Maternal and Child Health Services Title V Block Grant

North Carolina

FY 2026 Application/ FY 2024 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
KELLY KIMPLE • Director, Public Health

July 28, 2025

Laura Kavanagh, MPP
Associate Administrator (Acting)
ATTN: MCH Block Grant
Division of State and Community Health
5600 Fishers Lane, Room 18-31
Rockville, MD 20857

Dear Ms. Kavanaugh:

Enclosed is North Carolina's application for the Maternal and Child Health Services Title V Block Grant Fiscal Year 2026. This grant is essential for maintenance and enhancement of our public health services.

Your consideration of our request is greatly appreciated. Should you have questions about the information contained in this application, please call Belinda Pettiford, NC Title V Director/Women, Infant, and Community Wellness Section Chief, at (919)218-4698.

Sincerely,

Signed by:
Debra Farrington
455075340DA8489...
Devdutta Sangvai, Secretary

Enclosure: *Maternal and Child Health Services Title V Block Grant FY26 Application/FY24 Annual Report*

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF PUBLIC HEALTH
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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms",* OMB NO: 0915-0172; Expires: December 31, 2026.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

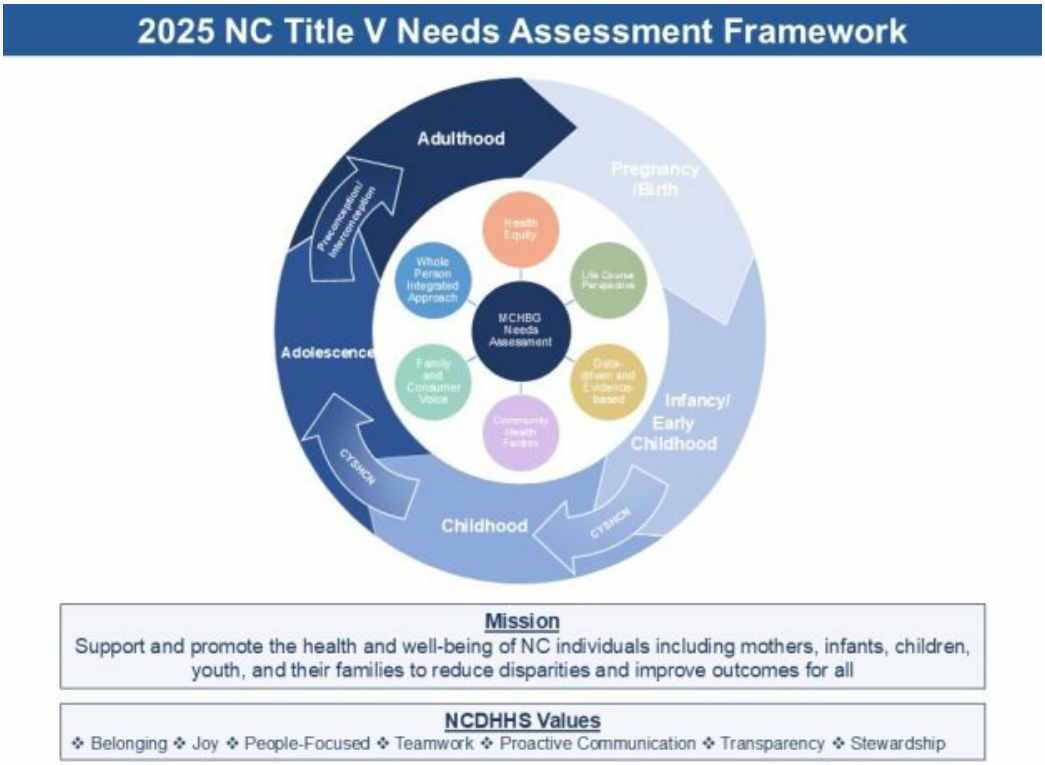
III.A.1. Program Overview

The Title V Program in North Carolina (NC) is administered by the NC Division of Public Health (DPH) and collaborates with programs across the NC Department of Health and Human Services (NCDHHS), other state agencies, statewide partners, local health departments (LHDs), community-based organizations as well as other stakeholders to improve maternal and child health in NC. The NC Title V Director serves as Section Chief for the Women, Infant, and Community Wellness Section (WICWS), which is made up of three branches – Maternal Health, Reproductive Health, and Infant and Community Health, in DPH. The NC CYSHCN Director is positioned in the Division of Child and Family Well-Being (DCFW) as the Assistant Director supervising the Whole Child Health Section (WCHS). Both the DPH and DCFW are part of the NCDHHS team to provide essential services to improve the health, safety, and well-being of all North Carolinians in collaboration with its partners and committed to whole-person care. The WCHS is made up of six units – Child Behavioral Health; School, Adolescent, and Child Health; Best Practices; Child and Family Wellness; Genetics and Newborn Screening; and Operations.

The NC Title V Program works across the NCDHHS to advance the Title V priorities and improve health and wellbeing of individuals of reproductive age, mothers, fathers, infants, children, and adolescents in the context of NCDHHS priority goals:

1. Advance **health** by increasing opportunity and improving outcomes for people who face greater health and situational challenges within NCDHHS and across the state.
2. Promote **child and family well-being** by making it easier for children and families to access the healthcare, programs, and supports they need to thrive.
3. Support **behavioral health and resilience** by prioritizing investments in coordinated systems of care that make services easy to access when and where they are needed and reduce the stigma around accessing these services.
4. Build a **strong and inclusive workforce** that supports early learning, health, and wellness across NC.
5. Achieve **operational excellence** by enabling efficient, effective, and innovative processes and services.

A 2025 NC Title V Needs Assessment Leadership Team was created in January 2024 which consisted of the former Title V Director; the CYSHCN Director; the WICWS Chief; and the State Systems Development Initiative (SSDI) Project Coordinator. The Title V Initiatives and Operations Manager joined the Team after she was hired in June. This group met monthly to create and implement a work plan of needs assessment activities, engaging WICWS and WCHS staff throughout the process as necessary for input and ideas. One of its first activities was to determine the 2025 NC Title V Needs Assessment Framework shown below which focuses on a life-course perspective driven by whole person integrated approach, community health factors, family and consumer voice, and ensuring data-driven and evidence-based approach. The intent from the start was to leverage other efforts and to align with strategic plans, programs, and projects that are already in place in NC to serve the maternal and child health (MCH) population across the life course. The methodology used in the 2025 NC Title V Needs Assessment was a mix of qualitative and quantitative data collection from stakeholders, families, and other partners. An MCHBG Priority Setting Meeting was held in December 2024 to discuss the results of the partner survey and previous data collection efforts, and seven final priority needs were determined through a voting process using prioritization criteria established by the Needs Assessment Leadership Team.



The major findings from the 2025 Needs Assessment process indicated that, in large part, the priority needs from the 2020 Needs Assessment process are still the major priorities for NC. Quantitative data from birth certificates, hospital discharge data, and the National Survey of Children's Health that are routinely monitored, not just during the needs assessment process, support these priority needs. Infant mortality rates have stagnated overall, and the Black, Non-Hispanic (NH) infants are now dying at three times the rate of white, NH infants. One in three infant deaths are attributable to prematurity or low birth weight. Severe maternal morbidity rates are rising and disparities by racial/ethnic population groups persist. Child death rates are also rising after stagnating for several years. The percent of infants breastfeeding exclusively for 6 months has increased slightly over the past five years. Developmental screening among children ages 9-35 months has not returned to pre-pandemic levels, and only about half of parents report that their child has a medical home, with this percentage being lower for CYSHCN. Most adolescents appear to be receiving well-visits, but not many, even those with special health care needs, are receiving services to prepare for transition to an adult provider. Qualitative data from an online Partner Survey and virtual focus groups supported the need to improve access to quality health care services across the MCH population domains, inclusive of not only physical health, but behavioral and mental health as well.

The following table lists the seven selected priority needs that emerged from the 2025 Needs Assessment with the accompanying National and State Performance Measures (NPMs & SPMs) by population domain.

MCH Priority Needs Linked to Performance Measures	
NC Priority Needs by Population Domain	**National/State Performance Measures**
Women/Maternal Health	
1. Promote comprehensive reproductive health care including postpartum care and support	Postpartum Visit NPM
Perinatal/Infant Health	
2. Prevent infant/fetal deaths	Breastfeeding NPM
Child Health Domain	
3. Promote safe and nurturing relationships for children and adolescents	Developmental Screening NPM
4. Improve access to quality whole child and adolescent health care	Medical Home for Non-CSHCN NPM
Adolescent Health	
3. Promote safe and nurturing relationships for children and adolescents	SPM 1: Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance
4. Improve access to quality whole child and adolescent health care	Adolescent Well-Visit NPM
CYSHCN	
4. Improve access to quality whole child and adolescent health care	Medical Home CSHCN NPM
5. Ensure all CYSHCN and families receive care in a well-functioning system	SPM 2: Percent of children with special health care needs who receive care in a well-functioning system
Cross-Cutting/Systems Building	
6. Engage individuals and families with lived experience, as well as community-based organizations, as partners in the development and implementation of people-centered programs and policies that reduce health disparities and address community health factors	SPM 3: Percent of Title V programs that offer compensated family engagement and leadership opportunities
7. Improve access to mental and behavioral health services for maternal and child health populations	SPM 4: Percent of counties who have providers who have utilized the NC-PAL or NC MATTERS psychiatry access lines

The mission of the NC Title V Program, to support and promote the health and well-being of NC individuals including mothers, infants, children, youth, and their families to reduce disparities and improve outcomes for all, aligns well with the goals of Title V. The NC Title V Program works closely with local, state, and national partners and serves as a critical collaborator and convener. From reproductive life planning and preconception health to perinatal and infant health to child/adolescent health including those with special health care needs, the NC Title V Program emphasizes a life course approach to achieving improved health outcomes for all populations. The NC Title V Program values evidence-based and evidence-informed strategies in promoting health, while following guidelines around best practice. Given the importance of cross-sector work, the NC Title V Program leverages the expertise and experience of our many partners and leaders in the state.

The NC State MCH Block Grant Plan is approved on a state fiscal year basis through the Budget Act passed by the NC General Assembly. Funding from the MCHBG supports local programs in women's, infant and children's health administered by both DPH and DCFW, as well as DHHS infrastructure. The NC Title V Program's broad scope promotes collaborative efforts while discouraging categorical approaches to the complex challenge of improving maternal and child health. The Program is committed to ensuring that services provided to families are easily accessible, user-friendly, culturally appropriate, and free from systemic barriers that impede utilization. While many staff members work in the central office in Raleigh or on a hybrid schedule, there are a number of regional consultants who work from home and regional offices and a growing number of home-based central office staff members. The Title V Block Grant funds 26 NC Title V Program state-level employees, with others funded in part per the cost allocation plan. These positions are primarily nurse consultants, public health genetic counselors, and public health program consultants within the Title V Office, WICWS, and WCHS, but also include staff members in the NC State Center for Health Statistics (SCHS), Chronic Disease and Injury Section (CDIS), and the Oral Health Section to fund collaborative efforts.

The NC Title V Program supports services and programs for underserved and vulnerable populations using state appropriations, grant funding, Title V, Medicaid Federal Financial Participation, and other receipts. The NC Title V Program provides Title V funding to LHDs through the Consolidated Agreement, which is a contract between the LHD, DPH, and DCFW that outlines requirements of each agency including funding stipulations, personnel policies, disbursement of funds, etc. Program specific requirements for each state funded activity are provided in Agreement Addenda. The funding that goes directly to LHDs is used to provide services for individuals without another payer source, as well as enabling services and population health education.

The NC Title V Program also collaborates on a number of activities with several professional organizations in the state including but not limited to: NC Medical Society; NC Pediatric Society (NCPS); NC Obstetrical and Gynecological Society; Midwives of North Carolina; NC Friends of Midwives; and the NC Academy of Family Physicians. The NC Title V Program partners with the NC Institute of Medicine, the NC Healthcare Association, and the NC Area Health Education Centers and works closely with the NC Partnership for Children (NCPC), Positive Childhood Alliance NC, the NC Chapter of the March of Dimes (MOD), NC Child, and other organizations. There are many accredited schools of public health and medicine in NC, and the NC Title V Program maintains close working relationships with many of them.

The NC Title V Program is committed to building the capacity of women, children, and youth, including those with special health care needs, and families to partner in decision-making about state Title V activities and programs. There are several NCDHHS advisory councils and commissions that are in place and involve family members including, but not limited to: the Commission on Children with Special Health Care Needs (CSHCN), Newborn Metabolic Committee, Newborn Hearing Advisory Committee, Office on Disability and Health Advisory Group, Association for School Health, MIECHV, Triple P, NC Baby Love Plus Community Consortium, and the Governor's Council on Sickle Cell Syndrome. The NC Title V Program continues to support a full-time Family Liaison Specialist (FLS) position in the WCHS, who is a parent of a CSHCN, to train and support family engagement in WCHS programs and maintains an active group of Family Partners. The WICWS has created Village 2 Village, a community and consumer engagement work group whose members provide feedback on the Perinatal Health Strategic Plan strategies, publications, and services. Participants are compensated for time, travel, meals, and lodging according to NC state government reimbursement guidelines. One of the state priorities for the next five years will focus on gathering data and implementing best practices around engaging with families and communities.

The NC Title V Program focuses on ensuring access while also facilitating a strategic approach utilizing needs assessments, data, and convening partners and leaders in the development of strategic plans. Continuing evaluation of Title V funded activities and programs is a priority for the upcoming five-year cycle. The WICWS has contracted with NC Central University to evaluate the Healthy Beginnings program which has demonstrated promising results around infant mortality reduction. Both federal Healthy Start programs also include an evaluation process. DCFW is also evaluating the Child Tiered Care Coordination University Support/NC High Fidelity Wraparound Training Program as part of child behavioral health efforts.

Despite substantial successes, the NC Title V Program remains challenged by a variety of systemic barriers and recognizes that there is still much work to be done to fully integrate a systems approach in NC. There remains a strong commitment to addressing community health factors in the MCH populations to achieve their full health potential. The NC Title V Program continues to advocate for NC residents and is central to the three NCDHHS priority areas of focus: Behavioral Health & Resilience, Child & Family Wellbeing, and Strong & Inclusive Workforce. The NC Title V Program continues to work with the many partners to help achieve our goals and create a more strategic vision for NC, while maintaining the safety net, public health infrastructure at our LHDs, and a focus on evidence-based programs for MCH. Promoting health and wellbeing and supporting North Carolinians, including our mothers, children and families, is especially critical to improve overall health.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Maternal and Child Health (MCH) Block Grant funds provide critical infrastructure, support, and resources to the state's overall MCH efforts. NC Title V Program uses the funds to leverage partnerships and blend with other federal and state funding sources on initiatives to improve national and state performance measures associated with MCH priorities. MCH Block Grant funding is also allocated to all North Carolina local health departments to support and supplement MCH efforts in local communities. An example of where Title V was able to complement the system is the NC care management services for young children and pregnant women. While Medicaid funding supports these care management programs for the Medicaid population, Title V also leverages the Medicaid system and provides funding to numerous local health departments to offer local care management services to infants and young children and pregnant women who are uninsured and do not qualify for Medicaid.

