



Communities *in Action*

A Newsletter for Healthy Carolinians Partnerships

www.schs.state.nc.us/SCHS

www.healthycarolinians.org

No. 1

April 1999

In This Issue

Page 1 *Evaluation Brief: An Overview of Issues and Terminology*

Page 1 *Using Data to Evaluate Task Force Accomplishments*

Page 5 *Highlights from Local Healthy Carolinians Task Forces*

Page 7 *A Message from the Director, Office of Healthy Carolinians*

Page 7 *Update/Notes*

WANTED: Guest Writers

We ask our readers to submit articles on community health improvement activities to:

Newsletter
Office of Healthy Carolinians
P.O. Box 29605
Raleigh, NC 27626

or e-mail:
fiorella_horna-
guerra@mail.ehnr.state.nc.us

Evaluation Brief: An Overview of Issues and Terminology

This is the first in a series of five articles about evaluation. The remaining four articles will be published in future issues of *Communities in Action*.

The need for evaluation

Evaluation is often mentioned as a priority among Healthy Carolinian task forces. In the broadest sense, evaluation can help inform decisions regarding continuation and improvement of health promotion efforts. Specifically, task forces have identified some of the following benefits of conducting evaluation: measuring progress, re-directing task force efforts when necessary, demonstrating successes to funding agencies, determining task force strengths and weaknesses, increasing visibility of the task force, influencing policy makers, and guiding the long term planning process. This article will describe a continuum of evaluation activities and will discuss some key issues relative to evaluation. It is worth distinguishing between evaluating a task force's efforts as a whole versus assessing the results of an individual program of the task force. The discussion presented here will focus on the former – determining the "health" of the coalition itself and its collective influence on the community. Although the concepts presented here are relevant to program evaluation, detailed information on assessing programs can be found in the reference provided at the end of this article.

(see *Evaluation Brief*, page two)

Using Data to Evaluate Task Force Accomplishments

The primary goal of a Healthy Carolinians task force is to improve the health and well-being of community residents. To this end, each of these local groups conducts a community health assessment and develops objectives and strategies to address local needs. But how do task forces know if they are making progress in solving their community's health problems? How do they identify those intervention programs that are working and those that need improvement? How do they determine whether there have been changes in the community or in targeted health risk behaviors that are the result of task force efforts?

(see *Using Data*, page three)

Communities in Action is a periodic publication of the North Carolina Community Health Assessment Initiative, within the State Center for Health Statistics and the Office of Healthy Carolinians.

Evaluation Brief (continued from page 1)

