partnering with representatives from minority communities. Utilize the strengths of all staff by cross-training when appropriate to achieve greater access to communities	July 2003	Documentation in work plans.	None	Current staff
8. Identify and advocate for public policies that aid in closing the health status gap.	Partner with healthcare agencies and organizations	January 2003			Current staff
9. Demonstrate Accountability and Ownership for Health Outcomes	Incorporate some level of focus on health issues within the work plan of appropriate staff in the DSDHH	July 2003	Biannually with Performance Management Program		Existing work plan format

Division of Child Development

Mission: The Division of Child Development oversees all aspects of childcare services in North Carolina. The division regulates child care facilities and responds to reports of illegal child care operations and allegations of abuse or neglect in child care facilities. It also oversees the state's subsidized childcare program, offering financial assistance to help eligible families pay for childcare. The Division of Child Development promotes education and training for childcare workers, and administers other early childhood initiatives to improve the quality of care for all children in the state. The Head Start Collaboration Office is also housed there, linking various services for young children and their families. http://www.dhhs.state.nc.us/dcd/

DIVISION OF CHILD DEVELOPMENT – HEALTH DISPARITIES IMPLEMENATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIMELINE	EVALUATIONS	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status.	DCD will continue to have representation on the state level *Walking the Wall* workgroup,, whose goal is to increase the number of well-qualified, culturally and linguistically diverse leadership personnel available to serve infants, toddlers, and young children, especially in North Carolina.	Ongoing	Collaborative activities.	As identified by group.	As identified by group.
	DCD is funding development of SIDS prevention training for child care providers that includes information on populations at high risk for SIDS.	Per contract	As required in contract with NC Healthy Start Foundation.	As provided in contract.	Federal Child Care and Development (CCDF) quality funds.
2. Communicate, document, and champion best practices in eliminating health disparities.	Local Smart Start partnerships will continue to promote health screenings for preschool children.	Locally determined.	Performance Based Incentive system outcomes.	As identified by NCPC	Smart Start funds
	DCD Infant/Toddler Quality Enhancement Project will continue to provide for health consultation to child care providers.	Contract cycle	As required in contract with UNC-CH.	As provided in contract.	CCDF quality funds.
	DCD will continue to use ERS assessments within the rated license, which include best practices for health.	Ongoing	Star rating system; ERS scores.	ERS subscale scores.	CCDF quality funds.
	DCD will continue to fund the Child Care Health and Safety Bulletin.	Contract cycle.	As required in contract.	As provided in contract.	CCDF quality funds.
	DCD will continue to fund the Health and Safety Resource Center calendar for child care providers, which focuses on a different children's health issue each month, including asthma, obesity, prevention of blindness, SIDS, and inclusion of children with special needs.		As required in contract.	As provided in contract.	CCDF quality funds.

DIVISION OF CHILD DEVELOPMENT – HEALTH DISPARITIES IMPLEMENATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIMELINE	EVALUATIONS	DATA NEEDS	AVAILABLE RESOURCES
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Local purchasing agencies will continue to refer families to NC Health Choice. TEACH Health Insurance recipients (see #6 below) will continue to be required to have health insurance or NC Health Choice for their children.	Ongoing Contract cycle.	Feedback from counties. As required in contract with Child Care Services Association.	N/A As provided in contract.	NC Health Choice materials. CCDF quality funds.
4. Monitor progress towards the elimination of health disparities.	DCD's Infant/Toddler project will provide data on the health status of children in child care.	Contract cycle.	As required by contract.	As provided in contract.	CCDF quality funds.
	DCD will monitor ERS health/sanitation subscale scores.	Ongoing	ERS subscale scores.	ERS subscale scores.	CCDF quality funds.
5. Promote customer friendly services that meet the needs of underserved populations (i.e. low-income and minority groups).	DCD's Customer Service Logistical Team will continue to track customer service training.	As determined by team.	As determined by team.	Training records.	Training opportunities.
	DCD's Multicultural Strategies Team will facilitate the translation of forms and documents, vital portions of the website, publications and brochures into Spanish, ensuring that important information is available to Hispanic/Latino families across the state.	Per contract	Per contract terms.	Quantity and quality of information translated.	CCDF quality funds.
6. Increase resources/investments to eliminate health status gaps. .	DCD will continue to use federal funds for TEACH Health Insurance, which pays for one-third of the cost of health insurance premiums for child care workers in the TEACH Early Childhood Project.	Per contract	Per contract	Per contract	CCDF quality funds
	DCD will continue to support increasing the quality of child care through training of child care providers in identifying, referring, and servicing children with or at risk for disabilities. This project is known as Partnerships for Inclusion.	Per contract	Per contract with Partnerships for Inclusion.	Per contract	CCDF quality funds