The Title V infrastructure positioned NC to receive multiple additional competitive grants over recent years, including Pediatric Mental Health Care Access Program, NC Maternal Mental Health MATTERS (Making Access to Treatment, Evaluation, Resources, and Screening Better), Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM), Southeastern NC Healthy Start Program, NC Healthy Start Baby Love Plus, and the Maternal Health Innovations grant. In addition to Title V, the Title V Director is responsible for the administration of programs such as Title X and other grants which require a coordinated, strategic approach, utilizing other federal or state funding while also leveraging the many partnerships with other state agencies, universities, federally qualified health centers, non-profit organizations, and LHDs. The Title V work across the life course is strengthened in the partnership with the Chronic Disease and Injury Section to enhance collaboration around preconception health, adverse childhood experiences, breastfeeding, injury and suicide prevention, tobacco prevention and cessation, substance use, breast and cervical cancer, and others, as well as with the Oral Health Section. Both the WICWS and the WCHS fund positions that support Title V activities and programs using state appropriations and other federal dollars. This helps to achieve success in these programs without expending additional MCH Block Grant funds on staff. The Title V Program will continue to work across NCDHHS and with other partners to improve the health and well-being of North Carolinians.

Child and family well-being is a NCDHHS priority with an emphasis on whole-person health and assuring that MCH populations achieve their full health potential, with Title V being central to these efforts. For example, the NC Title V Program brings resources, expertise, and training to fight the opioid epidemic to make sure women and their infants and children stay central to the conversation in a non-punitive public health approach. DPH and DCFW work collaboratively to ensure that mental health services are easy to access for all MCH populations and support the healthy development of families and children. Strengthening the public health workforce that supports early learning, health, and wellness is vital to the NC Title V Program. As NC continues to address challenges, such as high infant mortality rates, the MCH Block Grant funds are the foundation on which NC can form a strategy to promote the health of individuals, infants, children/adolescents, and their families.

III.A.3. MCH Success Story

NC has enjoyed recent successes through partnerships with nonprofit organizations and statewide conferences.

Fact Forward

The MCHBG has supported adolescents and specifically teen pregnancy prevention (TPP) efforts in NC for over a decade. When SHIFT NC (formerly Adolescent Pregnancy Prevention Coalition of NC) dissolved in 2022, there was concern about who would take on a statewide effort to support adolescent-serving agencies and professionals in the state. The NC DPH released a Request for Applications process in 2023 to find the next agency to support this field. Fact Forward, a South Carolina based nonprofit agency who was looking to move their well-known adolescent reproductive health work into NC was awarded the block grant funds to continue this work. During FY24 (their first year of funding), they worked to establish themselves in NC by reaching out to local agencies, creating listening sessions, and organizing trainings. Based on information gleaned from the listening sessions, Fact Forward hosted an Adolescent Health Spring Summit in April 2024 with 98 attendees. The conference, held over one and a half days, consisted of a variety of breakout sessions as well as an overview of the state of adolescent health in NC. Attendees reported the conference was a valuable resource for their professional work and appreciated the quality of the breakout sessions and speakers. Over the course of the year, Fact Forward also connected with adolescents interested in serving on a Youth Leadership Council (YLC). They recruited seventeen youth candidates who were interviewed and fourteen were confirmed as members of the new NC YLC. The goal of this group is to serve as a youth voice in leading TPP in NC while also providing opportunities for youth-serving professionals to directly hear from them. The YLC also worked to produce their own annual project, a media campaign, to lift up youth voices in adolescent reproductive health efforts in FY25. Fact Forward has quickly created a name for themselves and ensured that they are included in shaping adolescent reproductive health in NC.

39th Annual North Carolina School Nurse Conference

The 39th Annual NC School Nurse Conference, held December 12-13, 2024, brought together school nurses, vendors and experts to explore the essential role of school nursing in advancing student health and well-being. With the theme *School Nursing: Building Blocks of Knowledge*, the conference provided a dynamic platform for professional development, offering attendees valuable insights into best practices, innovative health strategies, and the latest in student care. The event's success was demonstrated by the 495 attendees and forty vendors who contributed to a rich, collaborative atmosphere. Participants also had the chance to connect with peers and experts in the field, exchanging ideas and resources. Comments such as the following cited in conference evaluations help demonstrate the success of the conference:

- It's a joy to learn new things, meet new people, and sometimes to just solidify your current practice. Collaboration is great.
- I will use all the information from conference to better serve the students at my elementary school.

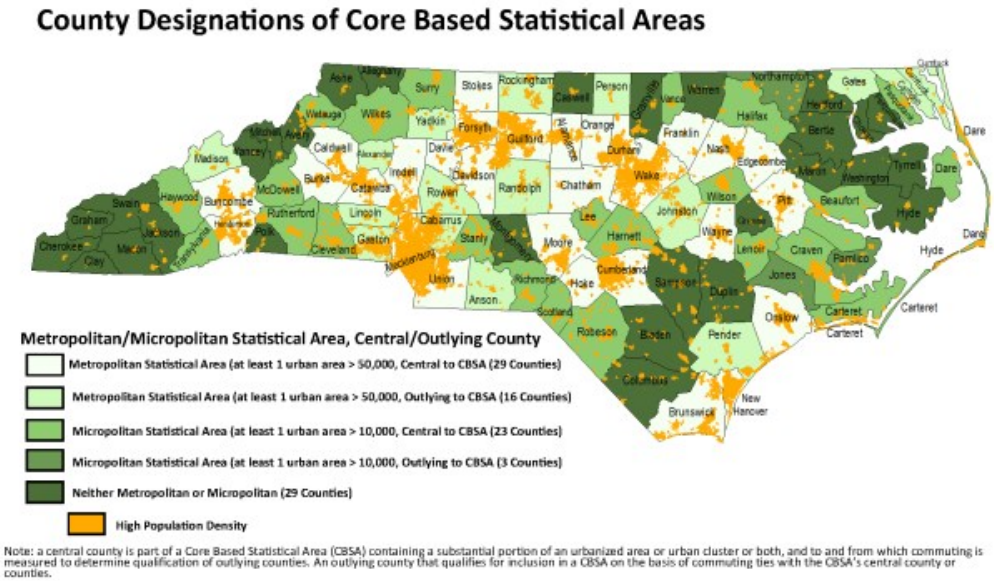
III.B. Overview of the State

III.B.1. State Description

North Carolina's Demographics, Geography, Economy, and Urbanization

NC covers 52,175 square miles including 48,710 in land, and 3,465 in water. The 100 counties that comprise the state stretch from the eastern coastal plains bordering the Atlantic Ocean, continue through the densely populated piedmont area, and climb the Appalachian Mountains in the west. These different geographical features pose a number of challenges to the provision of health care and other social services. In the sparsely populated western counties, there are vast areas of rugged terrain which make travel difficult especially during the winter months and contribute to the isolation of the rural inhabitants. In the coastal plain counties, which cover almost a quarter of the state, swamp lands, sounds that bisect counties in half, and barrier islands that are often inundated during hurricane season, also complicate transportation and contribute to isolation and health care access problems. While urban centers have better health care provider to population ratios, access to affordable health care may still be a problem due to potential disparities because of race/ethnicity, long wait times for appointments or lack of insurance coverage. Moreover, because most local health departments (LHDs) have maintained their single-county autonomy, rural departments are often under-funded and have difficulties attracting sufficient staff and operating efficiently. According to 2023 data from the NC Office of Rural Health, 71 of the 100 NC counties are considered rural. The 29 urban counties shown in white on the map below (Figure 1) have at least one urbanized area that has a population of at least 50,000. According to data from the State Demographer in the NC Office of State Budget and Management, in 2020, 65% of all North Carolinians (of 6.8 million people) lived within 22 urban or regional center/suburban counties, but it is estimated that by 2030, 69% of the state's projected population will do so.

Figure 1



Note: a central county is part of a Core Based Statistical Area (CBSA) containing a substantial portion of an urbanized area or urban cluster or both, and to and from which commuting is measured to determine qualification of outlying counties. An outlying county that qualifies for inclusion in a CBSA on the basis of commuting ties with the CBSA's central county or counties.

According to the Vintage 2024 population estimates released by the US Census Bureau in December 2024, NC's official population is now over 11 million people (11,046,000) and increased by 165,000 people from July 1, 2023, to July 1, 2024. This was the fourth largest population gain in the nation. NC remains the ninth largest state in the nation but is gaining ground on Georgia and Ohio, the eighth and seventh most populated states, respectively. Net migration has accounted for over 90% of the state's population growth since 2020.

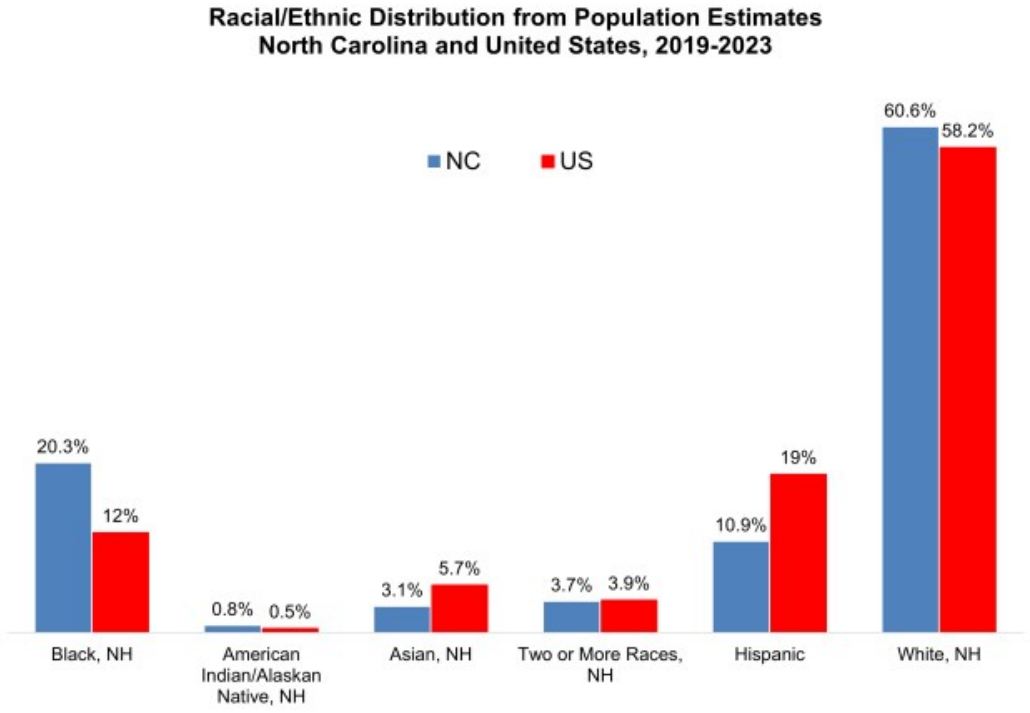
Per the 2019-2023 ACS, the age distribution of the female population of NC mirrors that of the nation. Females in NC and in the US are also aging at approximately the same rate. The median age in NC is 37.7 years; for women, it is 40.4 years. The number of women in NC in their reproductive years (ages 15-44) compose 38.6% of the total

female population, and the population projections for 2030 prepared by the NC State Data Center show that the proportion of women of childbearing age will stay steady at that rate.

The number of births in NC peaked in 2007, with 130,866 births, and there was a steady decline to a total of 118,983 born in 2013, but a slight rise to 120,826 in 2015 and a continued decline in 2020 with 116,755 births. The number of resident births increased to 121,557 in 2022 but has decreased back to 120,065. The general fertility rate for females ages 15 to 44 per 1,000 population of females in that same age group was 58.2 in 2018 and has remained fairly consistent, although it decreased to 55.8 in 2023. Based on 2019-2023 ACS population estimates, children under five years make up 5.7% of NC's population, while children under 18 years comprise 21.9%. These percentages are similar to those for the US (5.7% and 22.2% respectively).

2019-2023 ACS census population estimates indicate that more than one out of every three individuals in the state is a member of a minority group. The Black, NH population is the largest group at 20.3% of the population. The combined other minority groups – Hispanic (10.9%), American Indian and Alaska Native, NH (0.8%), Asian, NH (3.1%) and those reporting two or more races, NH (3.7%) – represent a smaller proportion of the total population, but their numbers have increased significantly over the past decade. See Figure 2 for a comparison of racial/ethnic distribution in NC and the US.

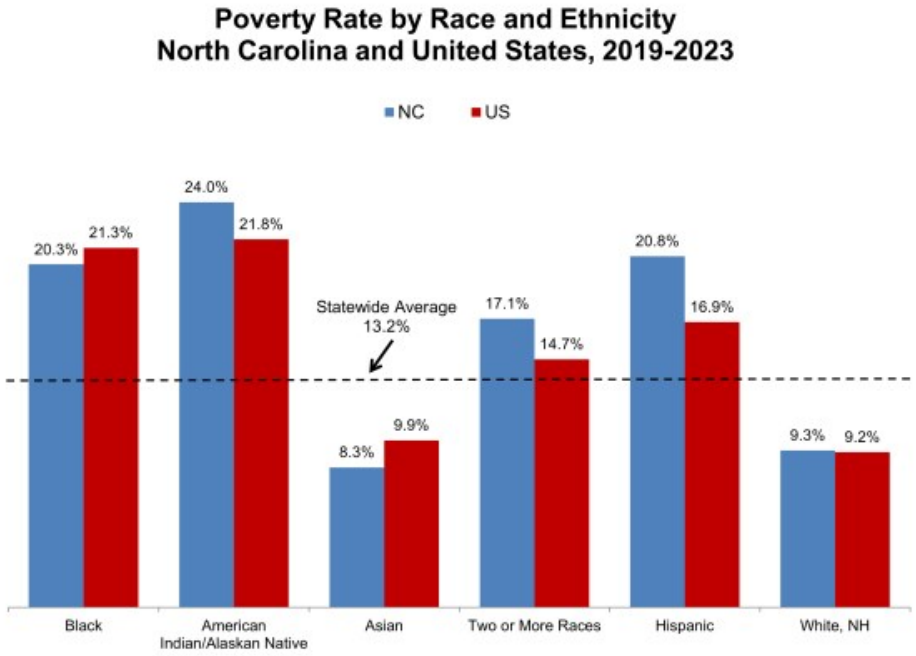
Figure 2



Source: U.S. Census Bureau: 2019-2023 American Community Survey 5-Year Estimates

According to single-year ACS data, almost 1.35 million North Carolinians (12.8%) lived in poverty in 2023, making NC the state with the 17th highest poverty rate. Poverty rates by race and ethnicity in NC from ACS 2019-2023 data are similar to national rates in all categories, except NC rates are higher for people of two or more races, American Indian/Alaskan Native, and for those of Hispanic/Latino ethnicity (Figure 3). Poverty rates for Black, American Indian, and Hispanic North Carolinians are more than twice the rates for whites and Asians. Women in NC are more likely to be in poverty (14.4%) than men (11.8%), and children under 18 in NC are at a higher rate of poverty (18.1%) than for the nation as a whole (16.3%).