Evaluation should be part of the planning process

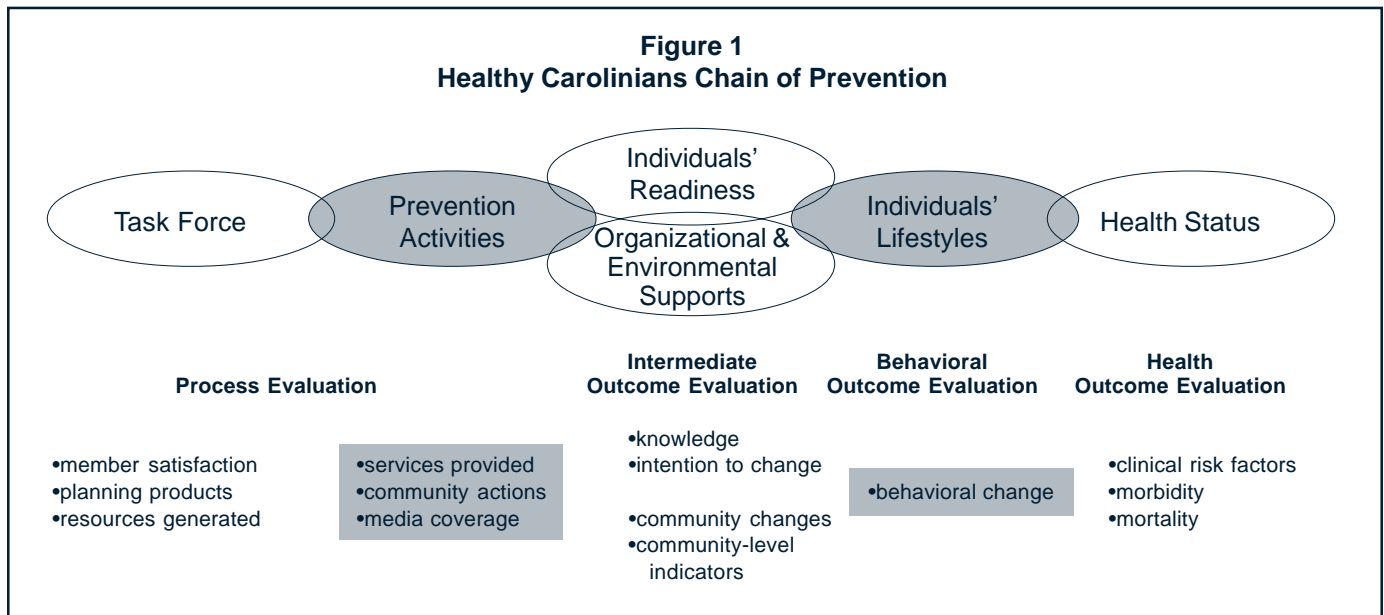
Despite the commonly expressed need to evaluate community prevention efforts, it is rare to see a strong commitment to evaluation during the planning stages. A focus on evaluation often comes at the end of an initiative, when staff or task force members are asked to report on the results of their prevention efforts. The evaluation process ideally begins as the planning process begins. When task force leaders sit down to specify objectives, consideration should be given to measurement of those objectives and systematic ways to document and reflect on task force processes. In other words, how will task force members know when their efforts have succeeded (outcome evaluation); also, how will members determine if the task force itself is healthy, if the activities are appropriate, and if the right people are being reached (process evaluation)? The Healthy Carolinians certification process obliges task force members to consider indicators of success as they set goals and objectives.

An evaluation continuum: more than just process and outcome

Evaluation terminology can be a source of confusion and anxiety for many people. In fact, textbooks and evaluation guides often provide different definitions for

terms commonly used in evaluation. For example, the same measure of behavioral status may be defined as an “outcome indicator” in one source and an “impact indicator” in another.

Think of evaluation as a method of reflecting on some process designed to create change. It is necessary to clearly articulate the objectives of a task force, i.e. what changes are intended and what processes must occur in order to accomplish those changes in a community? The process of creating change is a sequence of activities and results, or links in a chain, that will ideally lead to improved health and quality of life in communities. (See Figure 1) Evaluation is a continuum of methods that examines those links; it can range from monitoring the resources necessary for creating changes to measuring improvement in health status. Some links in the chain of creating a healthier community are likely to show improvement only after many years, particularly for chronic diseases. In general, the further away a link is from the task force, the more difficult it becomes to detect a change. Similarly, attributing changes in lifestyle behaviors and community health status to task force efforts can be difficult (or impossible) in many instances. A series of articles in the next several newsletters will describe the methods task force leaders can use to assess the different links in the “chain of prevention” in their community.



For further reading on evaluation:

Evaluating Community Efforts to Prevent Cardiovascular Diseases
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention
and Health Promotion, 1995
Fawcett, Sterling, Paine-Andrews, Harris, Francisco,
Richter, Lewis, and Schmid

To order a copy, write to:

Evaluating Community Efforts to Prevent
Cardiovascular Diseases
Technical Information Services Branch
National Center for Chronic Disease Prevention
and Health Promotion
Centers for Disease Control and Prevention
Mail Stop K-13, 4770 Buford Highway, N.E.
Atlanta, GA 30341-3724



Using Data *(continued from page 1)*

Clearly, these are very important questions for every task force. Data can help answer these questions. Because the collection, analysis, and interpretation of data is the groundwork for evaluating the success of task forces, it is important to understand the different types and sources of data, as well as how this information can be used in the evaluation process.

Types of Data: Quantitative vs. Qualitative Data

In general, there are two types of data: quantitative data and qualitative data.

