Division of Public Health
Agreement Addendum
FY 25-26

MASTER **Local Health Department Legal Name**	Chronic Disease and Injury Section **DPH Section / Branch Name**
886 Healthy Communities **Activity Number and Description**	Karen Stanley, 919-707-5230 karen.klein.stanley@dhhs.nc.gov **DPH Program Contact** (name, phone number, and email)
06/01/2025 – 05/31/2026 **Service Period**	**DPH Program Signature** **Date** (only required for a negotiable Agreement Addendum)
07/01/2025 – 06/30/2026 **Payment Period**	

☒ Original Agreement Addendum
☐ Agreement Addendum Revision # ___

I. <u>Background</u>:

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

In 2021, heart disease was the leading cause of death in North Carolina, and cancer was the second leading cause, resulting in 21,299 deaths and 20,225 deaths, respectively.[1] Among North Carolina residents, there were a total of 1,459 suicides (13.8 per 100,000 residents) in 2021.[2] There were a total of 4,339 drug overdose deaths among North Carolina residents (a rate of 41.4 per 100,000 residents) in 2022.[3]

In 2022, 12.1% of North Carolina's adult population had diabetes.[4] Obesity and smoking continue to be concerns as well. In 2022, 69.3% of adult North Carolinians were either overweight or obese, and the smoking rate for North Carolina adults was 14.5%.[5]

[1] NC State Center for Health Statistics. NC Vital Statistics 2021, Leading Causes of Death by Age Group, Volume 2, December 2023. Retrieved from https://schs.dph.ncdhhs.gov/data/vital/lcd/2021/docs/2021-TableA-LCDbyAge.pdf

[2] NC State Center for Health Statistics. NC Vital Statistics 2021, Leading Causes of Death, Volume 2, December 2023. Retrieved from https://schs.dph.ncdhhs.gov/data/vital/lcd/2021/docs/suicide-v2.pdf

[3] NC Opioid and Substance Use Action Plan Data Dashboard – 2022 Metrics https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard

[4] NC State Center for Health Statistics. 2022 BRFSS Survey Results: NC, Chronic Health Conditions, Diabetes. Retrieved from https://schs.dph.ncdhhs.gov/data/brfss/2022/nc/nccr/DIABETE4.html

[5] NC State Center for Health Statistics. 2022 BRFSS Survey Results: NC, Derived Variables and Risk Factors, Body Mass Index Grouping. Retrieved from https://schs.dph.ncdhhs.gov/data/brfss/2022/nc/all/rf1.html

Health Director Signature (use blue ink or verifiable digital signature) _____ Date _____

LHD to complete:
[For DPH to contact in case follow-up information is needed.]
LHD program contact name: _____
Phone and email address: _____

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

Heart disease, cancer, and diabetes are chronic health conditions that are often caused or exacerbated by social and environmental factors, which lead to poorer health outcomes and behaviors. Referred to as social determinants of health (SDOH), these are the nonmedical factors that influence health outcomes. Research shows that health-related behaviors, socioeconomic factors, and environmental factors contribute to about 80% to 90% of modifiable health factors.[6] Prominent SDOH include housing, food, and financial insecurity. Overall, one in seven people, including one in five children, in North Carolina face hunger[7] and approximately 12.8% of North Carolina's population lives in poverty[8] with about 40% of North Carolina's children that live in poor or low-income households.[9]

Another of the SDOH, social isolation and loneliness experienced by individuals also contribute to chronic diseases. According to the Centers for Disease Control and Prevention, these conditions or experiences are widespread in the U.S., posing a serious threat to mental and physical health. About one in three adults in the U.S. reports feeling lonely and one in four U.S. adults report not having social or emotional support. Loneliness and social isolation may be shaped by conditions in the environments where people are born, live, work, learn, worship, and play. Social isolation and loneliness can increase a person's risk for heart disease and stroke, type 2 diabetes, depression and anxiety, suicidality and self-harm, dementia and earlier death.[10]