Figure 3



Source: U.S. Census Bureau: 2019-2023 American Community Survey 5-Year Estimates

The state's poverty rate has declined over the past ten years (2009-2013 ACS data for NC showed a rate of 17.5% compared to 13.3% from the 2019-2023 ACS), and income levels have increased slightly. Per 2019-2023 ACS data, the median household income level for North Carolinians was $69,904 as compared to $78,538 for the US. 2009-2013 ACS data show the NC level at $46,3341 and the US level at $53,064. Men continue to have higher median income with 2019-2023 ACS data showing that median earnings for men with a bachelor's degree (not including people who also have a graduate degree) were $77,865 compared to $52,706 for women with a bachelor's degree. There are similar disparities at all other educational levels.

According to an analysis by the Economic Policy Institute of Bureau of Labor Statistics Local Area Unemployment Statistics (LAUS) data and Current Population Survey (CPS) data, the total unemployment rate for NC was 3.7% for the first quarter of 2025, but this rose to 5.8% for Black people and stayed at 3.7% for Hispanic people, while the rate for white people was 3% and 3.3% for Asian Americans and Pacific Islanders. (State Unemployment by Race and Ethnicity updated April 2025 and accessed May 2025).

Strengths and Challenges Impacting the Health Status of NC's MCH Population

The public health system in NC has a strong history with 86 autonomous LHDs serving all 100 counties ensuring access to maternal and child health services through Title V funding as well as other federal, state, and local funding. During FY18, the NC DPH submitted documentation to the Public Health Accreditation Board (PHAB) as part of the steps towards PHAB accreditation which highlighted some strengths and challenges that impact the health status of NC's maternal and child health population. Strengths included having a strong Division management team and strong relationships with local health directors and departments. Identified challenges included an aging workforce and loss of historical knowledge when staff members leave, updating and implementing new information technology systems, the growing population of our state leading to greater disparities in health status between rural and urban areas, and the aging of our populations with an impact on demand for health services. Work on the PHAB accreditation process was frozen for a one year period due to leadership changes within the NC DPH, but beginning in December 2019, the Division continued to move forward in pursuing accreditation. Document submission (as the next step in the process) was completed in March 2021, and PHAB review was completed in February 2022 with requests for additional documentation All NC DPH documents were submitted to PHAB in September 2022, and a virtual site visit was held in January 2023 followed by an in-person site visit in February 2023. PHAB awarded

national accreditation status to NC DPH in May 2023.

LHDs are working hard to maintain local public health care management services under Medicaid transformation and continue to build relationships with the managed care entities through regular meetings. Both DPH and DCFW have been working with NC Medicaid and the LHDs to maintain continuity for the Medicaid beneficiaries through the implementation of NC Medicaid Managed Care. Currently, the right of first refusal for LHDs to provide care management services for high-risk young children and pregnant women has been extended an additional year through June 2026. NC Medicaid has created a process to assess LHD performance in providing care management services for the CMHRP and CMARC populations with specified benchmarks for managed care plan contracting requirements for FY26.

The COVID-19 pandemic highlighted health disparities across the country, and this was taken as a call to action for NCDHHS to better support North Carolinians. NCDHHS made the decision to undergo a realignment to bolster whole person health, encourage transparency and accountability, and promote improving health outcomes for all across the department to create a healthier NC. To drive these initiatives and promote cross-divisional collaboration to improve access to and use of our programs and services, we realigned existing program structures. The DCFW was established as a new departmental agency in 2022. The goal of DCFW is to promote cross-program initiatives to support NC's children growing up safe, healthy, developing to their full potential, and thriving in nurturing and resilient families and communities. To achieve this vision, the Division brought together complementary programs from the DPH, DMH/DD/SAS, and DSS to increase access and enrollment in services and to improve outcomes for children and their families. This includes nutrition programs (FNS/SNAP, WIC, and CACFP), health & prevention services for children and youth (including CYSHCN), children's behavioral health programs, and early intervention programs. With this realignment comes the critical task of the Title V Program to ensure coordination across maternal and child health, highlighting the dyad and the family, and ensuring a life course approach to improve health and well-being.

Delivery of Title V Services within NCDHHS

With the change in administration in January 2025, several organizational changes were made within the NC DPH and to the Title V Program. Dr. Kelly Kimple, a pediatrician and preventive medicine physician who was named Title V Director in August 2016 and had been serving as acting Division Director since July 2024, was named permanent Division Director and Chief Medical Officer in June 2025. Belinda Pettiford, the Women, Infant, and Community Wellness Section (WICWS) Chief now serves as the Title V Director. The NC CYSHCN Director, Dr. Anne Odusanya, is positioned in the DCFW as the Assistant Director supervising the Whole Child Health Section (WCHS). The Title V Director reports directly to the DPH Director Kimple. The CYSHCN Director reports to Sharon Bell, the DCFW Deputy Director for the WCHS.

The mission of NCDHHS is the following: "in collaboration with its partners, DHHS provides essential human services to improve the health, safety and well-being of all North Carolinians." The Department's vision is "advancing innovative solutions that foster independence, improve health and promote well-being for all North Carolinians." Governor Josh Stein was sworn into as North Carolina's 76th Governor on January 1, 2025. Prior to being elected Governor, Stein served as the NC Attorney General from 2017 to 2024 and was previously a member of the NC Senate (2009-2016). In January 2025, Governor Stein selected Dr. Devdutta Sangvai, former President of Duke Regional Hospital and a family medicine physician and a professor at Duke University, to be the new Secretary for the NCDHHS, replacing Secretary Kody Kinsley. Secretary Sangvai was sworn in on January 12, 2025, and will continue to implement the NCDHHS 2024-2026 Strategic Plan. He has outlined the following priorities: to continue the work which started with Medicaid expansion, to strengthen health access in the state and make sure communities have access to the type of services that they need and that programs and services are working for all North Carolinians, and to build a sustainable workforce. Dr. Lawrence Geenblatt was appointed by Secretary Sangvai as State Health Director and Chief Medical Officer for NCDHHS in late May 2025. He has served as a general internist, educator, and leader in Medicaid policy with Duke University Health System and has worked to integrate behavioral health and addiction services into primary care.

The NC DPH is composed of the Director's Office and the following offices and sections and programs: Local and Community Support; Chronic Disease and Injury; Epidemiology; Environmental Health; Oral Health; Office of the

Chief Medical Examiner; SCHS; State Laboratory; Vital Records; WICWS; the Title V Office; and the Office of Child Fatality Prevention. NC DPH and DCFW work collaboratively with 86 sub-state administrative units (single- and multi-county LHDs). The LHDs, which have local autonomy, have a longstanding commitment to the provision of multidisciplinary perinatal, child health, and family planning services, including prenatal care, care management, health education, nutrition counseling, psychosocial assessment and counseling, postpartum services, care coordination for children, well-child care, and primary care services for children. They are also instrumental in providing leadership for evidence-based programs county-wide such as Nurse Family Partnership, Healthy Families America, Teen Pregnancy Prevention Initiatives (TPPI), Triple P, and other programs dictated by the needs of the county.

There is a weekly Division Management Team (DMT) meeting for DPH executive leadership and all the Section Chiefs within DPH. This meeting is a time to co-plan and discuss issues of overlapping responsibilities and strategies for service improvement. In addition, the Title V Initiatives and Operations Manager coordinates meetings of the MCH Steering Committee as a dedicated time for collaboration across Divisions.

DCFW WCHS units work collaboratively through numerous meetings and activities for Title V to center a whole child approach to programming in addition to partnering with other DCFW sections, divisions and community partners. Furthermore, DCFW WCHS provides consultation and technical assistance to various types of providers to support children growing up safe, healthy, and thriving in nurturing and resilient families and communities. Aside from the Title V action plan, there are strategic plans that DCFW maintain alignment with including but not limited to the DHHS Strategic Plan and the Olmstead Plan.

The NC DPH released its 2023-2025 Strategic Plan in March 2023 which guides the overall work of the Division. The plan has four aims: 1) safeguard the public's health; 2) support healthy people and communities; 3) enable NC's healthiest future generation; and 4) improve organizational health with a focus on our workforce. In addition to these aims, the Division's core public health work will: 5) earn trust; 6) strengthen partnerships; and 7) drive data-informed decision making and evidence-based policy. During 2023-2025, the NC DPH focused on the following three main strategic priorities: 1) support the recruitment, development, and retention of our public health workforce; 2) build a durable statewide infrastructure that supports key foundational public health capabilities; and 3) earn trust by listening to and uplifting the voices and value of public health.

In January 2022, the NCDHHS established the DCFW, bringing together staff and programs serving the behavioral health, physical health, and social needs of children and families. This reorganization was designed to bring together programs and staff that were operating across DPH, Division of Social Services (DSS), and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) with the focus on whole person care. These programs include:

- Community Nutrition Services Section (originating from DPH)
- Early Intervention Section (originating from DPH)
- Food and Nutrition Services Section (originating from DSS)
- Children and Youth (originating from DPH)
- Child Behavioral Health (originating from DMH/DD/SAS)

This reorganization has transitioned in several phases with the final phase being the FY24 budget passed by the General Assembly. In 2025, an Interagency Memorandum of Agreement between DPH and DCFW was established with assistance from the National MCH Workforce Development Center to ensure compliance of Title V requirements, ensure alignment of Title V goals, and promote sustainability of the new structure (Appendix A).

The Title V Block Grant funds 26 state-level employees, with many others funded in part per the cost allocation plan. These positions are primarily nurse consultants, public health genetic counselors, and public health program consultants within the Title V Program, but also funds staff members in the SCHS, the CDIS, and the Oral Health Section. The funding that goes directly to LHDs is used to provide services for individuals without another payer source, as well as enabling services and population health education.

State Statutes and Regulations Relevant to the MCH Block Grant

While the public health system at the local level in NC is not state administered, there are general statutes in place for assuring that a wide array of maternal and child health programs and services are available and accessible to NC

residents. State statutes relevant to Title V program authority are established for several programs administered by the NC Title V office. These statutes, primarily found in Article 5 – Maternal and Child Health and Women's Health of GS 130A: Public Health, include (not an exhaustive list):

- GS130A-4.1. This statute requires the NCDHHS to ensure that LHDs do not reduce county appropriations for local maternal and child health services because they have received State appropriations and requires that income earned by LHDs for maternal and child health programs that are supported in whole or in part from State or federal funds received from NCDHHS must be used to further the objectives of the program that generated the income.

- GS130A-33.60. This statute establishes the Maternal Mortality Review Committee. The purpose of the committee is to reduce maternal mortality in this State by conducting multidisciplinary maternal death reviews and developing recommendations for the prevention of future maternal deaths to be disseminated to policy makers, health care providers, health care facilities, and the general public. The duties of the committee are cited as well as guidelines for the use of the information shared and the protections provided to committee members and their activities.

- GS130A-124. This statute requires NCDHHS to establish and administer the statewide maternal and child health program for the delivery of preventive, diagnostic, therapeutic and habilitative health services to women of childbearing years, children and other persons who require these services.

- GS130A-125. This statute requires NCDHHS to establish and administer a Newborn Screening Program which shall include, but not be limited to, the following: 1) development and distribution of educational materials regarding the availability and benefits of newborn screening, 2) provision of laboratory testing, 3) development of follow-up protocols to assure early treatment for identified children, and provision of genetic counseling and support services for the families of identified children, 4) provision of necessary dietary treatment products or medications for identified children as indicated and when not otherwise available, 5) for each newborn, provision of screening in each ear for the presence of permanent hearing loss, and 6) for each newborn, provision of pulse oximetry screening to detect congenital heart defects.

- GS130A-127. This statute requires NCDHHS to establish and administer a perinatal health care program. The program may include, but shall not be limited to, the following: 1) prenatal health care services including education and identification of high-risk pregnancies, 2) prenatal, delivery and newborn health care provided at hospitals participating at levels of complexity, and 3) regionalized perinatal health care including a plan for effective communication, consultation, referral and transportation links among hospitals, health departments, physicians, schools and other relevant community resources for mothers and infants at high risk for mortality and morbidity.

- GS130A-129-131.2 These statutes require NCDHHS to establish and administer a Sickle Cell Program. They require that LHD provide sickle cell syndrome testing and counseling at no cost to persons requesting these services and that results of these tests will be shared among the LHD, the State Laboratory, and Sickle Cell Program contracting agencies which have been requested to provide sickle cell services to that person. In addition, these statutes establish the Governor's Council on Sickle Cell Syndrome, describing its role and the appointments, compensation, and term limits of the council members.

- GS130A-131.8-9 These statutes establish rules regarding the reporting, examination, and testing of blood lead levels in children. Statutes 131.9A-9G include requirements regarding the following aspects of lead poisoning hazards: 1) investigation, 2) notification, 3) abatement and remediation, 4) compliance with maintenance standard, 5) certificate of evidence of compliance, 6) discrimination in financing, 7) resident responsibilities, and 8) application fees for certificates of compliance.

- GS130A-131.15A. This statute requires NCDHHS to establish and administer Teen Pregnancy Prevention Initiatives. The statute describes the management and funding cycle of the program, with the Commission for

Public Health adopting rules necessary to implement the initiatives.

- GS130A-131.16-17. These statutes establish the Birth Defects Monitoring Program within the State Center for Health Statistics. The program is required to compile, tabulate, and publish information related to the incidence and prevention of birth defects. The statutes require physicians and licensed medical facilities to permit program staff to review medical records that pertain to a diagnosed or suspected birth defect, including the records of the mother.

- GS130A-152-157. These statutes establish how immunizations are to be administered, immunization requirements for schools, child care facilities, and colleges/universities, and when and how medical and religious exemptions may be granted.