DIVISION OF CHILD DEVELOPMENT – HEALTH DISPARITIES IMPLEMENATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIMELINE	EVALUATIONS	DATA NEEDS	AVAILABLE RESOURCES
7. Build, support, and fully utilize a diverse workforce capable of working in cross-cultural settings	DCD will continue its practices of hiring a workforce that reflects its client population. (Currently, individuals from minorities make up 31% of DCD's workforce.	Ongoing	DCD workforce demographics.	DCD workforce demographics	Continued recruitment efforts.
8. Identify and advocate for public policies that aid in closing the health status gap.	DCD will continue to support Smart Start and Head Start, which promote and provide health services for children.	Ongoing	As reported by Smart Stare and Head Start.		
9. Demonstrate accountability and ownership for health outcomes.	DCD funded Needs and Resource assessments for all counties to determine the numbers of children impacted by various economic and social indicators (impacts children's access to health).	Every 2 years, or as funded.	Per assessment contract.	Per assessment contract.	Funding
	DCD will continue to review outcomes related to health services for children.	Ongoing	Smart Start, Health Choice data	Smart Start evaluation data.	Continued funding for Smart Start evaluations.
	DCD has funded and supported evaluations that have examined Smart Start's impact on children's health: *The Effect of Smart Start Health Interventions on Children's Health and Access to Care* (October, 2001). *The Effect of Smart Start Child Care on Children's Access to Health Care* (September, 8, 2000) and *Smart Start and Quality Inclusive Child Care in North Carolina* (May, 2000).	Ongoing if funding is available	Smart Start evaluation.	Smart Start evaluation data.	Continued funding for Smart Start evaluations.
	DCD will continue to respond to national and state research on children's health and safety issues, resulting in continued support for infant/toddler health consultants, health and safety resource materials, ITS-SIDS training, etc.	Ongoing	Outcomes targeted to specific project.	Per contract per specific project.	CCDF quality funds.
	DCD will be proactively involved in developing sanitation regulations for child care facilities.	Ongoing	Rulemaking process	Input from licensing consultants, environmental health professionals	Time and opportunities for DCD staff participation and input.

Division of Services for the Aging

Mission: Established by State law in 1977, the Division of Aging is the organization within the NC Department of Health and Human Services responsible for planning, administering, coordinating, and evaluating the activities developed under the federal Older Americans Act and the programs for older adults funded by the NC General Assembly. The Division is the state's foremost leader in identifying and responding to the aging of our population. The Division of Aging works to achieve successful aging for North Carolina's older population by providing a system of services, opportunities, and protective supports that include: supporting home and community services to promote independence and self-sufficiency; promoting opportunities for citizen involvement to allow seniors to contribute in civic affairs and public policy making, and through volunteerism; ensuring the rights and protections of older people for their social, health, and economic well-being, and preparing younger generations to enjoy meaningful lives in their later years.
http://www.dhhs.state.nc.us/aging/

Priority Conditions/Issues: Top priority conditions include: cardiovascular disease; diabetes; cancer; mental health issues; arthritis and osteoporosis.

Service-Delivery Challenges: Service delivery challenges include transportation i.e. "lack of availability of health professionals and services in certain areas of the state", cost of non-insured/non-covered services, the cost of health coverage cost-sharing, transportation to health and wellness centers, language barriers, and the lack of service coordination.

DIVISION OF AGING – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	**ACTION STEPS**	**TIME FRAME**	**EVALUATION**	**DATA NEEDS**	**AVAILABLE RESOURCES**
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status	Identify sources of data and other information that will profile the health and long term care of seniors by race/ ethnicity, disability and socioeconomic status	September, 2003	Management team will receive a regular report	Documented sources of data and other information	Division personnel
	Work with DPH[16] to produce an update of *A Health Profile of Older North Carolinians*, to include examination of disparities	January, 2003	Management team will receive a regular report.	Document's publication's in print and on-line.	. Division personnel and some funding for printing of 1,000 copies of publication (estimate of $200 to $1,000 depending on quality of publication) c. Division personnel and collaboration of NC Institute on Aging and UNC CARES
	Work with the UNC Institute on Aging and UNC CARES to update the publications, *Gender, Race, and Class: Enduring Inequalities in Later Life: a North Carolina Perspective* and *Baby Boomers at Mid-Life*[17]	July, 2003	Management team will receive a regular report	Document's publication in print and on-line	
	Include a substantial review of health and service disparities in the division's 2003-07 State Aging Services Plan, which is required by state and federal statutes	March 2003	Management team will monitor this priority of the Division	Use data from multiple existing sources	Division personnel

[16] DPH=Division of Public Health
[17] See http://www.aging.unc.edu/news/publications.html for this fact sheet

DIVISION OF AGING – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
2. Communicate, document, and champion best practices in eliminating health disparities	Work with AAAs[18] and the NC Assoc. on Aging to identify and publicize "best practices," using NC Assoc. on Aging's "best practice" web site[19] to promote on-line	September, 2003	Management team will receive a regular report	New items added to NCAOA web site	Division personnel and collaboration of AAAs and NC Assoc. on Aging
	Use Project C.A.R.E. to document and publicize effective practices in reaching and supporting minority and rural families caring for persons with dementia[20]	September 2003	Management team will receive a regular report and this may be the subject of a "learning lunch" at the Division	Data required of project	Division personnel, continuation of grant, and collaboration of partners in project
	Seek a graduate student to expand survey of other states' health promotion activities to identify best practices focused on disparity issues[21]	September 2003 (most likely Summer 2003)	Management team will receive a regular report	Data would be secured during activity	Division personnel to supervise student; student deciding to do field work at Division
	Use the state's voluntary certification process and its required standards to promote good practice among Senior Centers (one of the standards that must	September 2003	Management team will receive a regular report	Responses to SCOPE instrument; revised standards	Division personnel and centers applying for certification or attending training

18 AAAs=Area Agencies on Aging of which NC has 17 located within the Councils of Government, see http://www.dhhs.state.nc.us/aging/aaa.htm

19 NCAOA is the North Carolina Association on Aging, which is the professional/trade association for local aging services providers. The Division of Aging helped NCAOA develop a web site of best practices (http://www.ncaoa.org/database.html)

20 The Division of Aging is in the second year of a three-year federal grant designed to improve the quality, access, choice, and use of respite services for families caring in the community for individuals with Alzheimer's Disease or related dementia. A special emphasis of the project is on providing information and assistance and arranging respite services to family caregivers who are not receiving services due to geographical factors, economic or racial isolation, or lack of available local resources.