Racial disparities in chronic disease and injury prevalence and mortality persist as well. Non-Hispanic African Americans have higher rates than non-Hispanic whites for most chronic diseases. Heart disease death rates and total cancer death rates for African Americans were 14% higher and 18% higher than the death rates for the white population respectively, and stroke death rates were 37% higher for African Americans. Death rates due to diabetes were 2.2 times higher for African Americans compared with the death rate for whites.[11]

The North Carolina Division of Public Health (DPH) uses Preventive Health and Health Services (PHHS) Block Grant funding to administer the Healthy Communities Program through the Chronic Disease and Injury (CDI) Section. The aim of this program is to reduce the burden of chronic disease and injury in North Carolina. Research shows that implementing policy and systems changes can result in positive behavior changes that decrease chronic diseases and injuries and improve health. Examples of such strategies include providing access to healthy foods[12], providing options for physical activity, providing opportunities for social connectedness, promoting tobacco-free facilities, and providing evidence-based interventions for injury and violence prevention in communities.

II. Purpose:

This Activity enables county and district health departments to implement community-based interventions that address poor nutrition, physical inactivity, social isolation, tobacco use, violence, and unintentional injury. Interventions should strive to provide opportunities for everyone in North Carolina to achieve their optimal level of health, regardless of race, ethnicity, gender, socioeconomic status, geographic location, education status, disability status or sexual orientation.

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[6] Adler, Kenneth G., MD, MMM, Screening for Social Determinants of Health: An Opportunity of Unreasonable Burden https://www.aafp.org/pubs/fpm/issues/2018/0500/p3.html#:~:text=The%20other%2080%20percent%20to,think%20of%20as%20medical%20care

[7] Feeding America – North Carolina: https://www.feedingamerica.org/hunger-in-america/north-carolina

[8] NC Quickfacts, U.S. Census Bureau, 2023. https://www.census.gov/quickfacts/fact/table/NC/PST045223

[9] North Carolina Child Health Report Card, 2023. https://ncchild.org/wp-content/uploads/2023/03/2023-NCreportcard-updated7.30.23.pdf

[10] The Centers for Disease Control and Prevention. https://www.cdc.gov/social-connectedness/risk-factors/index.html

[11] NC State Center for Health Statistics. North Carolina Resident Population Health Data by Race and Ethnicity, 2017-2021. Retrieved from https://schs.dph.ncdhhs.gov/schs/pdf/NCPopHealthDatabyRaceEth2022-FINAL.pdf

[12] U.S. Department of Agriculture and U.S. Department of Health and Human Services. *Dietary Guidelines for Americans, 2020-2025*. 9th Edition. December 2020. Available at DietaryGuidelines.gov

III. Scope of Work and Deliverables:

The Local Health Department (LHD) shall:

1. **Designate one qualified staff member** to oversee all duties outlined in this Agreement Addendum. The local health director or designee is responsible for notifying the Healthy Communities Program Consultant within 30 days when this position is vacated (including if the staff is on extended leave) and filled (including temporary designations due to extended leave). This staff member will coordinate with other local program staff funded through the Chronic Disease and Injury Section to ensure alignment of efforts.

2. Offer **at least one training opportunity** for LHD staff to learn about health equity and social determinants of health.

3. Implement **at least one internal organizational policy/practice/system change** that supports advancing health and/or racial equity.

4. Implement **at least one of the following policy, environmental and/or program supports** that addresses chronic disease and injury prevention from the 2025-2026 Community Action Plan:

   a. Increase the number of **organizations** that adopt new policy/practice changes that support suicide prevention. Address at least one of the following sub-strategies:

      1. Provide annual suicide prevention community helper training. Acceptable community helper trainings include the following: Applied Suicide Intervention Skills (ASIST); LivingWorks Start; LivingWorks safeTALK; LivingWorks Faith; Question, Persuade, and Refer (QPR); Counseling for Access to Lethal Means (CALM) or Mental Health First Aid training programs.
      2. Form a new firearm safety team within the county that addresses public health strategies that include suicide prevention.
      3. Adopt new protocols for staff response to those at risk of suicide.