- ✓ Quantitative data are based on numbers and often are called “statistics.” Counts of events (such as the number of cancer deaths) and rates (such as the infant mortality rate) are examples of quantitative data. Such data usually are calculated for a defined geographic region (e.g., a county or a state) and time period (e.g., one year or five years). Interview and survey data that are based on a structured format (e.g., when the participants’ responses are sorted into categories such as “yes” and “no”) also are considered quantitative data.
- ✓ Qualitative data is non-numerical information. This type of data is based mainly on the perceptions of participants and often is presented in narrative form. Examples of qualitative data include findings from focus groups, results from open-ended interview questions, and descriptions of a program or service based on participant observation.

It is important to realize that the very same method of data collection may be classified as either quantitative or qualitative, depending on the way that the information is gathered. For example, interviews are considered a quantitative method if each question is followed by response categories, but they are considered a qualitative method if they are made up of open-ended queries.

Combining Qualitative and Quantitative Methods

In general, using both qualitative and quantitative techniques will result in a more in-depth and reliable evaluation than using only one approach. When using both quantitative and qualitative methods, the data from each method should be analyzed separately and used to cross-validate the findings. If both the quantitative and the qualitative data suggest the same conclusion, then the results are strengthened. If they do not, then it is important to consider why the findings differ and this may indicate issues in need of further study. However, the best choice of methods ultimately depends on a variety of factors including the type of issues being addressed, the scope of the evaluation, the resources available for data collection, the expertise of those

conducting the evaluation, how frequent progress is to be measured, the requirements of funding agencies, and what community members and task force leaders want to know. In general, it is recommended to match the evaluation methods to the needs and expertise of your community.

To illustrate how qualitative information can complement quantitative data, consider a recent community study done by Forsyth county. In this investigation, they combined Census data, health statistics, and data from a telephone survey (quantitative data) with findings from a series of focus groups (qualitative data) to study certain health issues more in depth. For example, they combined survey results with focus group data to examine access to health care issues. The survey indicated that some population subgroups, such as young adults ages 18-34, African-Americans, and low income residents, have a high percentage of persons who do not have health insurance. However, the focus group data revealed that, above and beyond the problems with uninsurance among population subgroups, many people in the county are underinsured. For example, many residents who have health insurance also have high deductibles or have policies that will not cover needed health care services.

Sources of Data: Primary vs. Secondary Data

Data sources are classified into two main types, primary and secondary data. Both types of data (i.e., quantitative and qualitative) can be obtained from either primary or secondary sources.

- ✓ Primary data is information that is collected first-hand by those conducting the evaluation. This type of data would include original information gathered through surveys, focus groups, interviews, observations, and experiments.
- ✓ Secondary data is information that already has been collected by someone else. Often secondary data already have been analyzed and disseminated and can be used without any additional calculations. An example of this would be to look up data in one of the State Center for Health Statistics’ publications to track objectives. Sometimes secondary data are available with some analysis already completed, but one may need to perform additional calculations. For example, death certificate data can be combined with population estimates to calculate death rates. Also, some secondary data may be available only in an un-analyzed form and must be analyzed by those conducting the evaluation.

A Note on Secondary Data

Documenting success based exclusively on secondary data, such as morbidity and mortality rates, can be difficult because this kind of data often takes many

years or even decades to change. For example, it would be unreasonable to expect a county's cardiovascular disease death rate to drop in the year following the implementation of an intervention program since many other factors affect cardiovascular disease. Because secondary data often are not sensitive markers of change, it is a good idea not to rely solely on such information to evaluate the success of your task force's initiatives. Rather, it is recommended that your task force collect and analyze some primary data to assess the impact of interventions. Primary data usually are much more sensitive to change in a shorter period of time than are most types of secondary data and, as such, can serve as early indicators of the long-term impact of your Healthy Carolinians task force in your community.

Setting Objectives and Baseline Data

As part of the certification and recertification process, task forces are required to set objectives that are based on a community assessment. Basically, these objectives are statements of what your task force wants to accomplish. In setting these objectives, your task force must define those data that will be used to evaluate the strategies that are planned to accomplish each of the objectives. As your task force decides on these objectives, one thing to keep in mind is that the objectives must be measurable. If data are not available to track your objectives, then your task force will not be able to adequately evaluate its success.