- GS130A-371-374. These statutes establish the State Center for Health Statistics within NCDHHS and authorize the Center to 1) collect, maintain, and analyze health data, and 2) undertake and support research, demonstrations and evaluations respecting new or improved methods for obtaining data. Requirements for data security are also found in the statutes.

- GS130A-422-434. These statutes establish the Childhood Vaccine-Related Injury Compensation Program, explain the Program requirements, and establish the Child Vaccine Injury Compensation Fund.

- GS130A-440-443. These statutes require health assessments for every child in this State enrolling in the public schools for the first time and establish guidelines for how the assessment is to be conducted and reported. Guidelines for religious exemptions are also included.

III.B.2. State Title V Program

III.B.2.a. Purpose and Design

The mission of the NC Title V Program, to support and promote the health and well-being of NC individuals including mothers, infants, children, youth, and their families to reduce disparities and improve outcomes, aligns well with the goals of Title V. The NC Title V Program works closely with local, state, and national partners and serves as a critical collaborator and convener. From reproductive life planning and preconception health to perinatal and infant health to child/adolescent health including those with special health care needs, the NC Title V Program emphasizes a life course approach to achieving health for all populations, valuing evidence-based and evidence-informed strategies in promoting health, while following guidelines around best practice. Given the importance of cross-sector work, the NC Title V Program leverages the expertise and experience of our many partners and leaders in the state.

In providing preventive health services, programs for CYSHCN, as well as a wide range of programs addressing well-being of mothers, infants, children, and families, the NC Title V Program partners with our LHDs and other community agencies as experts in engaging local communities and stakeholders, while we provide regional consultation, training and technical assistance, and statewide leadership and vision. For example, an array of preventive health services is offered in virtually all LHDs, allowing most clients to receive a continuum of reproductive health services at a single site. Standards for provision of NC Title V Program supported prenatal and postpartum services are based on the ACOG guidelines. These standards have been revised to be consistent with best practices derived from the current scientific literature as well as with the relevant NC regulations and are published in the Maternal Health Policy Manual. They are also consistent with the new eighth edition of the American Academy of Pediatrics/ACOG Guidelines for Perinatal Care. Because of the consistency with these nationally recognized guidelines, there is a good case to be made that these standards should also provide the basis for standards for the prenatal care provided by Medicaid managed care and ultimately commercial managed care agencies. Consultation and technical assistance for all contractors is available from NC Title V Program staff members with expertise in nursing, social work, nutrition, health education, and medical services. Staff members include regional consultants who routinely work with agencies within assigned regions.

The NC Title V Program focuses on ensuring access while also facilitating a strategic approach utilizing data, needs assessments and convening partners and leaders in the development of strategic plans, including but not limited to the Perinatal Health Strategic Plan, the CYSHCN Strategic Plan, and the NCDHHS and DPH Strategic Plans. Despite substantial successes, the NC Title V Program remains challenged by a variety of systemic barriers and recognizes that there is still much work to be done to fully integrate a systems approach in NC. While there is a strong commitment to addressing community health factors to achieve health for all, as described in the Perinatal

Health Strategic Plan, this work will take time. The NC Title V Program is central to the current NCDHHS priorities of increasing behavioral health services and resilience, promoting child and family well-being, and growing a strong and inclusive workforce, and will continue to advocate for North Carolinians. The NC Title V Program continues to work with our partners to help us achieve our goals and create a more strategic vision for NC, while maintaining the safety net, public health infrastructure at our LHDs, and a focus on evidence-based programs for maternal and child health.

The Title V Office was recently moved to the Women, Infant, and Community Wellness Section (WICWS) within DPH. This move will allow for better coordination across the WICWS, which leads programs that cover the entire maternal and child health population, including a number of programs that are not Title V funded. The expertise within the WICWS provides additional support for Title V funded activities and the compilation of this report.

WICWS/Title V has extensive experience in administering a complex array of programs throughout the state which promote the well-being of women, infants, and children. It is the home of reproductive health/family planning, Teen Pregnancy Prevention Initiatives, maternal health, and infant mortality reduction efforts, along with the state's Sickle Cell Program. These program efforts are implemented in collaboration with local health departments, community health centers, community-based organizations, universities and other entities. The work involves critical engagement and centering with individuals of lived experience. Implementation also includes utilizing evidence-based, evidence-informed, and promising practices to address MCH outcomes.

As a partner, NC Title V has provided leadership in MCH across the state. The Title V Director serves on the Child Fatality Task Force, a legislative study body inclusive of legislators, agency heads, and other partners within the state. Appointments are made by the Governor, House, and Senate leadership. This commission examines data surrounding child deaths and develops strategies to prevent them in the future. The vast majority of the child deaths occur within the first year of life and thereby the work is led within the Perinatal Health Committee. More recently this committee has developed policies and recommendations related to safe sleep, levels of care development and implementation, doula reimbursement through Medicaid, breastfeeding support, and certification of professional midwives. The Perinatal Health Committee is led by two co-chairs with one being the WICWS Chief/Title V Director. Title V has provided leadership in developing a Doula Action Plan inclusive of what is needed for doula reimbursement and doula support in the state. It has also convened Action Teams related to updating neonatal levels of care and developing health system's maternal levels of care. Title V is currently partnering with Medicaid to establish a 24-hour breastfeeding hotline.

Title V is the home of the Maternal Mortality Review Committee as well. This committee was established by legislation in 2015, and members are appointed by the Secretary for DHHS. The MMRC is tasked with reviewing all maternal deaths in NC and making recommendations for improvement. The MMRC also determines if the death was pregnancy related or pregnancy associated. This dedicated group of volunteers are inclusive of clinical and non-clinical members representing maternal health advocacy, nurse midwifery, doula services, maternal fetal medicine specialist, obstetrician/gynecology, anesthesiology, legal, behavioral health, medical examiner, and nursing. The co-chairs work closely with the MMRC Program Manager to ensure that meetings are run efficiently while allowing sufficient time for discussion. The team of nurse and social work abstractors take the lead in providing the story for each woman that has lost her life while pregnant or within one year of the end of pregnancy. Recommendations include system, provider, and community impacts.

The Maternal, Infant, and Early Childhood Home Visiting Program is also housed within Title V. The MIECHV team leads collaborative efforts including the statewide Home Visiting Consortium. This group coordinates efforts with other programs serving pregnant and postpartum women and their children. Quarterly meetings of the Home Visiting Consortium allow for training, information sharing, and networking. It also reduces the likelihood of service duplication.

The Title V Director also serves on the leadership team for the Perinatal Quality Collaborative of NC. PQCNC is dedicated to improving the quality of perinatal care in the state through collaboration with hospitals, clinics, healthcare professionals, and individuals with lived experience. They serve as the lead for the Alliance for Innovation on Maternal Health (AIM) in the state. We have worked closely with PQCNC as they have led AIM initiatives related to cardiac conditions in obstetric care and obstetric sepsis. Other initiatives have included the care of the late preterm infant, comprehensively lessening opioid use disorder impact, and a birth certificate pilot. This partnership continues to focus on making NC the best place to be born.

Title V staff also participate with the Mind the Gap Initiative with March of Dimes, Postpartum Support International, and others to elevate perinatal behavioral health. More recently, Nurture NC is forming in the state. Title V staff are collaborating with foundations, business leaders, health and human service entities, individuals with lived experience,

and others to prioritize 1-2 issues related to maternal and infant health outcomes. This effort is in the early stages of development. The Title V Director and others are part of the leadership team to reduce duplication and ensure alignment throughout the process.

Title V also collaborates with NC Child and MomsRising in the state to address maternal and child health issues. NC Child is focused on eliminating barriers that impact children of all ages. Their priorities include high quality early childhood education, healthy children, and family economic security. They are seen as the voice for children in our state. Most recently, MomsRising's collaboration has focused on doula reimbursement and paid family leave.

Title V also houses the Governor's Council on Sickle Cell Disease and Related Disorders. This Council provides guidance and support for the state's sickle cell program. The 15-member Council is appointed by the Governor and is inclusive of individuals living with sickle cell disease, providers, and community members. Their work is implemented through four workgroups – Education, Legislative, Medical Research, and Client Services. The Council is a key partner with the implementation of the Sickle Cell Data Collection Program. This coordination has allowed us to have more accurate numbers of individuals living in our state with sickle cell disease along with the social determinants/non-medical drivers of health that impact them.

These ongoing collaborations and partnerships, and more, continue to contribute to improving MCH outcomes in NC. Centering efforts with individuals with lived experience remains a priority.

III.B.2.b. Organizational Structure

The NCDHHS is one of eleven agencies in the NC Governor's Cabinet and is divided into 30 divisions and offices which fall under four broad service areas – health, human services, administrative, and support functions. Divisions and offices include: Administrative Divisions and Offices (e.g., Budget and Analysis, Office of the Controller, Data Office, and General Counsel); Aging; Child and Family Well-Being; Child Development and Early Education; Disability Determination Services; Employment and Independence for People with Disabilities; Health Benefits (NC Medicaid); Health Service Regulation; Mental Health, Developmental Disabilities, and Substance Use Services; Office of Economic Opportunity; Office of Minority Health; Office of Rural Health; Office of the Secretary; Public Health; Services for the Blind; Services for the Deaf and Hard of Hearing; Social Services; and State Operated Healthcare Facilities (which oversees and manages thirteen state operated healthcare facilities that treat adult and children with mental illness, developmental disabilities, substance use disorders, and neuro-medical needs).

The Secretary of NCDHHS reports to the Governor and within his office has one Chief Deputy Secretary, a Chief Financial Officer, the State Health Director and Chief Medical Officer, and five Deputy Secretaries (in addition to the Chief Deputy who also serves as the Deputy Secretary for Operational Excellence), including the Deputy Secretary for Health under which DPH is located and the Deputy Secretary for Opportunity & Well-Being under which DCFW falls.

As described in the Program Overview, NC DPH and DCFW work collaboratively with 86 single- and multi-county LHDs. Each local public agency enters into an annual Consolidated Agreement with the DPH and DCFW that governs many public health services delivered by the local agency. Each individual service that agencies provide using state or federal pass-through funding is managed by an Agreement Addendum to this contract which contains a scope of work and specifies the standards of the services to be provided.

A list of the major programs/activities of the NC Title V Program by funding source(s) and population domain, including all those that are funded by the federal-state MCH Block Grant, can be found in Appendix B.

III.B.3. Health Care Delivery System

III.B.3.a. System of Care for Mothers, Children, and Families

NC Title V Program leadership works diligently to maximize services for low-income women and children by leveraging funds whenever possible, forming strong partnerships and interweaving funding from a variety of sources to support Title V performance measures, strengthen the integrity of the system of care and increase access for low income and disenfranchised individuals and families. The primary populations served through Title V funding are women, children, and families seen in LHDs for direct and enabling services. However, as part of the work of the Title V Program, all infants born in NC are served through newborn screening efforts, all women of childbearing age are served through campaigns to promote preconception health, and these campaigns are intentionally becoming more inclusive of male partners and fathers.

Along the MCH continuum with these initiatives, implementation of the Perinatal Health Strategic Plan (PHSP) continues. The 2022-2026 PHSP was released in August 2022 after embedding the Maternal Health Strategic Plan and Task Force into the broader structure of the PHSP. Bi-monthly Perinatal Health Strategic Plan Collective meetings are held as well as routine meetings of the Collective Leadership Team which is composed of the chairs of the five work groups: Communications; Data and Evaluation; Maternal Health; Village to Village (focused on community and consumer engagement); and Policy. These work groups meet as needed to move forward the work of the PHSP.

Title V Programs collaborate with all 84 local health departments (LHDs) in the state to support provision of maternal health, child health, and family planning services. NC Administrative codes require all LHDs to provide or assure/certify these services are provided to individuals living in their county jurisdiction. This is a critical component of our system of care for mothers, infants, adolescents, and all individuals of reproductive age.

In collaboration with LHDs, the Reproductive Health Branch coordinates the provision of a wide range of preventive care and planning services, critical to reproductive and sexual health. This service is available to all regardless of religion, race, color, national origin, disability, age, sex, number of pregnancies, marital status, or income on a sliding fee scale. The family planning clinics are supported in part with funding from Title V, Title X, other local and state funds. Programs offer a broad range of acceptable and effective family planning methods and services, including infertility services, and services for adolescents.

The reproductive health services include but are not limited to a broad range of medically approved contraceptive methods, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection services, and other preconception health services, including reproductive life planning. Every effort is made to ensure that families with incomes at or below 100% of the federal poverty level are given priority in receiving family planning services. Clients with incomes between 100% and 250% are also given priority but are charged according to a sliding fee scale.

The Maternal Health Branch oversees the provision of Title V funding to LHD to deliver low and limited high-risk prenatal care services for women in our state. A team of WICWS nurse consultants along with a nutritionist and licensed clinical social worker provide ongoing training, technical assistance, and monitoring to the LHD prenatal clinics. Services may also include health behavior intervention, skilled nursing home visits, and postnatal assessment and follow-up care. Title V also collaborates with the Division of Mental Health, Developmental Disabilities, and Substance Use Services to fund a Perinatal Substance Use Specialist position.

Care Management for High-Risk Pregnancies (CMHRP) services are also provided by most LHDs. It is an outcome-focused program, with an emphasis on improving birth outcomes through reducing the rate of preterm and low birthweight births and monitors the pregnant Medicaid population and prenatal service delivery system using data. CMHRP applies systems and information to improve care and assist members in becoming engaged in a collaborative process designed to manage medical, social, and behavioral health conditions more effectively. Meeting the varied and complex needs of members requires a holistic, person-centered approach that addresses both physical and behavioral health. A holistic approach must also consider the social determinants of health - "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Office of Disease Prevention and Health Promotion, 2016). The more complex the needs, the more comprehensive the approach should be for assisting the member with a care plan that addresses the whole person and collaborates with other systems that impact the member’s well-being.

The Care Management for at Risk Children (CMARC) Program is also operated by most LHDs in the state. This program provides care management services for children with special health care needs from birth to five years old, focusing on improving health outcomes and supporting families. The CMARC program works closely with LHDs providing child health services. Services address both physical and behavioral health needs from birth through childhood, inclusive of adolescent health.

LHDs are also responsible for implementing the Reducing Infant Mortality in Communities (RIMC) Program. It provides services to pregnant women and women of reproductive age utilizing five different evidence-based strategies that are proven to help reduce infant mortality rates: breastfeeding support services, Centering Pregnancy, doula services, infant safe sleep services, and preconception and interconception health services. The program is currently being implemented within eight local health departments, serving eleven counties in the state. Each program implements two evidence-based strategies and works with community partner organizations to provide services to individuals within the counties they serve.