   b. Increase the number of facilities that are newly designated as breastfeeding friendly.

   c. Increase the number of new community venues and small retail venues providing access to healthy foods and/or increase the number of existing community venues and small retail venues providing enhanced access to healthy foods in socially vulnerable areas according to the CDC/ATSDR Social Vulnerability Index.[13] Community venues for this Agreement Addendum also include small food stores. Healthy foods are defined by the USDA as nutrient dense foods across and within all food groups, as mentioned in the USDA's Dietary Guidelines for Americans 2020-2025.[14]

   d. Collaborate with community partners to increase physical activity opportunities in historically marginalized communities by transforming public spaces to strengthen connection between people and places (i.e., placemaking) and creating/improving routes (e.g., trails, sidewalks, bike lanes) that connect to these places.

   e. Establish new policies and/or practices in communities that support social connectedness. Address at least one of the following sub-strategies:

      1. Develop a community plan in collaboration with cross sectoral partners that supports social connectedness and identifies opportunities and gaps for solutions to reduce loneliness and isolation.

[13] CDC/ATSDR Social Vulnerability Index Interactive Map: https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html

[14] U.S. Department of Agriculture and U.S. Department of Health and Human Services. *Dietary Guidelines for Americans, 2020-2025*. 9th Edition. December 2020. Available at DietaryGuidelines.gov.

Commented [KS1]: Removed the following strategy for FY26: Support collaborative strategic planning to address substance use, overdose, and related issues and ensure that diverse partners, including people with lived experience, are engaged in the process.

Our team removed this strategy because there are other strategies on the strategy menu that need support and have little funding support and opioid strategies are well supported under the Opioid Settlement.

Commented [KS2]: Expanded sub-strategy options (Items 2 and 3) that LHDs can choose to address for suicide prevention.

Commented [KS3]: This is an innovative strategy that is new in FY26 and we plan to keep it on the menu for at least three years.

References:
The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community
https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

The U.S. Surgeon General's Advisory on Social Media and Youth Mental Health
https://www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-advisory.pdf

2. Increase the number of community organizations that newly offer group exercise programs for Seniors. Acceptable exercise programs include the following: **Tai Chi for Arthritis**; **Walk with Ease** group program; **AEA Arthritis Foundation Group Exercise** Programs (land-based or aquatic program); **EnhanceFitness** group program; **Bingocize**, or other evidence-based physical activity group program for seniors approved by the Healthy Communities Program Consultant.
3. Increase the number of schools that establish policies to prevent non-academic use of phones during school hours. This includes communications around the importance of tech free zones that encourage youth to foster in-person friendships.

f. Eliminate exposure to secondhand smoke by increasing the number of evidence-based, 100% smoke-free or tobacco-free local policies, regulations, and/or ordinances in one or more of the following:
   1. Government buildings, grounds, parks and recreation, and enclosed public places through ordinances or Board of Health rules.
   2. Colleges and universities.
      (Note: State law allows local community colleges to prohibit the use of all tobacco products on their campuses. State law allows the UNC System universities to prohibit smoking only within 100 linear feet of the campus buildings. Private and independent colleges and universities can prohibit the use of all tobacco products on their campuses.)
   3. Behavioral health properties, including buildings, grounds, and vehicles.
      (Note: Reference https://medicaid.ncdhhs.gov/blog/2024/03/21/tobacco-related-policy-requirements-go-effect-july-1-2024 plan-tobacco-free-policy-requirement and updates hereafter.)
   4. Multi-unit housing properties with a minimum coverage of all indoor spaces and balconies, and porches.

g. Increase the number of providers and/or clinics that sign up to be QuitlineNC referral sites.[15]

h. Implement community and/or school policies and/or programs that support prevention and cessation of tobacco use by youth.