In addition to defining objectives that can be measured, it is also a good idea to collect and report baseline data for each objective as part of the process of setting your target. Consider the following example: your task force plans to set an objective to increase the number of fitness trail miles per population in your county. To decide exactly where to set the goal, your coalition should begin by collecting baseline data to document the present number of trail miles. It is a good idea to collect baseline data for two reasons. First, baseline data give you an idea as to how high or how low you should set your goal. That is, knowing your current number of fitness trail miles per population

would allow you to set a quantitative goal such as, "By the end of the year 2003, increase fitness trail miles in the county to 1 per 1,000 population."

The second good reason to collect baseline data is that they can serve as a yardstick from which to measure progress at various time periods until your goal is reached. For example, say your county sets a goal to increase the acres of park and recreation open space by 25% by 2003. If your task force waited until 2003 to collect any data on the number of acres of park and recreation space, it would be very difficult to know by how many acres these areas had increased or decreased since the start of your initiative.

The Link Between Assessment and Evaluation

Evaluation is really part of a larger cycle that also involves the collection and analysis of data, the prioritization of needs, and the development and implementation of plans. This link between assessment, planning, action, and evaluation is critical, but often is overlooked. Without follow through from assessment to evaluation, the findings of an evaluation study will be greatly limited. This is because assessment data provides important baseline information that serves as a starting point against which to measure the task forces' accomplishments. In addition, tracking objectives during the implementation stage can help identify that which is working well and that which needs to be refined, and as a result, can greatly improve the effectiveness of your intervention programs.

Practicing Safe Statistics

Conducting an evaluation carries some responsibilities in terms of properly collecting and analyzing data as well as drawing appropriate conclusions. The State Center for Health Statistics publishes a series of *Statistical Primers* that are intended to help public health professionals use data appropriately. In addition, both the State Center for Health Statistics and the Office of Healthy Carolinians provide consultation and technical assistance to counties related to assessment and evaluation. Don't hesitate to contact us for such support.

For more information on data:

Visit these web sites or contact the State Center for Health Statistics for the publication, "Sources of Data for Community Profiles: A Resource Guide for Community Health Assessment in North Carolina".

Office of State Planning – <http://www.ospl.state.nc.us/>

Institute for Research in Social Science – <http://www.unc.edu/depts/irss/>

North Carolina Child Advocacy Institute – <http://www.ncchild.org>

North Carolina Department of Commerce – <http://www.commerce.state.nc.us>

North Carolina Department of Public Instruction – <http://www.dpi.state.nc.us>

State Bureau of Investigation – <http://sbi.jus.state.nc.us>

North Carolina Department of Transportation – <http://www.dot.state.nc.us/transit/transinet/>

North Carolina Department of Agriculture – <http://www.agr.state.nc.us/stats/>

North Carolina Employment Security Commission – <http://www.esc.state.nc.us>

University of North Carolina Highway Safety Research Center – <http://www.hsrc.unc.edu>

Environmental Defense Fund – <http://www.scorecard.org>

Highlights from Local Healthy Carolinians Task Forces

Pediatric Asthma: Pitt Partners for Health

Asthma is the leading serious chronic childhood disease in the nation and the third ranking cause of hospitalization among children¹. Using data on emergency room visits, hospital discharges, and school absenteeism the Information Systems Department at Pitt County Memorial Hospital was able to show that childhood asthma has emerged as a serious health problem for Pitt County as well. As the result of this assessment, Pitt County Memorial Hospital received a three-year grant in 1996 to develop new pediatric asthma efforts targeting children in grades kindergarten through five.

A unique community case management model was implemented consisting of school based, outpatient, and inpatient components. Pediatric primary care providers in the county have adopted a standard of care (NIH Guidelines) and consistently provide written plans for asthma management that extend across the continuum of care. The use of the pediatric asthma management model has significantly impacted the management of the asthmatic child in Pitt County, where 70% of the asthmatics utilizing the health care system are Medicaid recipients. This model focuses on the development of an asthma action plan to control and prevent symptoms so those with the disease can lead active and healthy lives. The goals of these plans are:

- to prevent asthma episodes from reoccurring;
- to direct the best action when an asthma episode occurs;
- to allow exercise and play without asthma symptoms;
- to allow sleep at night without asthma symptoms; and
- to decrease and avoid emergency visits and admissions to the hospital.