21The Centers for Disease Control and Administration on Aging recently made a move to increase health aging programs collaboration between state units on aging (SUAs) and health departments (SHDs) nationwide. In response, the Division of Aging secured a student of the Duke Leadership in an Aging Society Program in Summer 2002 to conduct a survey to review current health promotion programming of other states, especially as it relates to Title III-D funding from the Older American's Act.

DIVISION OF AGING – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
	be met by a certified Center is outreach to special populations) [22]				
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status	Continue support of NC Senior Games as a important vehicle for good health and active aging by managing State funds for program, serving in an advisory capacity, promoting program among AAAs, and by encouraging at least 6 division staff to volunteer.	September 2003	Management team will receive a regular report	Review of Area Plans, # of Division staff participating	Division personnel
	Request NC Senior Games to provide data annually profiling participants to assure adequate representation consistent with NC's senior demographics.	September 2003	Management team will receive a report	Data to be furnished by Senior Games	Division personnel; relationship with NC Senior Games
	Offer pertinent information for consumers and providers on the DHHS web site for Long Term Care and the Division's own web site[23]	September 2003	Management team will review web sites	Content on web sites and feedback from users	Division personnel
	Collaborate with DPH and others to encourage participation of at-risk groups to receive flu and pneumonia shots	January 2003	Management team will receive a report	Data to be furnished by DPH	d. Division personnel; collaboration with other agencies and groups including the Senior Vaccination Season Coalition.

22 The Division of Aging implemented in 1998 a voluntary process to certify Senior Centers of "Merit" and "Excellence." Among the items considered in the Senior Center Operations and Program Evaluation (SCOPE) tool used in the certification process was a focus on whether and how the Center provided special outreach to people in rural areas, those with low income, those from ethnic minority groups, those with disabilities, and those with limited ability to speak English. Based on its experience with the use of this SCOPE tool, the Division is now in the process of revising its required standards for centers receiving public funds. The Division will also incorporate training on reaching special needs populations within its developing curriculum for Senior Center managers.

23 The Division of Aging is responsible for not only maintaining its web site (http://www.dhhs.state.nc.us/aging/home.htm) but also a new web site for DHHS on long term care (http://www.dhhs.state.nc.us/ltc/). On both of these sites, visitors will be able to access information and make contacts for assistance with hearing and visual impairments and other disabling conditions.

DIVISION OF AGING – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
4. Monitor progress towards the elimination of health disparities	Seek a graduate student who can do a follow-up survey of I&A providers to assess the extent to which and why some providers report problems "communicating with minority populations" and the need for "cultural sensitivity" training[24]	September 2003 (most likely in Summer 2003)	Management team will receive a report	Data to be collected during survey.	Division personnel to supervise student; student deciding to do field work at Division
	Continue to use ARMS data to monitor extent to which HCCBG funds are used to reach socially and economically needy by county, region and statewide[25]	September 2003	Management team will receive a report	ARMS data	Division personnel
5. Promote customer-friendly services that meet the needs of under-served populations (i.e., low-income and minority groups)	Analyze and strengthen the community resource information that is available to all Division staff to aid in providing referrals to callers, web visitors and others (e.g., information on aging and special population groups)	September 2003	Feedback from Division personnel; management team review	Resource documents produced; observation of personnel in interaction with consumers; review of control letters and other correspondence	Division personnel; cooperation of other agencies
	Incorporate in staff work plans appropriate responsibilities and dimensions that relate to customer-friendly services	November 2003	Review by management team	Completion of work plans (initial and evaluative)	Division personnel; expectations from management team

24 The Division of Aging conducted a survey in 2000 of 40 local providers of Information and Assistance services for older adults and their family caregivers. Among the survey's findings were: (1) 42% of respondents report often or sometimes having problems communicating with minority populations; and (2) 33% requested "cultural sensitivity" training and 20% wanted training on "sensitivity to minority populations." The Division believes that it needs further help in pinpointing the nature of the perceived problem and need for training so that it can develop a meaningful response.

25 The Division of Aging maintains an Aging Resource Management System (ARMS) to collect client and expenditure data for services funded under the Home and Community Care Block Grant (HCCBG). The client data include demographics (e.g., race, self-reported economic status, ADL limitations). The Division also requires Area Agencies on Aging to develop targets for reaching the socially and economically needy relative to the demographics of their region.

DIVISION OF AGING – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
	Sponsor and promote training designed to promote services to aid under-served persons, including sessions at the 2002 NC Conference on Aging on *substance abuse and older adults*, *planning for populations with special medical needs in times of* emergencies & *disasters, best practice models of good health promotion programs, assistive technology resources for seniors, fighting hunger in NC, understanding depression in older adults, and reaching out to NC's elderly refugees*	September 2003	Management team will receive a regular report	Training programs	Division personnel; collaboration with other agencies; support from Division's budget for "mission critical" travel
6. Increase resources/investments to eliminate health status gaps	Identify and pursue grants that will assist the Aging Network in promoting good health and access to health and social services[26]	September 2003	Management team will receive a regular report	Log of grants submitted and funds received	Division personnel; necessary matching resources when required
	Review of intrastate funding formulas to ensure that it continues to address those most in need[27]	September 2003	Management team will review and approve any formula changes	Formulas themselves	Division personnel; Census and other data; input from consumers and providers in public hearings

26 The Division of Aging has secured several grants whose outcomes support elimination of health disparities. These include: (a) Project C.A.R.E. to improve the quality, access, choice, and use of respite services for families caring in the community for individuals with Alzheimer's Disease or related dementia; In addition, the Division has recently submitted these federal grants: (a) Performance Outcome Measures Project to pilot-test performance outcome measures in four areas (family care giving, information and assistance, transportation, and in-home aide services); (b) a Food Stamp Program Outreach Research Grant to improve program access and participation in the Food Stamp program by eligible seniors; and (c) a state innovation grant to plan and implement a Communications and Planning Network to Support Families in their Long Term Care Roles.