In addition to LHDs, Title V works with other members of the healthcare systems. Ongoing collaborations include the NC Association of Community Health Centers. Along with LHDs, they serve as safety net providers in many communities. Title V collaborates with the NC Healthcare/Hospital Association with the implementation of several MCH efforts, including Levels of Care and Maternal Mortality Reviews. We also provide training and educational materials when requested.

In FY25, the WICWS received a second five-year HRSA State Maternal Health Innovation (MHI) grant which provides funding to assist states in collaborating with maternal health experts and maximizing resources to implement specific actions that address disparities in maternal health and improve maternal health outcomes, including the prevention and reduction of maternal morbidity and severe maternal morbidity. One stipulation of this funding was to create a Maternal Health Task Force (MHTF), which was done through partnership with the NCIOM, with this Task Force continuing to promote adoption of some of the PSOC Task Force recommendations while creating its own set of recommendations. A decision was made in March 2022 to merge the work of the MHTF into the PHSP Collective to avoid duplication of efforts. The NCIOM will continue to play a vital role in promoting the recommendations identified by the MHTF.

The North Carolina Maternal Mental Health: Making Access to Treatment, Evaluation, Resources and Screening Better (NC MATTERS) program aims to decrease barriers to screening and treating for maternal mental health and substance use disorders (MMH/SUD) by increasing the capacity of the health care professionals (e.g., obstetricians, pediatricians, family physicians, midwives, home visitors, psychiatrists) who need enhanced training and support to meet the needs of their patients. Housed within the WICWS, Maternal Health Branch (MHB), NC MATTERS contracts with the University of North Carolina at Chapel Hill (UNC) and Duke University to achieve the goals and objectives of making access to screenings, treatment, evaluation and resources for depression and related behavioral health disorders more accessible and advantageous in North Carolina.

NC MATTERS provides access to education and training, including screening and treatment support for health care professionals. These core program components are delivered through:

- A clinical psychiatric access line staffed by perinatal mental health specialists to answer patient-specific treatment questions
- Referral and resource coordination services
- Telepsychiatry assessments to perinatal patients at no cost
- Publications and toolkits as detailed guides in managing perinatal behavioral health conditions
- Training and technical assistance such as:
    - The Maternal Mental Health Fellowship, a cohort-based learning opportunity for selected providers to increase their knowledge, skills, and capacity to address MMH/SUD within their scope of practice
    - The Patient-Centered Outcomes Research Institute (PCORI) Pathways Project to implement recommended perinatal mental health guidelines into obstetric settings
- A Stakeholders Network consisting of professionals who serve as advisors in NC MATTERS program implementation and MMH/SUD care recommendations
- Outreach and engagement including practice touchpoints and participation in conferences, events, and community activities

NC Psychiatry Access Line (NC-PAL) is a free telephone consultation and education program to help health care providers address the behavioral health needs of pediatric and perinatal patients. Behavioral Health Consultants can respond to questions about behavioral health and local resources and can connect providers to on-call psychiatrists to assist with diagnostic clarification and medication management questions. Funding for this project expanded significantly through the blending of funds from multiple sources. Prior to 2021, NC-PAL was primarily funded through HRSA grants and the program's focus was on the development of the call center. In 2021-2022, NCDHHS more than doubled the investment in this program by dedicating more funding through Mental Health Block Grant and Medicaid. In 2023, HRSA awarded NCDHHS with a new 3-year grant. Mental Health Block Grant and Medicaid funds continue to support the program. With the increased funding, NC-PAL has been able to expand offerings to include the

following supports:

- Participation in daily clinical staffing calls with DHHS staff, county DSS staff, and pre-paid health plan staff to focus on children in Emergency Departments or DSS offices awaiting medically recommended behavioral health services. They provide recommendations on services, needs assessments, and medication reviews.
- Development of pilot program with four county DSS offices, working with social services staff to support better permanency planning for children with significant behavioral health needs.
- Implementation of a school training and consultation program, supporting schools with needs related to complex behavioral health challenges.
- Implementation of a pilot program for early intervention programs, providing consultation and support to local CDSAs.
- Implementation of a training initiative for psychiatrists and other practitioners to support behavioral health needs of children in their practices and local communities.

Rapid Response Team (RRT) was established in late 2020 in response to the growing number of children in DSS offices and in Emergency Departments without access to necessary behavioral treatments. The RRT process was established in state statute in 2021. RRT is a cross departmental initiative coordinated and administered by the WCHS Child Behavioral Health Unit. The cross departmental team accepts referrals from local partners for children in DSS custody awaiting necessary treatment placements. Meetings are held daily to staff the referrals with local DSS and Medicaid Pre-paid Health Plans. RRT provides the local team with support and suggestions aimed at identifying needed treatment options and also works to alleviate any state system barriers impacting access to care. In 2023, RRT facilitated calls with local DSSs and MCOs for 208 children to plan and troubleshoot challenges with access to care.

High Fidelity Wraparound (HFW) services assist families when youth experience mental health or behavioral challenges. HFW professionals partner with youth and families to identify their specific priorities and goals, assemble a team that gives them the support they want and need, and develop a process that empowers them to achieve their unique vision for the future. HFW is evidence-based and nationally standardized. In July 2021, less than a third of all counties in NC had HFW services available to their residents. By June 2022, 66% of counties had HFW services available to families in their area. By the end of calendar year 2023 HFW services were available in 76% of NC counties and services will be expanded to the remaining counties over the next year. In 2023, NC received a three-year Substance Abuse Mental Health Administration grant to support the continued expansion of this service and to support System of Care expansion in the state. The grant will provide start-up funds to expand HFW services, improve identification of children for HFW, and increase training and support for local System of Care Collaboratives.

According to data from the interactive NC Health Professions Data System, in 2024, for NC as a whole, there was an average of 7.74 physicians with a primary care practice per 10,000 individuals. However, 33 counties have relatively few primary care physicians (less than 4 per 10,000 people) and one county did not have any primary care physicians. NC also has an increasing shortage of health care professionals performing deliveries, and there have been eight rural hospital closures since 2010 in NC. Also in 2022, there was an average of 1.58 physicians whose specialty was general pediatrics per 10,000 population, but nineteen counties did not have any pediatricians. NC has several children's hospitals nationally ranked in pediatric specialties, but access to these hospitals is often difficult for children not born in nearby cities and counties.

The Positive Parenting Program (Triple P) System in NC consists of the NC State Partnership for Strategy and Governance (PSG), the NC Triple P Support System (which consists of Triple P America, The Impact Center at UNC FPG, and Positive Childhood Alliance), the Triple P Design Team (The Impact Center and Triple P America), and the lead implementing agencies (LIAs). This system practices model flexibilities designed to maximize LIA and practitioner service delivery. The PSG (leadership level) practices flexibility with regards to deliverables, especially relative to the "Scale-Up Plan." LIAs makes efforts to work towards their developed goals and objectives based on community need and infrastructure to determine scaling counties (those with Triple P online and levels two to four) and supporting counties (non-scaling) to allow for flexibility. The current operating principle is that the Scale-Up Plan, which emanated from the Strategic Plan, is a "living" document, and allows for the flexibility of editing and revising at any time that it is a reasonable expectation to do so. The NC Triple P Support System worked with each LIA to assess the training and support needs of local practitioners to deliver Triple P as part of their work.

The WCHS supports the Triple P System in NC through Title V and the NC Division of Social Services (DSS) funding by employing a State Triple P Coordinator, funding the LIAs for infrastructure and training support, and providing a part-time data specialist to work in coordination with the WCHS Data Manager to support statewide data collection and reporting and using data for local CQI projects.

In addition, the WCHS partners with the NC DSS to support Incredible Years and Strengthening Families cohorts in

local communities and integrate those evidence-based family strengthening programs with Triple P as those initiatives are very compatible and integrate well with Triple P. The WCHS receives funds from DSS to provide additional funding for the LIAs and provide a co-chair for the PSG with the State Triple P Coordinator serving as the other co-chair. DSS utilizes the Triple P evidence-based program in their menu of approved family strengthening programs, that can be supported by local DSS funds.

The Triple P State Learning Collaborative, consisting of all the coordinators at the LIAs, continues to provide a learning environment in which coordinators meet to learn, share, and plan to implement best practices, offer collective problem solving and efficiencies, determine sustainability needs, and encourage model fidelity based on the Triple P Implementation Framework. The Collaborative members are an incredibly effective group of Triple P partners/coordinators who consistently provide perspectives for quality assurance and improvement for the operationalization of the Triple P Program.

With the addition of state appropriations transferred from DSS to the DCFW under an annual agreement, Triple P coverage has been expanded to all 100 counties in NC, which includes Triple P Online that is available statewide at no cost to families. In addition, hybrid support continued to be offered to families. Hybrid support refers to the active engagement of a practitioner in aiding a caregiver's comprehension of the Triple P Online modules' content and lessons. This involves the practitioner regularly checking in with the caregiver, providing answers and clarification for module concepts, assessing the caregiver's understanding of the learning goals, and encouraging the completion of all modules.

The partnership between DCFW, DSS and The Duke Endowment has continued to support the implementation of Triple P to ensure consistent delivery and availability of model implementation in all regions, a process referred to as the “Practitioner Round-Up” continues to be implemented that required all LIA Coordinators to seek out and follow up with all trained practitioners to assess their current status relative to delivery of the model at their agency. This process is in place to ensure that investments made in practitioner training at the local level are being sustained with full access to Triple P services as needed. The Practitioner Round-Up survey has been transformed into the Practitioner Impact and Needs Evaluation (PINE) report since the “Round-Up survey process proved to be a challenge in some cases with practitioners moving outside the service delivery region and/or having changed agencies or careers, thus no longer providing services. The hope for the PINE report is to streamline data collection processes for LIAs and practitioners informed by regular input from LIA data team leads during weekly data team meetings in addition to data requests from funders.

III.B.3.b. System of Services for CSHCN

Services and resources for CYSHCN are included within all programs and initiatives under the NC Title V Program. Within DCFW, each section (WCHS, Early Intervention, Community Nutrition Services, and Food and Nutrition Services) delivers programming to CYSHCN and their families. In relation to WCHS, all programmatic units (Best Practices, Child and Family Wellness, School, Adolescent and Child Health, Child Behavioral Health and Genetics and Newborn Screening) house programs serving CYSHCN and families to promote a whole child health approach This intra-agency approach is comprehensive, helping to ensure that all programs that serve young children, youth, and their families also provide for the subset of CYSHCN. There is no longer a discreet, separate agency/office or program for CYSHCN in NC as exists in many other states. The NC Title V Program does not reimburse for services directly but supports the provision of services to children and youth who are not enrolled in Medicaid by contracting with LHDs, community-based organizations and major medical facilities. For example, WCHS contracts with multiple entities to provide a variety of services for CYSHCN, such as the Positive Parenting Program (Triple P), Innovative Approaches (system changes), genetic services, evaluation and treatment of communicative disorders related to hearing loss, care management for at-risk children (CMARC), school nurses supervising specialized clinical services and associated health teaching for students with chronic conditions and other special health needs, and reimbursement to family and youth partners for time spent informing section efforts from development to implementation and evaluation. In addition, WCHS staff are supported by Title V to provide training and technical assistance to various audiences: Birthing hospitals, LHDs, Head Starts and allied health professional organizations to support newborns and toddlers with hearing loss; home visitors; Child Care Health Consultants (CCHCs); school nurses; CMARC care managers and child health nurses at LHDs; pediatricians; Innovative Approaches 2.0 agencies, families, dental providers; and partners for NC System of Care (SOC) child behavioral health initiatives. To the greatest extent possible, services are offered within family-centered, community-based systems of care.

Work on a revised CYSHCN Strategic Plan for the WCHS was initiated in spring 2025 which will build on the concepts of the plan created in 2017 based on the Standards for Systems of Care for CYSHCN and will center

around the six core outcomes measured through the NSCH that indicate whether NC has a well-functioning system of services for CYSHCN. Latest data from the 2022-23 NSCH show that 15.6% of parents of CYSHCN responding indicated that their child was receiving care in a well-functioning system. While this was a slight increase from the 2021-22 NSCH result of 11.1%, there really has been no change in the results since the 2018-19 NSCH as the confidence intervals overlap. State rates do not differ much from national rates, with the US rate for 2022-23 being 13.1% (with overlapping confidence intervals with the NC rate). These survey results show that there is still much room for improvement in NC's system of care for CYSHCN. The hope for updating the strategic plan is to integrate tenets into the strategic plan to advance and strengthen the system of services for CYSHCN, their families and caregivers building on lessons learned as participants in the National Center for a System of Services for CYSHCN Learning Collaborative. The strategic plan will be updated through the collection and convening of various system partners to inform recommendations and action steps to implement and monitor to assess progress. The following describes the current system of services for CYSHCN in NC.

With regard to families as partners in decision-making, CMARC, which serves CSHCN from birth to 5 at no charge, involves parents/caregivers in the decision-making process to maintain a collaborative partnership approach. WCHS Family Partners develop, implement and deliver a cadre of various trainings to parents/caregivers to continuously ensure that trainings are responsive to the needs of parents/caregivers. Additionally, resources including toolkits related to medical home, dental home and more are incorporated into these trainings for parents/caregivers to use. When it comes to dental home, families through the Commission on CSHCN have expressed the barriers they encounter concerning dental care for their children and youth. This has led to Family Partners restructuring the dental home training delivered to parents/caregivers and dental providers. Family Partners also inform, create and evaluate activities, such as creating and/or leading support groups, participating in learning collaboratives, serving as co-chairs (e.g., Genetics and Genomics Advisory Committee, EHDI Advisory Committee) and/or members for program advisory committees, contributing to needs assessments, attending block grant reviews, attending and/or presenting at conferences, drafting and submitting stories and testimonials for the CYSHCN website, and reviewing the CYSHCN website. To address the lack of family partner leadership for the WCHS Family Partner Engagement and Leadership Committee, a Family Partner will now serve as a co-chair alongside the Family Liaison Specialist. The WCHS largely centers family voice and is taking steps to collaborate more with youth. Youth serve as partners, advocates, leaders and trainers for SOC and advocacy efforts for child behavioral health alongside family partners. Furthermore, planning is underway to have a summit to convene various programmatic youth groups to connect and inform a strategic plan, including YSHCN. Lastly, YSHCN reviewed and provided feedback for the health care transition from pediatric to adult health care component of the newly formed medical home training.