Children who continue to have symptoms while exercising, resting, or at night and/or early morning are referred to their physicians for re-evaluation.

The success of this program is due to the physicians, families, and school system staff who enthusiastically support this model. A unique database tracks program success and areas for improvement. A data analyst evaluates program impact using data on length of stay, inpatient costs, student absenteeism, and academic performance. Added support for this program is provided

by case managers. Case managers monitor moderate and severe asthmatics in an effort to maximize asthma management, remove barriers to care, and decrease hospital utilization. This support has increased access to funding for medications, coordinated transportation for recipients, and assisted in securing environmentally-healthy housing. Academic improvement has also been documented in several of the asthmatics followed by this program.

The pediatric asthma program assists the American Lung Association in providing an asthma camp each summer. Camp Sea Breathe is held for a week in Arapahoe, North Carolina located near New Bern. The camp is designed along with summer school programs to provide program follow up, increase knowledge about asthma, and teach self-management skills.

This successful case management model could be replicated for other chronic illness initiatives of Pitt Partners for Health and the Healthy Carolinians Task Force. This program receives funding and support from Pitt Memorial Hospital, Duke Endowment, Children's Miracle Network, and Pharmaceutical Services.

For more information please contact Kimberly Farrior, MSN Coordinator, Community Pediatric Prevention Program, Phone: (252) 816-6833, Fax: (252) 816-6859.



Sexual Assault and Domestic Violence: Wilkes Community Health Council

When Lil Barrett, program director of SAFE, Inc. (Sheltered Aid to Families in Emergencies) decided to form a task force on domestic violence and sexual assault, she presented the idea to the Healthy Carolinians steering committee of the Wilkes Community Health Council. "Domestic and sexual violence are leading health problems for women," Barret said, "so it made sense to work with the local Healthy Carolinians group."

For example, in North Carolina 1996, one forcible rape¹ occurred every three hours and 52 minutes. Of these 2,264 rapes, only 22% were committed by a stranger². Regarding domestic violence, there were more than 31,000 victims of domestic violence ages 18 and up in the State in 1996 reported to the North Carolina Council of Women.

¹ American Lung Association. *Fact Sheet – Asthma in Children, 1997.*

¹ Includes both actual and attempted rapes.

² State Bureau of Investigation. *Uniform Crime Report 1996.*

The magnitude of these problems in their community convinced Health Council members to establish the new task force as a subcommittee of the local Healthy Carolinians. The purpose of the Wilkes County Domestic and Sexual Violence Prevention Task Force is to reduce the amount of domestic violence and sexual assault in the community and improve services to victims. Task force members are enthusiastic and they represent a wide range of agencies involved in this issue.

“We need to do all we can to promote families who live in peace and harmony and disagree without resorting to violence,” said task force member Edgar B. Gregory, chief district judge, after the group’s first meeting in October 1997. “I would love to see our young men taught the right way to handle relationships and the right way to treat women,” said task force member Hope Combs, Maternity Care Coordinator at the Wilkes County Health Department.

In its first six months, the task force has developed a resource guide for victims and established a support group for female survivors of domestic violence. One of the most important contributions of the task force is providing a forum for diverse community agencies to talk to one another. “It brings different professions together, all working toward the common goal of reducing domestic and sexual violence,” said Detective Ralph Pittman of the North Wilkesboro Police Department, after the task force’s first meeting. “Before the task force there was very little communication between the professions, hence, solutions were not found or sought.”

Having community leaders on the task force has also helped raise the issue’s profile in the community. “[The task force] lends a lot of credibility to what we do here,” Barret says, “it was a big boon to our program. Now our religious community has embraced our preventive efforts.” A few months before forming the task force, Barret was able to expand SAFE’s rape prevention efforts. With a \$15,000 rape prevention grant from the North Carolina Council for Women, she hired a

half-time sexual assault prevention educator, Michelle Smith. Smith is working with the task force to develop a public awareness campaign that will also be funded by a rape prevention mini-grant.