27 The Division of Aging is responsible for allocating funds for the Home and Community Care Block Grant, the Family Caregiver Support Program, Senior Centers, Adult Day Services, the Ombudsman Program, and other monies. In each instance the Division is concerned with respecting the intent of the authorizing legislation, which in most instances is intent on serving the socially and economically needy defined by such variables as low-income minority, rurality, disabilities, and limited English-speaking abilities.

DIVISION OF AGING – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings	Assure diverse representation on committees, task forces, etc.	September 2003	Examine membership on the following groups for which Division has direct or indirect responsibility: Governor's Advisory Council on Aging, NC Senior Tar Heel Legislature, Provider Performance Review Committee, and Family Caregiver Support Steering Team. In addition, Division will continue to monitor the representation of AAAs' Regional Advisory Councils.	Demographics, group memberships, applicable federal and state laws[28]	Division personnel

28The Older Americans Act [306(a)(6)(D)] requires certain representation on the advisory council of an Area Agency on Aging, including minority individuals and individuals in rural areas who are participants or who are eligible to participate in programs assisted under the Act.

DIVISION OF AGING – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings – continued	Work with new Associate Director of Aging and Diversity at UNC Institute on Aging to examine findings of the Institute's workforce survey and plan appropriate responses to support cross-cultural work in aging[29]	September 2003	Management team will receive a regular report and review findings.	Data from survey already conducted	Division personnel and cooperation of UNC Institute on Aging
	Work with AARP in its expansion of diversity training[30]	September 2003	Management team will receive a regular report.	Documentation of training activities	Division personnel; cooperation with AARP
	Assure that the workforce of the Senior Community Service Employment Program (Title V) is diverse and representative of the demographics in the areas where the program operates[31]	September 2003	Management team will receive a report.	Data from Title V project	
	Hold at least two learning lunches for Division staff focused on raising awareness and building sensitivity to a health disparity among sub-populations of seniors[32]	September 2003	Holding of learning lunches and feedback from attendees	Lunches and feedback from attendees	Division personnel and possibly outside presenters
	Assure that under- served and special needs older adults have opportunities for volunteer and educational participation	September 2003	Management team will receive a report	Report on volunteer opportunities and community college participation	Division personnel and input form N.C. Community College System and volunteer agencies

29 Dr. Peggye Dilworth-Anderson has been appointed a Professor in the UNC School of Public Health and Associate Director of Aging and Diversity within the UNC Institute on Aging. The Divisions of Aging and Social Services assisted the UNC Institute on Aging in conducting a statewide survey of the workforce serving older adults in 2000-2001 (see http://www.aging.unc.edu/education/final.pdf for details).

30 AARP has developed and is piloting a training curriculum on aging and diversity with its volunteers. AARP hopes to expand this training to include the Aging Network. The Division of Aging serves on the advisory committee for this initiative in North Carolina.

31 The Division of Aging operates the Senior Community Service Employment Program (Title V of the Older Americans Act) in six regions which covers 34 counties. The program provides part-time, subsidized work-training opportunities for persons age 55 and older with incomes

32 The Division of Aging holds learning lunches for its personnel and interested others designed to educate about and discuss noteworthy initiatives and issues.

DIVISION OF AGING – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
8. Identify and advocate for public policies that aid in closing the health status gap.	a. Build eliminating disparities into state and local policies and practices regarding such emerging and important initiatives as prescription drug assistance and long-term care reform	a. September 2003	a. Management team will review and discuss regularly.	a. Evidence of work completed or underway	a. Division personnel; collaborative activities with other agencies and stakeholders
	Review service standards to assure that they adequately address responding to the needs of special populations, including ADA compliance (note: senior center operations standards have been revised to incorporate ADA accessibility guidance[33]	September 2003	Management team will receive a regular update of this division priority	Service standards themselves	Division personnel; assistance from DHHS and others in processing APA rule changes
	Channel to the NC Aging Network appropriate policy communications from the U.S. Administration on Aging and other sources[34]	September 2003	Management team will discuss activity.	Evidence of information communicated via print, email, web site, and face-to-face	Division personnel; relevant information from Administration on Aging, CDC, NASUA and other sources
	Work with the UNC Institute on Aging's NC Healthy Aging Network and its Program in Healthcare and Aging Research[35]	September 2003	Management team will receive a regular report on this.	Products influenced by Division's involvement	. Division personnel; cooperation of UNC Institute on Aging

33 The Division of Aging is responsible for maintaining and enforcing service standards for each of the 17 Home and Community Care Block Grant services.

34 The U.S. Administration on Aging has undertaken a number initiatives associated with healthy aging and health disparities. Most recently, the Administration launched USA on the Move: Steps to Healthy Aging, a two-part project sponsored with the National Policy and Resource Center on Nutrition and Aging at Florida International University. This pilot project is designed to improve nutrition and physical activity in older adults.

35 The UNC Institute on Aging has a two-year grant from the Centers for Disease Control (CDC) to identify clear goals, strategies and action plans to foster research relative to healthy aging and to effectively disseminate information about healthy aging to various service and consumer constituencies. Supported by a National Research Service Award (NRSA) Institutional Training Grant from the National Institute on Aging, the Institute is also offering pre-doctoral and postdoctoral training opportunities through its Carolina Program in Healthcare and Aging Research (CPHAR).