As for medical home, there are numerous programs that address this core outcome for children, including CYSHCN. Social Security Disability Insurance links families to resources to help them find a medical home. CMARC care managers and home visitors partner with families, primary care providers, LHDs, NICUs, hospitals, DSS, WIC, early intervention, and other community partners to foster a patient-centered medical home approach. State child health nurse consultant (SCHNC), regional child health nurse consultants (RCHNCs), and the DCFW Senior Medical Director (SMD) provide technical assistance and consultation to LHDs to support the medical home approach. Some LHDs serve as a medical home while others communicate with or link families to a medical home. LHDs are required to link families to a medical home as part of Medicaid requirements for well visits at all ages. To decrease the number of families choosing to leave the CMARC program before goals and needs are met, the SCHNC and RCHNCs will continue to provide technical assistance to develop patient-centered care plans. School health nurse consultants (SHNCs) deliver consultation and technical assistance to local school nurses to support medical homes of students. School Health Centers (SHCs) ensure students enrolled or served have a medical home. The Community Outreach Team centers messaging about the importance of choosing a quality medical home during outreach activities. Furthermore, the training cadre for parents/caregivers includes *Teaching Parents of Children and Youth with Disabilities About the Medical Home Approach* and *Dental Home Strategies for Success.* The Rapid Response Team in child behavioral health works with multiple divisions and other entities, including a pediatric psychiatrist and psychologist for daily team meetings, providing consultation on diagnoses and medication, behavioral interventions, and referral to appropriate services.

For adequate health insurance, the Community Outreach Team staffs the toll-free statewide CYSHCN Help Line (which includes insurance as a demographic question of all participants) and responds to inquiries, including those about insurance and conducts outreach to communities through community partner events to promote enrollment in and provide assistance in navigating children's health insurance programs. The Community Outreach Coordinator serves as the co-chair of the NC Coalition to Promote Health Insurance for Children which provides a forum for statewide collaboration on outreach. State CMARC nurse consultants and local CMARC care managers collaborate with advanced medical homes and health plans in addition to support CSHCN who are underinsured and uninsured. Home visitors monitor continuity of insurance coverage for at least six consecutive months since enrollment in home

visiting as one of the MIECHV performance data measures. Regarding the launch of Medicaid Tailored Plans, families have had questions which the Commission of CSHCN has helped to answer by inviting senior representatives from the LMEs/MCOs.

In relation to early and continuous screening, DPH and WCHS work together to ensure screening (metabolic, heart and hearing) and follow up for infants in NC. To assess children's development, home visitors ask primary caregivers if they have any concern regarding their child's development, behavior or learning; provide individualized developmental support; and refer families to EI (comprised of sixteen Children's Development Services Agencies [CDSAs] throughout the state) to receive an evaluation or other community services; complete the Ages and Stages Social-Emotional Questionnaires; and complete developmental screenings. The SCHNC and the RCHNCs alongside the DCFW SMD provide technical assistance to LHD providers on the Medicaid requirement to provide, document, and discuss the results of developmental screenings with families. Additionally, developmental surveillance and/or a variety of screenings (developmental, behavioral health, psychosocial, and community factors) are provided at each well visit though services provided by LHD clinics and outreach to primary care providers via the NC Pediatric Society. Also, local CMARC managers include general developmental screening using the Survey of Well-being of Young Children (SWYC) and Life Skills Progression Assessment tools.

For ease of community-based services, home visitors refer families to helpful resources. Referrals for resources in the community help families improve the quality of the home environment. Referrals can include child development, support for those experiencing intimate partner violence, parent support groups, literacy programs, housing, child care, transportation, parenting classes and mental health providers as an example. Regarding EHDI, families are linked to various community-based resources, including but not limited to parent consultants, organizations serving families, family fun days, parent-professional collaboratives, the Family Focus newsletter, and the Deaf and Hard of Hearing (DHH) Heroes Program. CCHCs who are trained to support CSHCN also serve as a community-based resource for early care educators. Regarding the CYSHCN Help Line, majority of call reasons relate to access to community services/resources and result in referrals to a variety of community-based resources to meet the needs of callers. In addition to staffing the help line, the Community Outreach Team promotes community-based resources and state programs when tabling at community partners' events. The CYSHCN webpage and training cadre reference community-based resources. CMARC care managers offer families referrals to community resources to meet the specific needs of families. For child behavioral health, SOC Community Collaboratives (CC) are community-based groups comprised of family members, child-serving public agencies, and private providers that work with families, school systems, community-based organizations, and other stakeholders concerned with the behavioral health of all children in their community. CCs bring together families and child representatives across different sectors to support coordinated service delivery and problem-solving.

When it comes to transition from pediatric to adult care, there has been a lack of strategies addressing this due to staff vacancies in the past few years. However, work has begun to better center transition from pediatric to adult health care. All the Innovative Approaches 2.0 (program to promote system changes for CYSHCN) grantees will focus on health care transition from pediatric to adult care. Additionally, the NC Office on Disability and Health (NCODH) Director serves as co-chair of the UNC-Chapel HIll Whole Brain Health Program Advisory Council for assuring a cross-systems approach to addressing transition for youth with autism and/or epilepsy. *Teaching Parents of Children and Youth with Disabilities About the Medical Home Approach* includes a module about transition from pediatric to adult care. Lastly, the DCFW SMD will work with the SHCs Program Manager to provide technical assistance and consultation to support YSHCN with health care transition from pediatric to adult care.

III.B.3.c. Relationship with Medicaid

The NC Title V Program has a history of partnering with NC Medicaid (NC Division of Health Benefits [DHB]) to ensure quality services and programs. Title V Program staff members serve on different interagency NC Medicaid committees to plan, coordinate, and evaluate Medicaid services. The current Title XIX Medicaid Inter-Agency Agreement (IAA)/Memorandum of Agreement (MOA) which is included as an attachment to this application details the specifics of areas of coordination and collaboration between NC Medicaid, DPH, and DCFW.

The NC DHB's enrollment dashboard for Medicaid reflects the number of people by county and program aid category who are authorized to receive Medicaid services for each report month. As reported in the NC Medicaid Annual Report for State Fiscal Year 2024, in SFY24, NC Medicaid provided access to care and services to more than 3 million people in the state, with many served through outreach and enrollment efforts of Title V programs and partners. According to the 2023 NC Composite Linked Birth File, 51% of all resident births were to women receiving Medicaid. NCDHHS launched Medicaid Expansion on December 1, 2023, which increased the eligible population to adults aged 19-64 who have incomes up to 138% of the federal poverty level. Approximately 273,000 people, most of whom had been receiving Medicaid for family planning coverage alone, were covered on the first day of

enrollment. NCDHHS projected that the state's enrollment under expansion would reach 600,000 within two years, but this goal was reached within one year on December 16, 2024. As of May 4, 2025, there were 656,676 people enrolled.

NC Title V Program and NC Medicaid staff members work together to coordinate outreach efforts for NC Medicaid care management programs serving high-risk pregnant women and at-risk children ages 0-to-5 as well as for other programs serving the MCH population such as the NC "Be Smart" Family Planning Medicaid Program. In addition, the WCHS has a Community Outreach Team who assist with enrolling eligible children into NC Medicaid. A description of their work is found in the CYSHCN Domain Annual Report. The Title V Program also participates in the Pediatric Advisory Group and the Maternal Health Advisory Group convened by the PQCNC to provide direct input to the DHB on current projects and ensure quality MCH programs. WICWS staff members attend monthly Medicaid Maternal Health meetings and bi-monthly NCDHHS Maternal Health Learning Collaborative meetings.

Legislation to transform and reorganize NC's Medicaid and NC Health Choice programs from fee-to-service to managed care was passed in September 2015, with additional legislation mandating that Medicaid transformation happen by July 1, 2021. The goal of the state's transition to managed care is to improve the health of North Carolinians through an innovative, whole person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health. NCDHHS created the NC Medicaid Managed Care Quality Strategy which details the aims, goals, and objectives for quality management and improvement and details priority QI initiatives, incorporating the quality activities of all managed care plans, including the BH I/DD Tailored Plans, the Eastern Band of Cherokee Indians (EBCI) Tribal Option, and Community Care of NC.

All beneficiaries moving to NC Medicaid Managed Care were enrolled in one of five health plans or the EBCI Tribal Option. All health plans offer the same basic benefits and services, although some health plans offer added services, and some plans may require a copay. Beneficiaries had the option of selecting a health plan during open enrollment by calling the NC Medicaid Enrollment Broker Call Center, going to www.ncmedicaidplans.gov, or using the free NC Medicaid Managed Care mobile app. Those beneficiaries who did not choose a health plan were automatically enrolled in a health plan by NC Medicaid, and the auto-enrollment process prioritized existing relationships between beneficiaries and their primary care provider. Federally recognized tribal members living in the Tribal service who did not choose a health plan were enrolled into the EBCI Tribal Option which is primarily offered in five counties (Cherokee, Graham, Haywood, Jackson, and Swain.)

All pregnant women enrolled in NC Medicaid Managed Care through a health plan continue to receive a coordinated set of high-quality clinical maternity services through the Pregnancy Management Program (Pregnancy Medical Home), administered as a partnership between the health plans and local maternity care service providers. A key feature of the program is the continued use of the standardized screening tool to identify and refer women at risk for an adverse birth outcome to the Care Management for High-Risk Pregnant Women (CMHRP) program, a more intense set of care management services that will be coordinated and provided primarily by LHDs. The Care Management for At-Risk Children (CMARC) program, provided mostly by LHDs for at-risk children ages 0-to-5, promotes use of the medical home, links children and families to community resources, and provides education and family support. Often staff members work across both the CMHRP and CMARC programs. The WICWS CMHRP Program Manager meets regularly with the DCFW CMARC Program Manager to ensure program policies align closely to support the implementation of best practice. The CMHRP Program also maintains a strong relationship with CMARC because infants of members who receive CMHRP services are sometimes eligible for CMARC services so referrals from CMHRP to CMARC are often made after delivery. The Programs work to maintain a smooth transition from one care manager to another, or it is possible the family may maintain the same care manager in some cases. The right of first refusal for LHDs to provide care management services for high-risk young children and pregnant women was extended an additional year to June 2025. NC Medicaid has created a process to assess LHD performance in providing care management services for the CMHRP and CMARC populations with specified benchmarks for managed care plan contracting requirements for FY26.

The NC budget law for FY23 directed NCDHHS to submit any necessary State Plan amendments to the CMS for the merger of the NC Health Choice program into the NC Medicaid program to occur no later than June 30, 2023. Effective April 1, 2023, NC Health Choice beneficiaries automatically moved to the Medicaid program with no action

needed by beneficiaries or providers.

The BHI/IDD Tailored Plan which covers doctor visits, prescription drugs, and services for mental health, substance use, intellectual/developmental disabilities (I/DD), and traumatic brain injury in one plan launched July 1, 2024. Approximately 220,000 North Carolinians are now enrolled. Tailored Plans are managed by the Local Management Entities Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health. NC Medicaid partnered with the DMH/DD/SUS to provide beneficiaries with accessible communications and resources to help them better understand NC Medicaid programs and policies. Tailored Plan website traffic increased from 800 visits per week to 3,600 visits per week after the toolkit launched.

As part of the transition to Medicaid Managed Care, NC launched the Healthy Opportunities Pilot (HOP) program in spring 2022. Up to $650 million in state and federal Medicaid funding was authorized for these pilots which operationalize Medicaid payments, using a standardized fee schedule, for evidence-based, non-medical services that address social needs. The HOP program, which operates in three regions of NC covering 33 counties, began covering 24 non-medical services that address needs related to food, housing, transportation, and toxic stress during spring/summer 2022. The HOP program uses the NCCARE360 platform for service authorization, referrals, and invoicing of HOP program services. In FY24, more than 20,000 enrolled beneficiaries received more than 461,000 non-medical services across 33 counties. An interim evaluation found that that HOP resulted in lower health care expenditures to participants, fewer emergency department visits, and improved social needs. NC is seeing $1,020 in annual health care costs savings per Healthy Opportunities enrollee, and stronger local economies that are supported by local businesses from family farms to home repair. NCDHHS renewed the federal 1115 waiver in October 2023 which included a request to allow expansion of Healthy Opportunities statewide.

III.B.4. MCH Emergency Planning and Preparedness

The NC Title V Program follows guidance from the NC Emergency Operations Plan (NCEOP) as part of the Department of Public Safety. According to NCEOP 2024 Plan Foreword, the NCEOP “establishes a comprehensive framework of policy and guidance for state and local disaster preparedness, response, recovery and mitigation operations. The plan details capabilities, authorities and responsibilities. It establishes mutual understanding among federal, state, local and other public and private non-profit organizations. The NCEOP is designed for worst case scenarios – to include catastrophic events.” In addition, it describes a system of how to effectively use both federal, state, and local government resources as well as private resources and is intended in all instances to be consistent with the National Incident Management System. The NCEOP is reviewed annually, with the most recent updates posted in August 2024 (prior to Tropical Storm Helene impacting the state). If, after the annual plan review, more than 25% of the content requires a change, a revision occurs to the plan. The most recent revision of the NCEOP was in December 2017, with only updates (<25% of the content changed) occurring at least annually since then.

Again, per the NCEOP 2024 Plan Foreword, “Chapter 166A of the North Carolina General Statutes establishes the authority and responsibilities of the Governor. The Governor delegates authority to the Secretary of the Department of Public Safety who will serve as the State Coordinating Officer (SCO) and will be responsible for direction and control of state operations. The Secretary of the Department of Public Safety delegates authority to the NC Emergency Management (NCEM) Director who is granted the responsibility and authority to respond to emergencies and disasters as the State Emergency Response Team (SERT) Leader.”

The Operations Section of the SERT is responsible for coordinating and directing state government and emergency management field activities in response to emergencies and recovery from disasters. There are four branches that fall under the Deputy Operations Chief which are Communications, Emergency Services, Human Services, and Infrastructure. While the needs of the MCH population are considered under each of these branches, they are particularly supported by the Emergency Services Branch as they manage the delivery of health and human related services in times of disaster for all citizens, but especially the most vulnerable including children, elderly, disabled, and low-income families. The SERT is comprised of subject matter experts from state agencies, including DPH, private industry, voluntary, and faith-based organizations. The MCH populations are included in the access and functional needs category which is housed under the human services section of the Emergency Management Structure. Historically, there has not been a representative with subject-matter expertise in MCH in the human services section. When this expertise is needed, someone from the MCH team is requested.