When Help, Inc., a domestic violence agency in Wentworth, began plans to start a sexual assault program, Executive Director Cynthia Pugh took the collaborative approach. “The only way to address [sexual assault] is to address it as a community issue,” she says. The sexual assault program opened July 1, using victim advocate teams. These multi-agency teams coordinate to provide an ongoing continuum of services to victims of both sexual assault and domestic violence. Many of the agencies, such as Annie Penn Hospital, are also represented on the Rockingham County Healthy Carolinians Task Force.

“Working with Healthy Carolinians is collaboration – which is the way to go,” Pugh says. “We continue to work with them on various projects.” Susan Jones, Healthy Carolinians co-chair and executive director of the Annie Penn Hospital Foundation, has been very helpful, she says. “The hospital is very supportive of what we are doing, embarking on the sexual assault program.” Thus, when money for a joint project between Healthy Carolinians and a local sexual assault agency became available from the North Carolina Court Appointed Special Advocate Association, Pugh was ready to seize the opportunity to meet a community need.

Help, Inc., teamed up with Healthy Carolinians to produce a three-month public awareness campaign that raises awareness about acquaintance rape and announces the agency’s new sexual assault services. One of the campaign’s purposes is to counter the myth that rapists are usually strangers who leap out of the bushes in the dark. “We hope to give the message to women, “you’re not alone; this does happen in families,” Pugh says. The ads, designed by an advertising agency, read “Rape...It’s not always a stranger,” and include the Healthy Carolinians logo and Help, Inc.’s phone number.

Interesting Websites:

<http://www.healthycarolinians.org>
Official Healthy Carolinians Website

<http://chip.onslowonline.net>
Onslow CHIP, A Turning Point Initiative

Healthy People 2010 Draft document
<http://web.health.gov/healthypeople/2010Draft/index.htm>

<http://www.surgeongeneral.gov/phs200>
An educational web site that features on-line videos, exhibits, games and a downloadable screen saver, all in connection with the 200th anniversary of the U.S. Public Health Service.



A Message from the Director Office of Healthy Carolinians

Mary Bobbitt-Cooke

“Healthy Carolinians is a community-based partnership to improve the health of North Carolinians. With leadership from public health and hospitals, this process brings together community members, leaders, businesses, churches, schools, civic organizations, health care providers, and human service organizations to set priorities for addressing the health and safety problems in the community, and execute creative solutions to these problems.” These are the opening words of my presentations at various national meetings.

Healthy Carolinians is now being recognized at the national level. As the federal government prepares the national health objectives for the Year 2010, the US Department of Health and Human Services, Office of Disease Prevention and Health

Promotion, wanted to know how various states were responding to the Healthy People 2000 objectives. Last October, I was invited to present information about North Carolina’s Healthy Carolinians at a meeting with representatives from 13 Southeastern states. Beginning in 1992 with the Governor’s Task Force Report on Health Objectives for the Year 2000 and six initial task forces, I explained that Healthy Carolinas has grown dramatically with more than 70 counties currently engaged in the Healthy Carolinians process. Healthy Carolinians counties have been very successful in assessing and establishing community health priorities, mobilizing resources to respond to these issues, and creating health at the community level.

I have since given presentations about Healthy Carolinians at Centers for Disease Control and Prevention in

Atlanta and at the annual National Civic League/Community Care Network meeting in Washington, D.C. At each meeting, the work and success of Healthy Carolinians task forces were met with much enthusiasm and created much interest.

For the past year, the federal government has engaged the nation in a discussion and review of health objectives for the Year 2010. Soon these health objectives will be released and the states will be challenged to mobilize their resources to meet these national health objectives. This year, North Carolina will set new state health objectives for the Year 2010. We anticipate that soon Governor Hunt will appoint new members to his task force that will lead North Carolina in this process. Part of this process will include a review of our progress toward meeting the Year 2000 objectives. This process will also provide an opportunity for Healthy Carolinians task forces to participate in setting health objectives for the Year 2010. Listening to community voices is a critical part of creating health in North Carolina.

Update/Notes:

1998 Healthy Carolinians Conference: Approximately 350 people attended the annual Healthy Carolinians Conference. Participants represented over 55 health departments, 45 hospitals and health care centers, eight universities and colleges, approximately 20 state-wide organizations and associations, and many, many community level agencies, not-for-profits organizations, faith community representatives, businesses, health care providers, Chambers of Commerce, economic development offices, and a few elected officials. The conference evaluations told us that participants attended sessions that were valuable and instructive for develop-

ing and sustaining Healthy Carolinians task forces. Thanks to the 30+ sponsors that made this conference possible. If you want to be a sponsor or part of the 1999 Healthy Carolinians Conference planning committee, please contact Fiorella Horna-Guerra, (919) 715-0414.