DIVISION OF AGING – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
9. Demonstrate accountability and ownership for health outcomes	Make this Plan a priority of the Division, along with its Customer Service initiative, and do an annual review of this Plan and the Division's related activities to assess achievements and update actions[36]	September 2003	Adoption of this Plan by Division's management team and by the Department	Evidence of support	Personnel of Division and DHHS
	Identify staff responsible for initiatives and include related tasks in respective work plans	September 2003	General review by management team and specific review by individual managers	Plan with assigned personnel; individual work plans	Division personnel

36 With input from all personnel, the Division of Aging, Management Team prepares an annual list of priorities that they monitor closely for progress and issues. This list of priorities generally directs a significant amount of staff time and attention. The Division has joined other DHHS units in undertaking a multi-faceted customer service initiative, which is another priority of DHHS Secretary Carmen Hooker Odom.

Abbreviations used in report:

AAAs – Area Agencies on Aging
ADA – Americans with Disabilities Act
APA – Administrative Procedures Act
ARMS – Aging Resource Management System
C.A.R.E. – Caregiver Alternatives for Running on Empty
CDC – Centers for Disease Control
CPHAR – Carolina Program in Healthcare and Aging Research
DHHS – Department of Health and Human Services
DPH – Division of Public Health
HCCBG – Home and Community Care Block Grant
NASUA – National Association of State Units on Aging
NCAOA – N.C. Association on Aging
NRSA – National Research Service Award
SCOPE – Senior Center Operations and Program Evaluation
SHDs – State Health Departments
SUAs – State Units on Aging
UNC CARES – University of North Carolina Center for Aging Research and Educational Services

Office of Minority Health and Health Disparities

Mission: The bridge the health status gap between racial-ethnic minorities and the general population by advocating for policies and programs that improve access to public health services for racial/ethnic minorities and other underserved populations in the state.

Priority Conditions/Issues: The main priority issues include minority health and health and service disparities faced by racial and ethnic minorities and other underserved groups in the state.

Service Delivery Challenges:

A. Limited control and influence over resources and programs serving minority populations

B. Lack of resources (human and financial) to carry out the mission to eliminate health disparities.

C. Lack of ownership and accountability across the Department on Minority Health issues.

D. Lack of workforce diversity throughout the department.

Socio-cultural Challenges:

A. Language and Communications barriers

B. Limited understanding of the role of culture in health and service delivery

C. Limited represented of minority communities most affected disparities on state and local decision making entities.

D. Limited capacity to address the need of checks with limited English proficiency

Disparity Focus Areas: The main disparity focus areas include race/ethnicity, cultural diversity, workforce diversity, and addressing social determinants of health.

OFFICE OF MINORITY HEALTH & HEALTH DISPARITIES – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability, and socioeconomic status.	Conduct 1-health disparities to parity presentation to the NCDHHS	DHHS January, 2003	Progress towards meeting the recommendation would be survey participants to determine how efforts would be made to move from disparity to parity in health; the increase of program funds, increase in collaborative efforts with organizations, tribes, and agencies; increase in funding of initiatives and training.	Morbidity and mortality rates; poverty rates; county data; state data.	Staff; survey instruments; county and state data; limited administrative funding.
	4 regional presentations across the state of North Carolina	December, 2003			
	1 presentation to NC General Assembly	Legislative February, 2003			
	1 presentation to MHAC	MHAC Anniversary			
	Conduct a media campaign (e.g., Radio One HIV/AIDS), contracting with local media, state media, and Universities. This includes 4 press releases, 4 one on one interviews with leaders and policy makers from educational and business arenas, and participation in public forums at the local level and state level.	1 Press release by December, 2002, 3 press releases (AI, AA, H/L) quarterly to be completed by December, 2003. Interviews to be held quarterly; and participation in forums as requested.			
	Issue a report card on health disparities by December, 2003	December, 2003			
2. Communicate, document, and champion best-practices in eliminating health disparities	Develop criteria to identify best practice programs to EHD.	June, 2003	Criteria and format complete and best practices accessible to others.	Collect data of pre and post focus groups.	Use health educators and interpreters to collect data and lead focus groups.
	Collaborate with DHHS and local agencies for replication/expansion of best practices.	Ongoing	Partnerships developed/enhanced and programs expanded/replicated.	Providers and community consumers.	Contact radio, TV, video companies and printers for low price materials to be used for health improvement of the community.

OFFICE OF MINORITY HEALTH & HEALTH DISPARITIES – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
2. Communicate, document, and champion best-practices in eliminating health disparities - continued	Seek funding for replication.	Ongoing			Invite local private companies to join and champion best practices by donating money and teaching good practices to their employees.
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Identify all community-based agencies that have a working relationship with the DPH.	Ongoing process	Developed electronic directory of CBOs and tribal organizations. Link to OMHHD website.	Create a database of CBOs who address health disparities in the state.	Current personnel and grants that may be available.
4. Monitor progress towards the eliminate of health disparities	Strengthen/Support State's capacity to collect reliable data on minority populations and conduct surveillance.	Ongoing		Funding for BRFSS over sampling, Tribal roles	Tribal rolls, Hispanic Contact, Printing
	Talk to BRFSS coordinator about over sampling of AI and Hispanics	February, 2003			
	OMHHD staff coordinate and meet with tribal leaders to request their support in answering BRFSS and also request contact phone number that BRFSS can use.	February, 2003			
	OMHHD find additional funds to support over sampling of small groups in BRFSS.	February, 2003			
	OMHHD and BRFSS coordinator make a proposal to identify potential funding for BRFSS over sampling.	February, 2003			
	Help recruit bilingual interviewers for the BRFSS (student interns, etc).	February, 2003	Finish action agenda.		Production and dissemination funds.
	Health Parity "Call to Action"	January, 2003			
	Develop a Health Parity Report	January, 2003	Finished and disseminated report	Key indicators	Production and dissemination funds.