IV. Performance Measures / Reporting Requirements:

1. Staff contact information is submitted to the Healthy Communities Program Consultant by June 15, 2025, and updated as changes occur.

2. Evidence of offering at least one training opportunity for LHD staff to learn about health equity and social determinants of health.

3. Evidence of implementation of at least one internal organizational policy/practice change that supports advancing health and/or racial equity.

4. Evidence of implementation of **at least one** policy, environmental, and/or program support that addresses chronic disease and injury prevention. Performance Indicators: Information for all strategies selected by the Local Health Department, from among the strategy options listed in Section III.4:

   a. Number of organizations that adopt new policies and/or practices in support of suicide prevention by addressing at least one of the sub-strategies listed in Section III., Paragraph 4.a.

[15] https://quitlinenc.dph.ncdhhs.gov/health-professionals/become-a-referral-site.html

b. Number of facilities newly designated as breastfeeding friendly.

c. Number of new community and small retail venues providing access to healthy foods and/or the number of existing community and small retail venues providing enhanced access to healthy foods in socially vulnerable areas, as indicated in Section III., Paragraph 4.c.

d. Number of public spaces transformed in historically marginalized communities to strengthen connection between people and places (i.e., placemaking) and number of routes created or improved (e.g., trails, sidewalks, bike lanes) that connect to these places.

e. Number of new policies and/or practices in communities that support social connectedness by addressing at least one of the sub-strategies listed in Section III., Paragraph 4.e.

f. Number of new 100% smoke-free, smoke-free/e-cigarette-free, or tobacco-free policies covering the locations listed in Section III., Paragraph 4.f.

g. Number of providers and/or clinics that sign up to be QuitlineNC referral sites.

h. Number of community and/or school policies and/or programs that support prevention and cessation of tobacco use by youth.

5. Evidence that progress on the 2025-26 Healthy Communities Action Plan activities is reported by required deadlines.

   a. **Quarterly Progress Reports** about the implementation of the 2025-26 Community Action Plan are submitted to the Healthy Communities Program Consultant by these due dates: September 10, December 10, March 10, and June 30. (If these dates fall on a weekend, the reports are due the following Monday.)

   b. Submission of at least one success story included in the quarterly progress report due on June 30, 2026.

6. Evidence that the 2026-27 Community Action Plan and Budget are submitted by required due dates and address health equity.

   a. Draft State Fiscal Year 2026-27 Community Action Plan and Budget are submitted by March 16, 2026.

   b. Revisions to the 2026-27 Community Action Plan and Budget are made based on technical assistance provided by the Healthy Communities Program Consultant.

   c. Final 2026-27 Community Action Plan identifies priority populations based on demographic factors (e.g., race or ethnicity, socioeconomic status) or geography.

   d. Final 2026-27 Community Action Plan describes how priority populations and/or organizations representing these populations are engaged in planning, implementing, and/or evaluating the chosen strategy or strategies.

   e. Final 2026-27 Community Action Plan and Budget are submitted by May 16, 2026.

   f. Final 2026-27 Community Action Plan includes training opportunities for LHD staff to learn about health equity and/or social determinants of health.

7. **Reporting Required Subcontract Information**
   In accordance with revised NCDHHS guidelines effective October 1, 2024, the LHD must provide the information listed below for <u>every subcontract</u> receiving funding from the LHD to carry out any or all of this Agreement Addendum's work.

This information is not to be returned with the signed Agreement Addendum (AA) but is to be provided to DPH when the entities are known by the LHD.

a. Subcontracts are contracts or agreements issued by the LHD to a vendor ("Subcontractor") or a pass-through entity ("Subrecipient").
    1. Subcontractors are vendors hired by the LHD via a contract to provide a good or service required by the LHD to perform or accomplish specific work outlined in the executed AA. For example, if the LHD needed to build a data system to satisfy an AA's reporting requirements, the vendor hired by the LHD to build the data system would be a Subcontractor. (However, not all Vendors are considered Subcontractors. Entities performing general administrative services for the LHD (e.g., certified professional accountants) are not considered Subcontractors.
    2. Subrecipients of the LHD are those that receive DPH pass-through funding from the LHD via a contract or agreement for them to carry out all or a portion of the programmatic responsibilities outlined in the executed AA. (Subrecipients are also referred to as Subgrantees in NCAC.)