DPH activities, coordinated under the leadership of NCDHHS and supported by Public Health Law, Chapter 130A of the NC General Statutes, include assessment of public health needs, human health surveillance, food and drug device safety, public health information, vector control, biological hazards, and victim identification and mortuary services, among others. There is a Public Health Preparedness and Response Steering Committee that meets quarterly as part of the Communicable Disease and Biohazard Response Operations, and the University of North Carolina houses a Center for Public Health Preparedness which delivers training, conducts research, and provides technical assistance to public health professionals statewide. If there is an infectious disease outbreak, the Public Health Command Center will be activated. The NC Public Health Information Network (NCPIHN) is used to monitor and provide alerts for cases and outbreaks of human illness and integrates routine disease surveillance, syndromic surveillance through the NC Disease Event Tracking and Epidemiologic Collection Tool (NCDETECT) and the Health Alert Network (HAN). NC DPH also leads the Public Health Heat Emergency Response Work Group.

The NC Title V Program is frequently involved in response activities, whether it be in response to hurricanes that frequently impact North Carolina or the COVID-19 pandemic. NC Title V Program staff work closely with others on activities such as making sure that vaccine is appropriately stored and distributed where needed under adverse conditions, that metabolic formula reaches those families in need, shelters are staffed by public health nurses, or ensuring that the nutritional needs of infants, children and families are met while maximizing flexibility under federal waivers. While the NC Title V Program is not an official member of the SERT, the Title V Director and other staff are called upon as needed depending on the type of emergency response that is warranted. NC Title V Program support for LHDs is ongoing and is enhanced during times of emergencies.

During Hurricane Helene, WICWS worked with local health departments and local health systems in western NC to support pregnant women. The health systems released guidance encouraging pregnant women who were 36+ weeks gestational to leave the impacted area. This was due to limited healthcare availability, clean water, electricity, sanitation, and other needed resources. Various communication means were utilized to help locate providers and care managers who were able to assist pregnant women to relocate and secure new providers in other parts of the state and beyond. Similar efforts occurred related to breastfeeding support. Educational materials were developed in collaboration with WIC, Breastfeed Durham, NC Breastfeeding Coalition, and others related to feeding infants in a disaster inclusive of breast and formula feeding.

One of the Sickle Cell Educator Counselors was also directly impacted by Hurricane Helene as she resided in the area. Once her communications were restored, she quickly reached out to individuals living with sickle cell disease to offer support as we worked to secure resources for them. During the aftermath of Hurricane Helene, our team also provided outreach to providers and individuals related to the Medicaid flexibilities that were established related to family planning. This included allowing services to be provided via telemedicine or in person for new and established family planning beneficiaries.

The WCHS submitted a legislative request and received funding to support child behavioral health needs in schools specifically in Western NC through a collaboration with the Department of Public Instruction. The Early Childhood Behavioral Health Program Specialist created a document in English and Spanish focused on Social Emotional Resources for Young Children and Caregivers. The Regional School Health Nurse Consultant team held a virtual Fall Update for the west and northwest lead school nurses. In addition to the standard presentation shared with all regions, time was dedicated to allowing the nurses to share their stories, needs, and consideration for ongoing support. The UNC Child Care Health and Safety Resource Center and the State Child Care Nurse Consultant provided resources for childcare health consultants and reached out to emergency preparedness trainers to confirm resources.

The Office on Disability and Health’s Director supported housing needs, while coordinating efforts with DCFW and DHHS leadership. The Early Intervention Team converted appointments to virtual or rescheduled them as needed. The Community Nutrition Services Section contacted tertiary clinics to identify unmet needs related to metabolic infant formula. They also coordinated WIC needs for residents who had relocated with their infants to other states to help with verification of certification internal and external to the state. The Food and Nutrition Services Team conducted disaster supplemental nutrition assistance program (D-SNAP) training for all counties and issued D-SNAP cards.

Staff from both WICWS and WCHS volunteered to travel to the impacted area and provided needed support and guidance during this traumatic event. This included helping local health department staff to recover and deal with their own trauma. These efforts remain today as recovery efforts continue.

The Title V Operations and Initiatives Manager participated in a Maternal and Child Health Emergency Preparedness and Response leadership academy hosted by AMCHP in spring 2025. The academy included in-person and virtual training and capacity building sessions about maternal and child health, emergency preparedness and response, and the intersection of the two. A requirement of the academy was a capstone project that would assist each participant's state or jurisdiction in better integrating the MCH populations into emergency preparedness and response. For NC, the capstone project focused on compiling lessons learned from the response and recovery efforts following tropical storm Helene. This project will leverage existing relationships across both the DPH and DCFW as well as focus on cultivating new partnerships within the NCDHHS.

Within 30 days of employment, all NC Title V Program employees are required to complete two online Incident Command System Trainings offered through the Federal Emergency Management Agency Emergency Management Institute. The courses, ICS-100: Intro to Incident Command System (ICS) and ICS-700: Intro to National Incident Management System (NIMS), provide overviews of the principles and basic structures of ICS and NIMS and explain the relationship between them.

In addition, NC Title V Program employees are required to familiarize themselves with the DPH Emergency Action Plan during orientation as well as receive a copy of the site-specific Emergency Evacuation Plan for their work location which they review with their supervisor.

The NC Office of Disability and Health has a strong partnership with SERT and NCEM. They work together to improve preparedness efforts for children and adults with disabilities through involvement in statewide workgroups including C-MIST (Communication, Maintaining health, Independence, Support and Safety, and Transportation) Advisory Committee, Shelter Accessibility Workgroup, and Functional Assessment Support Team (FAST) Workgroup.

III.C. Needs Assessment

III.C.1. Five-Year Needs Assessment Summary and Annual Updates

III.C.1.a. Process Description

NC Needs Assessment Process Goals, Framework, and Methodology

Process Goals

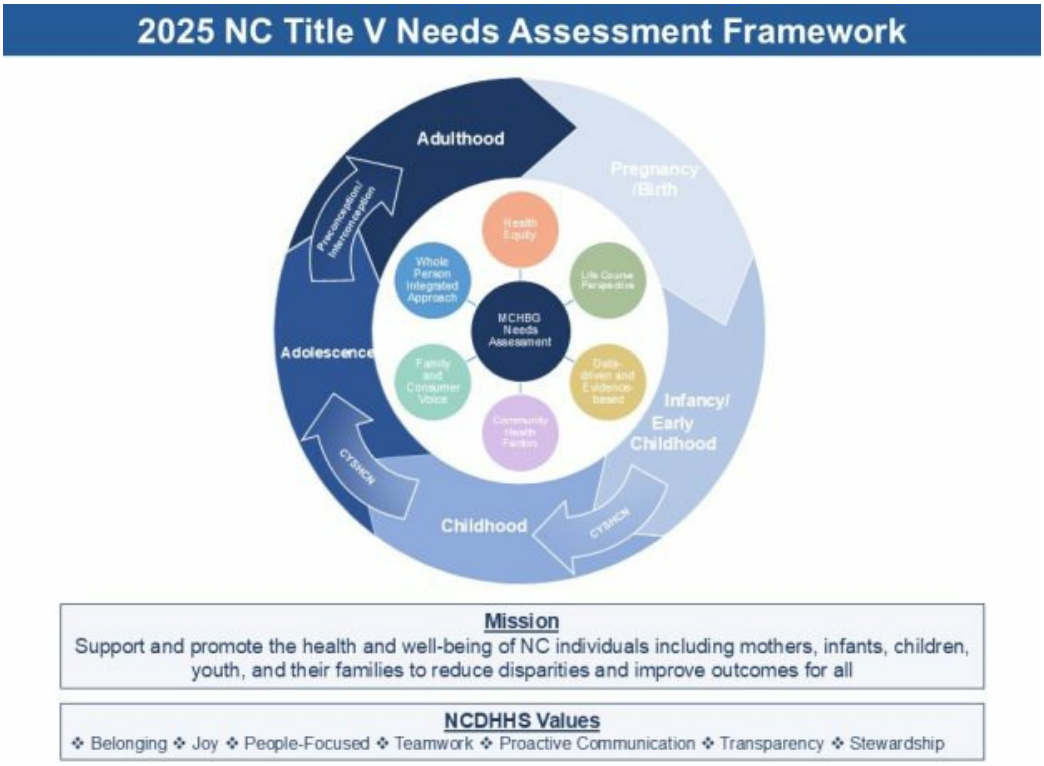
The NC Title V Program conceives of needs assessment and priority-setting as a continuous process, in which useful data, both quantitative and qualitative, relevant to the broad mission of the NC Title V Program are continuously gathered and analyzed with an eye to adjusting the priorities and the activities of the Program as appropriate. The data capacity of the NC Title V Program is strong. There is an MCH Epidemiologist and SSDI Project Coordinator housed in the NC Title V Office, and each Section within the NC Title V Program has staff members whose roles and responsibilities include coordinating data collection and analysis activities to guide effective monitoring, evaluation, and surveillance efforts and to help with program policy development and program implementation. These staff members also work directly with statisticians and data analysts in the NC State Center for Health Statistics (SCHS) who provide further analyses, as necessary. In addition to these ongoing analyses of relevant inputs, the NC Title V Program utilizes formal needs assessment processes, such as the five year MCH Block Grant needs assessment, to review and adjust Program priorities and activities. Throughout its work on the 2025 NC Title V Needs Assessment, the goal was to ensure that the needs assessment process worked in alignment with the strategic planning efforts and priorities of the Divisions of Public Health and Child (DPH) and Family Well-Being (DCFW) and the NC Department of Health and Human Services (NCDHHS) so that Title V resources could be leveraged as much as possible. The 2025 NC Title V Needs Assessment afforded the NC Title V Program an opportunity to reexamine the priority needs selected during the 2020 Needs Assessment Process and determine whether they were still useful or needed to be changed entirely.

Framework

A 2025 NC Title V Needs Assessment Leadership Team was created in January 2024 which consisted of the Title V Director; the CYSHCN Director, who is also the Whole Child Health Section (WCHS) Chief; the Women Infant and Community Wellness Section (WICWS) Chief; and the State Systems Development Initiative (SSDI) Project Coordinator. The Title V Initiatives and Operations Manager joined the Team after she was hired in June. This group met monthly to create and implement a work plan of needs assessment activities, engaging WICWS and WCHS staff throughout the process as necessary for input and ideas. One of its first activities was to determine the 2025 NC Title V Needs Assessment Framework shown below (Figure 5) which focuses on a life-course perspective driven by whole person integrated approach, community health factors, family and consumer voice, and ensuring data-driven and evidence-based approach. The intent from the start was to leverage other efforts and to align with strategic plans, programs, and projects that are already in place in NC to serve the MCH population across the life course. The MCHBG Needs Assessment was built within the context of multiple collaborative efforts, some of which are listed below:

- NCDHHS 2024-2026 Strategic Plan
- NC DPH 2023-2025 Strategic Plan
- NC Perinatal Health Strategic Plan
- Maternal Mortality Review Committee
- NCIOM Maternal Health Task Force
- NC Public Health Genomics Plan
- NC Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Needs Assessment
- NC Opioid Action Plan
- Healthy NC 2030
- NC State Health Improvement Plan
- Integrated Care for Kids (InCK)
- NC Child Fatality Task Force
- NC Blueprint for Change Learning Collaborative

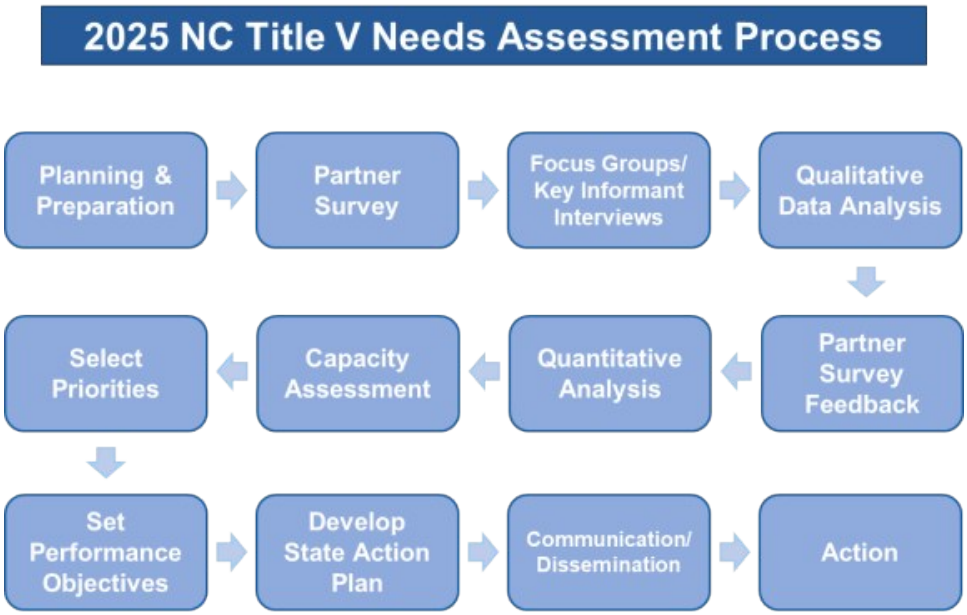
Figure 5



Methodology

The methodology used in the 2025 NC Title V Needs Assessment was a mix of qualitative and quantitative data collection from stakeholders, families, and other partners. It was an iterative process that started with a partner survey conducted in late spring/summer 2024, then moved to focus groups and key informant interviews which were held that summer and fall. An MCHBG Priority Setting Meeting was held in December 2024 to discuss the results of the partner survey and previous data collection efforts, and seven final priority needs were determined through a voting process using prioritization criteria established by the Needs Assessment Leadership Team. The general process is shown in the below figure:

Figure 6



Stakeholder Involvement, Including Families (Individuals and Family-Led Organizations)

The 2025 NC Title V Needs Assessment included lots of opportunity for involvement by Title V stakeholders, including families and community representatives, program participants, and programmatic partners and providers which are highlighted below in the descriptions of the quantitative and qualitative assessment methods.

Quantitative and Qualitative Assessment Methods

NC MCHBG Partner Survey

The first step in the qualitative data collection process of the 2025 NC Title V Needs Assessment was to conduct an electronic survey (see Appendix C) of Title partners and stakeholders to identify priorities and guide planning within the five MCHBG population domains. Partners and stakeholders received a personal invitation from the NC MCH Title V Director, the WICWS or WCHS Chiefs, or other Title V program staff to respond to the survey through a link to Dynamics 365 Customer Voice survey available in both English and Spanish. The English version was distributed to partners from May 6 to June 7, 2024, while the Spanish version was distributed from May 21 to June 10,2024. Partners included local health departments, nonprofits, universities, etc. Some examples of these entities include NC Institute of Medicine, Local Health Directors, Perinatal Quality Collaborative of NC, and NC Office of Rural Health. The WICWS of NCDHHS shared the survey with 15 partners, including the Perinatal Health Strategic Plan Collective listserv (comprised of over 500 people), the Women's Health Nurse Listserv, Sickle Cell Medical Centers, Teen Pregnancy Prevention Program staff, and many others. The WCHS shared it with 80 different partners, including the Commission of Children with Special Health Care Needs, Exceptional Children's Assistance Center, Nurse Family Partnership staff, the State Refugee Office, Disability Rights, NC, the WCHS Family Partners, and the Early Hearing Detection and Intervention and Newborn Screening Advisory Committees.