OFFICE OF MINORITY HEALTH & HEALTH DISPARITIES – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME FRAME	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
5. Promote customer friendly services that meet the needs of underserved populations (i.e. low-income and minority groups).	Conduct at least 2 customer service trainings for OMHHD staff.	December, 2002	Completed training		OMHHD staff.
	OMHHD will identify 2 public access areas (i.e. vital records and prevention field services) improve access for people with Limited English Proficiency.	Ongoing			Website
6. Increase resources/investment to eliminate health status gaps.	Develop strategic plan for financial resource development for OMHHD eliminating health disparities initiatives.	9/02 – 12/02	Progress report to OMHHD management team.	Health status data on priority populations.	.5 FTE Health Disparities Liaison.
	Develop a plan for OMHHD unit on work force Development and Diversification.	10/02 - .01/03	Progress report to OMHHD management team.	HR Data on Workforce	.05 FTE Health Disparities Liaison.
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings.	Develop work plan responsibilities (KRRs) that document efforts build, support, and utilize a diverse workforce.	June, 2003			
	Offer and promote components of the cultural diversity training initiative within DHHS.	Ongoing	Number of trainings – Number of participants.		OMHHD staff and Cultural Trainers.
	Promote the expansion of a pipeline for bilingual providers.	Ongoing			

OFFICE OF MINORITY HEALTH & HEALTH DISPARITIES – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	**ACTION STEPS**	**TIME FRAME**	**EVALUATION**	**DATA NEEDS**	**AVAILABLE RESOURCES**
8. Identify and advocate for public policies that aid in closing the health status gap.	Develop and disseminate public policy strategies in accordance with MHAC priorities.	Ongoing	Production of document, number of outlets forwarded to, passed/defeated legislation, financial and additional resources allocated to EHD.	State and county morbidity/mortality statistics, evidence based research.	MHAC and OMHHD staff.
	Advocate for DHHS policies to eliminate health disparities.	Ongoing			MHAC, Steering Committee, OMHHD
	Partner with advocacy groups with similar agendas to MHAC priorities (e.g. Prevention Partners).	Ongoing			
9. Demonstrate Accountability and Ownership for Health Outcomes	Develop and publish a health disparities report card with input from key agency and community stakeholders.	January, 2003	Report card published and disseminated	Mortality data by race, gender, age geography, BRFSS data by race/gender.	Epi Team, EHD Focus Group, OMHHD staff, funding for printing/postage.
	OMHHD will develop a system for documenting and monitoring progress towards DHHS's "Call to Action".	September, 02 – March 03	Data collection tools developed and disseminated to 14 Divisions/Offices' Report requirements outlined; System in place to collect and analyze data.	Measurable strategies per Division/Office.	OMHHD staff, computer software.
	Revise and publish minority health FACT SHEETS for racial/ethnic minorities including AA, AI, H/L.	February, 2003 – December, 2003	Fact Sheets published and disseminated.	Baseline data on mortality rates by race, gender, age, geography; BRFSS data by race, gender, age.	SCHS, OMHHD staff, Public Affairs.

Office of Education Services

Mission: The Office of Education Services is composed of: The Governor Morehead School for the Blind and Preschool, North Carolina School for the Deaf, Eastern North Carolina School for the Deaf, Eastern, Central and Western Early Intervention Programs for Children who are Deaf or Hard of Hearing and the Central Office. The Office of Education Services focuses on the academic and social needs of students through a variety of instructional programs. The schools provide day and residential academic programs on campus. The early intervention and preschool programs provide itinerant home based services to children and their families. The Outreach and Resource Support programs provide assistance and professional training for educating students in the public schools, their families and the professionals who serve them.
http://www.dhhs.state.nc.us/docs/divinfo/deie.htm

Priority Conditions/Issues: The top five priority conditions for the Office of Education Services includes the: deaf; blind; hard of hearing; low vision; and deaf and blind/multi-disabled.

Service Delivery Challenges: The office cited increasing "parent and community awareness of our preschool and school resources and services", "geography/easy access to services", staff training and development and public school willingness to refer students as their top service delivery challenges.

Socio-cultural Challenges: Social cultural challenges include parental knowledge of child's rights to a "free and appropriate education", access to services because of vision, hearing and language barriers, and cultural attitudinal differences.

OFFICE OF EDUCATION SERVICES – HEALTH DISPARITITES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status.	Use individual school's EEO plan to identify the ratio of minority teachers at the Schools for the Deaf. Use the above information to target HBCUs with Teacher Education Programs and recruit minority teachers.	June 2003	Identification of the EEO plans and strategies	EEO plan List of Historical Black Colleges with Teacher Ed. Programs	Human Resources Dept EEO administrator
2. Communicate, document, and champion best-practices in eliminating health disparities	Identify documented strategies to increase our students' academic performance in the different subgroups	2002	Teacher meetings and discussions about the performances of the students (Meeting notes)	List of Closing the Gap strategies issued by DPI	Curriculum Intervention Specialist
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Work collaboratively with DPI and LEAs to address the specific needs of our minority population (HI/VI) Parent and Community component will be put in the School Improvement Plans	June, 2003	Meeting notes and suggestions Submission of the final School Improvement Plan at each School	"Green Book" that identifies the performance of the subgroups within their school system	Outreach coordinator Curriculum Intervention Specialist School Improvement Teams
4. Monitor progress towards the elimination of health disparities	Use school disaggregated data to identify the academic disparities among the various subgroups within our schools.	July 2003	Timetable	SIMS data CIMS data	SIMS coordinators CIMS coordinator Curriculum Intervention Specialist