The following information must be provided to the DPH Program Contact listed on Page 1 of this AA for review prior to the entity being awarded a contract or agreement from the LHD:

- Organization or Individual's Name (if an individual, include the person's title)
- EIN or Tax ID
- Street Address or PO Box
- City, State and ZIP Code
- Contact Name
- Contact Email
- Contact Telephone
- Fiscal Year End Date (of the entity)
- State whether the entity is functioning as a pass-through entity Subcontractor or Subrecipient of the LHD.

V. Performance Monitoring and Quality Assurance:

1. The Chronic Disease and Injury Section's Healthy Communities Program Consultant will monitor the LHD's Healthy Communities Program through review of the quarterly progress reports, monthly Aid-to-Counties expenditure reports, and by conducting conference calls with the LHD. The Healthy Communities Program Consultant will conduct a required subrecipient monitoring site visit with the LHD at least once every three years to assess programmatic and fiscal risk which involves a detailed review of programmatic activities relative to the community action plan and related expenditures.

2. If deficiencies in programmatic or fiscal performance are identified, DPH shall notify the LHD immediately via email or telephone and if needed, it will be communicated that a corrective action plan is required. Failure to comply with the requirements in the resulting corrective action plan may result in a decrease in funding or removal from consideration for future funding.

VI. Funding Guidelines or Restrictions:

1. **Federal Funding Requirements**: where federal grant dollars received by the Division of Public Health (DPH) are passed through to the Local Health Department (LHD) for all or any part of this Agreement Addendum (AA).

    a. Requirements for Pass-through Entities: In compliance with 2 CFR §200.331 – *Requirements for pass-through entities*, DPH provides Federal Award Reporting Supplements (FASs) to the LHD receiving federally funded AAs.

1. Definition: A FAS discloses the required elements of a single federal award. FASs address elements of federal funding sources only; state funding elements will not be included in the FAS. An AA funded by more than one federal award will receive a disclosure FAS for each federal award.
2. Frequency: An FAS will be generated as DPH receives information for federal grants. FASs will be issued to the LHD throughout the state fiscal year. For a federally funded AA, an FAS will accompany the original AA. If an AA is revised and if the revision affects federal funds, the AA Revision will include an FAS. FASs can also be sent to the LHD even if no change is needed to an AA. In those instances, the FAS will be sent to provide newly received federal grant information for funds already allocated in the existing AA.

b. Required Reporting Certifications: Per the revised Uniform Guidance, 2 CFR 200, if awarded federal pass-through funds, the LHD as well as all subrecipients of the LHD must certify the following whenever 1) applying for funds, 2) requesting payment, and 3) submitting financial reports:

> "I certify to the best of my knowledge and belief that the information provided herein is true, complete, and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2, 1001, 1343 and Title 31, Sections 3729-3730 and 3801-3812."

2. The LHD may **not** use the funds associated with this Agreement Addendum for any of the following (as stated in CDC's Guidance document for the Preventive Health and Health Services Block Grant – 2024 CDC-RFA-PW-24-2400):

   a. Purchase of Naloxone, syringes, drug disposal programs (drop-boxes, bags, or other devices, and/or take-back events), clinical care, incentives, or construction.

   b. Preparation, distribution, or use of any publicity-type or propaganda-type material, or to pay the salary or expenses of grant recipients, contract recipients, or agents that aim to support or defeat the enactment of legislation, regulation, administrative action, or executive order proposed or pending before a legislative body, beyond normal, recognized executive relationships.

3. Individual expenditures, except for salary and fringe, of more than $500 must receive prior approval by the Healthy Communities Program Consultant.