Turning Point/Assessing the Assessments: As part of the work of North Carolina’s Turning Point (a Robert Wood Johnson/K. W. Kellogg initiative), a group of representatives from East Carolina University, NC Center for Health Statistics, Sheps Center for Health Services Research, UNC-CH, Wake Forest School of Medicine, and the Office of Healthy Carolinians have been assessing community assessments to learn what communities

across North Carolina have identified as critical health issues. We have reviewed the community diagnoses that local health departments conduct biannually, as well as assessments done by Healthy Carolinians task forces, hospitals, and universities. Communities across North Carolina have identified 110 critical health issues. We will put this long list of health concerns through a Delphi process (a voting process that builds consensus) to ultimately determine the critical health concerns in North Carolina. These critical issues will be the focus for the 1999 Turning Point Summit where partners in the Turning Point initiative will discuss and determine a blueprint for action to respond to the problems. Also, the critical issues will provide valuable

information to the Governor's Task Force as it sets the new state health objectives in 1999.

New Division of Public Health: Last October, the State public health offices were reorganized into the Division of Public Health, NC DHHS. Dr. Ann Wolfe has been named Director of the new Division. Many of the reorganization details are still being worked on. The Office of Healthy Carolinians is in the Local Health Services Section which reports to Dr. Wolfe.

Consultant Services for Healthy Carolinians: The Office of Healthy Carolinians currently has two of the five regional consultant positions vacant. Until we are able to fill these two vacancies, three consultants – Hans Johnson, Carlton Adams, Tom Milroy – will be covering the State and responding to Healthy Carolinians needs. Please call the Office of Healthy Carolinians, for more information about consultant services for Healthy Carolinians (919-715-0416).

Women's Health: The Office of Women's Health is planning a Mini-Summit in April of 1999 on HIV/AIDS/STDs and Women. This event will focus on and expand the vision and strategies that were developed at the 1998 Women's Health Summit on HIV/AIDS/STDs.



The Office of Women's Health will also be expanding the task forces on Access, Data, Policy, Reproductive Health, Health Promotion (including chronic disease prevention and long-term care), and HIV and other sexually transmitted diseases. If you are interested in becoming involved with these groups, please call Sheila Cromer at (919) 715-3407.

Welcome Aboard Kalani MacGregor! The State Center of Health Statistics and the Office of Healthy Carolinians is pleased to announce that Ms. Kalani MacGregor has accepted the position of Community Assessment Educator/Trainer for the CDC Community Health Assessment Initiative. Her key role is developing a training curriculum for comprehensive community assessment and assisting local task forces in constructing a profile of their community.

Kalani is a recent graduate of the UNC-School of Public Health and has excellent experience in community health assessment, program planning, management, biostatistics, and experience in SAS and Epi-Info software. Kalani has worked in a variety of positions and volunteered for various community-based organizations such as Safe Kids, the Interfaith Community Homeless Shelter, and the West Hawaiian Children's Advocacy Center.

North Carolina
Department of Health and Human Services
State Center for Health Statistics
P. O. Box 29538
Raleigh, North Carolina 27626-0538
(919) 733-4728 • FAX: 733-8485
www.schs.state.nc.us/SCHS

State of North Carolina
James B. Hunt Jr., Governor
Department of Health and Human Services
H. David Bruton, M.D., Secretary
State Center for Health Statistics
John M. Booker, Ph.D., Director
Office of Healthy Carolinians
Mary Bobbitt-Cooke, M.P.H., Director
www.healthycarolinians.org



For more information about
Communities in Action contact:

Gabrielle Principe
State Center for Health Statistics
(919) 715-7472
gabrielle_principe@mail.ehnr.state.nc.us

Fiorella Horna-Guerra
Office of Healthy Carolinians
(919) 715-0414
fiorella_horna-guerra@mail.ehnr.state.nc.us