OFFICE OF EDUCATION SERVICES – HEALTH DISPARITITES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
5. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups)	Develop a brochure about the OES schools that market our services. Brochures must be translated into Spanish and distributed to LEAs and community organizations. OES personnel must attend in-service on the use of the TTY and use when appropriate	June, 2004 September 2002	Timetable with due dates	List of community organizations	Curriculum Intervention Specialist
7. Build, support and fully utilize a diverse workforce capable of working in cross-cultural settings.	Teachers will attend Diversity and Multiculturalism training. All staff at the schools for the Deaf must be proficient enough in sign language to be able to communicate effectively with students and staff within 2 years of initial employment	Aug, 2003	Staff Development Training schedule for 2002-2003 Continuing Education Credits awarded once completed.	List of state personnel who provide diversity training and multiculturalism	State Diversity trainers Sign language teacher
9. Demonstrate Accountability and Ownership for Health Outcomes	Collect baseline data of student performance based on SIMS data and the State ABC reports.	June 2003	Timetable with due dates	ABC report Disaggregated subgroup test data	SIMS coordinators Curriculum Intervention Specialist

Office of Economic Opportunity

Mission: The Office of Economic Opportunity helps poverty-stricken families to achieve economic independence. There are many rural areas and sections of urban North Carolina where the Community Action Agency funded by OEO may be the only group able and willing to reach out to the poor. Families may receive help in finding a job or housing or any number of services that lead to independence. The office also provides grants to homeless shelters, helping an average of 2,000 homeless individuals and families per day to get shelter, food, health care, and child care as well as psychological and substance abuse counseling. In 1981 the Office was assigned the responsibility of administering the federal Community Services Block Grant Program. Since that time, the Office has assumed the responsibility for administering additional programs: Community Action Partnership Program (CAPP) and Emergency Shelter Grants Program (ESGP) and Weatherization Services. http://www.dhhs.state.nc.us/oeo/

Priority Conditions/Issues: Priority conditions or issues include: age; education; race/ethnicity; and geographical location

Service Delivery Challenges: The office cited federal/state legislation, funding, and coordination of services among agencies as their top service delivery challenges.

Socio-cultural Challenges: The only socio-cultural challenge identified was "beliefs that health care is not important as some other needs and not making regular appointments".

Disparity Focus Areas: The key focus areas for the Office are income and education based on federal mandate, office mission, and allowable activity criteria. With reference to available resources, the Office observed, "if health is identified as a priority problem, funds may be proposed to eliminate the disparity based on potential of providing the service, available resources, benefits to the target population, and the extent to which the proposed assistance will impact the economics of the family".

OFFICE OF ECONOMIC OPPORTUNITY – HEALTH DISPARITIES IMPLEMENTATION PLAN					
KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUTION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status.	Distribute disparities fact sheets to network of grantees	As provided by Task Force	Fact Sheets distributed	Fact Sheets	Health Disparities Staff OEO Field Staff
2. Communicate, document, and champion best-practices in eliminating health disparities	Promote the utilization of health selected strategies to grantees	As provided by Task Force	As strategies are provided	Strategies	Health Disparities Staff OEO Field Staff
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Encourage coordination/partnerships of grantees with local health partners	ongoing			Health Disparities Staff OEO Field Staff
4. Monitor progress towards the elimination of health disparities	Encourage the use of any state developed data to advocate gathering more health related data on intake forms	ongoing			OEO Staff
5. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups)	Increase emphasis on the collection of health related data among grantees	April,2003			OEO Field Staff
6. Increase resources/ investments to eliminate health status gaps	Utilize health related needs assessment information in project development of goals, objectives and activities	April, 2003			OEO Staff

OFFICE OF ECONOMIC OPPORTUNITY – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
7. Build, support, and fully utilize a diverse workforce capable of working in cross- cultural settings.	Encourage grantees to develop more health related projects	ongoing			OEO Staff
8. Identify and advocate for public policies that aid in closing the health status gap.	Evaluate agency discrimination policies related to disabilities	ongoing			
9. Demonstrate Accountability and Ownership for Health Outcomes	Promote utilization of health related measurements of success for performance reporting in health related projects	Ongoing			Health Disparities Staff OEO Staff

Office of Research, Demonstrations, and Rural Health Development

Mission: The Office of Research, Demonstrations, and Rural Health Development performs a number of functions to strengthen primary care development in medically underserved areas of the state. Its chief mission is to provide technical assistance to primary care centers in rural and underserved communities. The office was founded in 1973 and is responsible for provider recruitment, technical assistance to small rural hospitals, and technical, and grant assistance to community health care centers. The office encompasses broad-based programs that promote research into health access issues, support demonstration projects to improve access, and strengthen rural health services in North Carolina. http://www.dhhs.state.nc.us/docs/divinfo/orhrd.htm

The Office of Research, Demonstrations, and Rural Health Development performs a number of functions to strengthen primary care development in medically underserved areas of the state. Its chief mission is to provide technical assistance to primary care centers in rural and underserved communities. The office was founded in 1973 and is responsible for provider recruitment, technical assistance to small rural hospitals, and technical, and grant assistance to community health care centers. The office encompasses broad-based programs that promote research into health access issues, support demonstration projects to improve access, and strengthen rural health services in North Carolina.

Priority Conditions/Issues: According to their response, the Office of Research, Demonstrations, and Rural Health Development does not focus on any particular disease area. However, current ACCESS II and III programs target congestive heart disease, asthma, and diabetes. The Office also focuses on farm worker health.

Service Delivery Challenges: For the Office, retention of providers in rural settings and getting health care agencies and providers to collaborate are the top service delivery challenges faced by the Office.

Socio-cultural Challenges: The top socio-cultural challenges identified relate to the three service delivery challenges. The Office cited establishing trust among providers and between providers and patients, isolation and distance of populations served and the lack of resources as the top socio-cultural challenges.

Disparity Focus Areas: The focus areas for the office include race/ethnicity, income, education, and geographical location. The criteria used in selecting these focus areas include: recognition of the needs of Latinos in NC due to the fact that over 90% of the target population for the Farm workers Health Program is of Latin American origin. In addition, income is a focus area because classifications of underserved populations are based on economic indicators such as percent living in poverty.

OFFICE OF RESEARCH, DEMONSTRATIONS, AND RURAL HEALTH DEVELOPMENT
HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability, and socioeconomic status.	Develop a health "report card" including information on disparities for all funded center service areas to be presented to health center boards and staffs on an annual basis. Conduct a Spanish language capability assessment for services.	-By August 2003 -By June 30, 2003	-Report cards completed -Survey complete	Medicaid, Health Dept. community assessments, State Center, Sheps Center Center Budgets submitted	-ORDRHD Staff -NCPHCA, ORDRHD
2. Communicate, document, and champion best-practices in eliminating health disparities.	Encourage Centers to participate in chronic disease quality improvement initiatives, especially through ACCESS II and III, to obtain best medical practices for managing diseases that disproportionately affect minority and low income populations.	-All centers aware of initiatives by 12/31/03	-Operations team report	ACCESS II and III information	-ORDRHD Staff
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Engage community governing board participation in discussion on disparities using health report cards. Encourage Centers to offer cultural competency training.	-By December 2003	-Discussions held at centers	Board meeting minutes	-ORDRHD Staff
4. Monitor progress towards the elimination of health disparities	Monitor use of Medical Access Plan (MAP) funding for health centers. MAP ensures that grants from this office are used for medical care discounts given by centers to low income, uninsured patients.	-Ongoing	-Monthly Reports	Monthly Reports	-ORDRHD Staff

OFFICE OF RESEARCH, DEMONSTRATIONS, AND RURAL HEALTH DEVELOPMENT HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
5. Promote customer friendly services that meet the needs of under served populations (i.e., low-income and minority groups)	Promote diversity in hiring at funded centers so that staff reflects diverse population.	-By June 30, 2003	-Staffing will more closely reflect the demographics of the service population.	Population and staff demographics	-ORDRHD Staff
6. Increase resources/ investments to eliminate health status gaps	Increase percentage of operational funding that supports MAP (funding for indigent care).	-By June 30, 2003	-Monthly Reports and Annual Operational Budgets	Monthly Reports	-ORDRHD Rural Health Center Grant Funding
7. Build, support, and fully utilize a diverse workforce capable of working in cross-cultural settings.	Through our Medical Placement Services, increase the cross-cultural and bilingual candidate pool for medical and dental providers.	-By June 30, 2003	-Examination of the candidate pool	Practice Sites Software	-Medical Placement Services Incentive Funding
8. Identify and advocate for public policies that aid in closing the health status gap.	Participate in the development of a Statewide Strategic Plan in conjunction with the NC Primary Health Care Association.	-By June 30, 2003	-Meetings held	Meeting Agendas	-NCPHCA and ORDRHD staff
9. Demonstrate Accountability and Ownership for Health Outcomes	Generate discussion among boards and staffs around disparity issues identified in their health report card.	-By December 2003	-Discussions held at centers	Board meeting minutes	-ORDRHD staff

Division of Environmental Health

Mission: To safeguard life, promote human health, and protect the environment through the practice of modern environmental health science, the use of technology, rules, public education, and above all, dedication to the public trust.

Priority Conditions/Issues: The top priority conditions or issues for the Division of Environmental Health were: food and waterborne diseases; vector borne diseases; child lead; and cancer (from environmental causes).

Service Delivery Challenges: The division also identified language barriers, resistance to regulations, beliefs (i.e. beliefs that one should be able to do as they please with their land) and limited understanding of sanitation as their main service delivery challenges.

Socio-cultural Challenges: The Division of Environmental Health did not report any socio-cultural challenges.

Disparity Focus Areas: The top priority focus areas include income, age, and geographical location.

Department of Public Instruction

Sections/Programs: the *School Health Programs to Prevent Serious Health Problems and Improve Education Outcomes* completed the disparity assessment survey for the Department of Public Instruction.

Priority Conditions/Issues: The top priority conditions or issues for the program include: high student performance; safe orderly and caring schools; quality teachers, administrators, and staff; strong family, community and business support; and effective and efficient operation.

Service Delivery Challenges: The program identified several service delivery challenges but no socio-cultural challenges. The top service delivery challenges include: lack of regular physical activity among youth; encourage healthy eating; prevent/reduce teen tobacco access and use; coordinating health services in schools; and creating an infrastructure to support school-based health initiatives.

Socio-cultural Challenges: The School Health Program reported no socio-cultural challenges.

Disparity Focus Areas: The main disparity focus areas include education and race/ethnicity, specifically, addressing the achievement gap between students of color and White students.

External Reviewers

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