Respondents were asked to rank their top three priorities in addressing health needs or concerns for six different population domains based on the HRSA domains (women before becoming pregnant; women during and/or after a pregnancy; infants; children; youth; and children with special health care needs). A list of several concerns was provided for each domain along with a request to mention additional priorities that might not have been included. There were 763 respondents to the partner survey who represented 96 counties in NC. The majority (750 or 98%) of these respondents completed the English version of the survey, while 13 completed the Spanish version. The responders were predominantly LHD employees (53%), health care professionals (16%), or community service providers - social worker, home visitor, infant-toddler specialist, etc. (13%). State employees (6%), advocacy organization employees (2%), parents of children with special health care needs (2%), community members (2%), and members of WCHS advisory councils or coalitions (1%) also responded as well as a few insurance or managed

care organization employees and consumers (1% combined). The majority of responders were 40 years or older (73%) and White (70%). Eighteen percent of the respondents identified as Black and seven percent as Hispanic. Six percent were younger than 30 years of age. Only 5% of the respondents identified as being a man with the rest identifying as being a woman or declining to answer. Future efforts will be made to amplify the youth voice, parent/caregiver voice, and those from historically marginalized communities.

The Title V Office virtually hosted a Title V MCH Internship Team supported by the National MCH Workforce Development Center during summer 2024 which allowed two MCH students, one in graduate school at the University of North Carolina Gillings School of Global Public Health and the other an undergraduate at East Carolina University, to assist in qualitative data collection activities for the 2025 NC Title V Needs Assessment. They, with help from the SSDI Project Coordinator and the MCH Epidemiologist, and two analyzed the partner survey data.

The MCH Epidemiologist created tables and graphs by population domain with the concern areas sorted from the most often prioritized in the top three to the least. The Title V MCH interns reviewed the qualitative data included the free response section from each domain, where respondents could type anything they felt was a priority that was not included in the ranking process. The interns separately categorized the responses into five to seven themes by identifying various code words and phrases, such as development, child care, access, support, etc. Theme names were created based on categorizations, and results were compared between analysts. A collaborative final draft document was created after comparing analyses. The analysts used Chat GPT to verify the data and went through the following process six times for each domain. Free responses were pasted into Chat GPT, and analysts prompted the site to categorize the list into five to seven themes. Once the themes were provided, Chat GPT was prompted to share which free response was categorized under each theme. Analysts found that Chat GPT provided very similar theme names that were already created, thus ensuring that the process was valid. A full summary of the partner survey analysis written by the interns can be found in Appendix C, but highlighted results show that a recurring high priority theme consistently present across all domains was access to health care, which included mental health services. Mental health and development were addressed through terms such as safe and nurturing relationships, mental health programs, and mental and behavioral health services. The close relationship between physical and mental health was evident in the results. The qualitative data provided by the free responses was consistent across all six domains with the most prevalent themes being access to high quality child care and public education, along with access to high quality health care which existed in some form across each domain. The needs for education, related to reproductive health and parenting skills, and support, involving mental/emotional health and finances, were also highlighted in each domain. The tight interconnectivity of the needs across the domains reiterated the use of the life course perspective with each life stage/domain influencing the next, causing similar issues to exist in each one.

Focus Groups and Key Informant Interviews

Virtual focus groups were held by the Title V MCH interns for each of the five population domains of the MCH Block Grant. Staff members from both the Women, Infant, and Community Wellness Section (WICWS) and the Whole Child Health Section (WCHS) who had subject matter expertise in specific domains worked with the Title V MCH interns, the SSDI Project Coordinator, and the Title V Initiatives and Operations Manager to identify the focus of each discussion based on the results of the partner survey and to recruit participants. Participants received invitations via email. The Child Health focus group included seven enhanced role nurses and providers from Union, Albemarle, Dare, Cabarrus, and Surry counties. The Adolescent Health focus group included six Youth Health Advisors (YHAs) from different regions of the state. The seven Women/Maternal Health focus group participants represented Craven, Albemarle, Jackson, and Macon counties who held positions such as Maternal Health Coordinator, Registered Nurse, Director of Nursing, and Certified Nurse Midwife. Participants for the Children and Youth with Special Health Care Needs (CYSHCN) focus group included ten mothers of CYSHCN who were recruited to join by the WCHS Family Liaison Specialist. A translator was available for three bilingual participants. Lastly, the Perinatal/Infant Health focus group included one individual working for the Division of Social Services in rural NC.

Focus group guides were used to conduct the meetings via Zoom. Guides included information about the Title V Needs Assessment, meeting norms, and questions. Zoom meetings were recorded in order to accurately capture what participants said and to obtain a transcript. Answers to each question were summarized separately by the two interns and then compared to ensure a valid analysis. Focus groups lasted between 30 minutes and 1.5 hours and were conducted from July 8 to July 23, 2024. The significant work of these interns greatly contributed to a

comprehensive and informative qualitative data collection portion of the 2020 NC Title V Needs Assessment.

In addition to these focus groups, in September, the Title V Initiatives and Operations Manager and the WCHS Minority Outreach Coordinator conducted two additional virtual focus group via Zoom. The first was held with nine leaders of organizations serving immigrants and refugees in NC, and the second, which was conducted in Spanish, was with nine Hispanic/Latino adults with families.

Quantitative Data Sources

The main quantitative data sources of the NC 2025 Title V Needs Assessment, as well as the MCHBG annual reports, are the data systems that Title V, WICWS, and WCHS staff members routinely use for ongoing surveillance and needs assessment. These include the following:

- NC Maternal and Infant Health Data Dashboard
- Vital Statistics (e.g., birth and death files) from the NC State Center for Health Statistics (SCHS) including:
  - Tracking Maternal and Child Health Data in North Carolina
  - Tracking Preconception Health in North Carolina
  - NC Composite Linked Birth File
- National Survey of Children's Health (NSCH)
- Federally Available Data (FAD) for National Performance and Outcome Measures
- Behavioral Risk Factor Surveillance System (BRFSS)
- US Census Data
- Local Health Department - Health Systems Analysis (LHD-HSA)
- School Health Center Annual Report
- Healthy NC 2030 A Path Toward Health Data Book
- The NC Child Health Report Card
- WCSWeb Database
- NC Crossroads WIC System
- Title V CSHCN Help Line Data
- QuitlineNC Data
- NC Division of Health Benefits (NC Medicaid) data

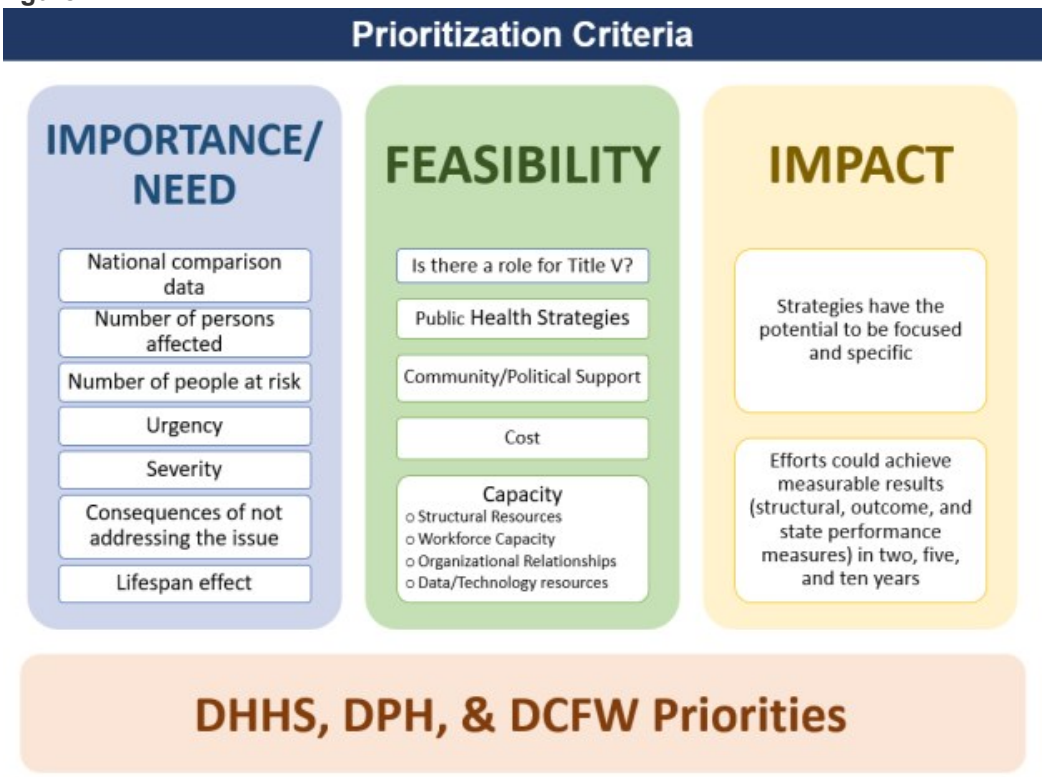
Interface between Collection of Data, Finalization of the Priority Needs, and Development of NC's State Action Plan

On December 4, 2024, the NC Title V Priority Needs Meeting was held. Branch and Unit Supervisors and other critical WICWS and WCHS staff members were encouraged to attend as well as several partners with lived experience. More than 50 people attended. The agenda for the afternoon meeting included introductions and an icebreaker and a review of the Title V Mission and the Needs Assessment Framework by the Title V Director, who also provided background context on how Title V funding is used in North Carolina and an overview of the current context of the NCDHHS priorities and how Title V activities were aligned. The SSDI Project Coordinator provided a summary of important quantitative data indicators for each of the population domains as well as the qualitative data findings from the focus groups and partner survey. Based on stakeholder feedback, the Title V Director shared potential priorities by domain that the NC Title V Needs Assessment Leadership Team had gleaned from the data collection activities, and staff members were given the opportunity to add to or modify these potential priorities. Prior to the meeting, the Leadership Team developed prioritization criteria which were summarized into this image (Figure 7). These criteria were shared with staff during the meeting along with an overview of the Title V Performance Measure Framework and a handout with recent data trends for each of the National Performance Measures (See Appendix C). A discussion period about the potential priorities was held, and then Mentimeter was used for each participant to vote for 7 to 10 priorities (and all had to vote for at least one priority in each of the domains). After the initial voting, there was a bit more discussion to come to consensus on the priority needs. In addition, staff members were encouraged to volunteer to participate in work groups by domain to develop NC's State Action Plan.

The development of NC's 2026-2030 State Action Plan was truly a collaborative effort by staff members of the NC Title V Program. During December to February, the Title V Initiatives and Operations Manager and the SSDI Project Coordinator facilitated seven work groups (one for each population domain and two Cross-Cutting/System Building

groups), ranging in membership from eight to seventeen participants, in creating the plan. A minimum of three meetings were held by each work group and ideas were generated using SharePoint documents in between meetings to finalize the wording of each of the seven priority needs and to determine the National and State Performance Measures, the Evidence-Based or -Informed Strategy Measures, and the objectives and strategies for the plan. The Leadership Team reviewed and finalized the State Action Plan in early March.

Figure 7



III.C.1.b. Findings

III.C.1.b.i. MCH Population Health and Wellbeing

Women/Maternal Health

Access to quality health care services, including mental health services, and, in particular, postpartum care and support, was one of the emerging priority needs based on the qualitative data collection and analysis for the Women/Maternal Health domain, and a review of quantitative data collection supports this need. In addition, addressing socioeconomic and other conditions affecting health, preventing maternal deaths and complications related to pregnancy, and increasing planned pregnancies were also identified as needs. 2022 Census data shows that the state's uninsured rate is the tenth highest in the country at 11.2%, and the uninsured rate for females is 9.9% which is also the tenth highest state percentage. Table 1, which compares results of the Behavioral Risk Factor Surveillance system for 2019 and 2023 for female respondents age 18 to 44, shows that while most preconception health indicators have improved or remained steady over that time period for the total population, disparities between race/ethnicities still exist. The BRFSS data indicate that Black women were more likely to have a routine checkup in the past year than white or Hispanic women and are slightly less likely to smoke or binge drink, but are more likely to experience overweight/obesity and hypertension.

Table 1 - Characteristics of Women of Childbearing Age by Race/Ethnicity North Carolina, 2019 & 2023									
Percent of women respondents aged 18 to 44 who:	Year	Total	95% CI	NH White	95% CI	NH Black	95% CI	Hispanic	95% CI
Had a routine checkup in the past year	2023	75.7	71.2-79.7	76.8	70.9-81.7	80.6	70.9-87.6	67.0	55.8-76.6
	2019	76.1	72.4-79.5	74.6	69.2-79.3	86.4	80.1-90.9	69.8	60.2-78.0
Currently have some type of health care coverage	2023	86.9	83.4-89.8	94.8	91.4-96.9	93.0	85.3-96.8	53.4	41.7-64.8
	2019	80.3	76.8-83.4	88.6	83.9-92.0	85.0	78.4-89.9	35.6	27.1-45.0
Are overweight or obese based on body mass index (BMI)	2023	56.2	50.7-61.6	58.7	52.2-65.0	64.8	52.5-75.4	61.8	47.6-74.3
	2019	62.4	58.1-66.5	55.7	49.8-61.4	73.8	65.7-80.5	67.4	55.6-77.3
Have been told by provider that they had hypertension (including during pregnancy)	2023	15.2	11.7-19.7	13.2	9.7-17.7	22.7	13.9-34.8	8.9	4.8-16.0
	2019	16.9	14.1-20.2	14.2	10.5-18.9	24.3	18.1-31.7	15.3	9.5-23.9
Currently smoke every day or some days	2023	9.7	7.0-13.4	11.2	7.8-15.7	9.9	5.1-18.3	7.4	1.4-30.6
	2019	16.9	14.0-20.3	18.7	14.6-23.7	16.9	11.7-23.9	5.7	2.8-11.3
Participated in binge drinking on at least one occasion in the past month	2023	14.9	11.6-18.9	17.9	13.6-23.2	17.1	8.4-31.8	9.4	4.9-17.3
	2019	17.3	14.4-20.7	20.2	16.0-25.1	14.3	9.5-20.9	9.6	5.2-16.9

The most comprehensive postpartum care service data available for North Carolina is by reviewing Medicaid claims data. In 2023, 51% of all births were paid for by Medicaid, and of those births 60.7% of deliveries had a postpartum visit on or between seven and 84 days after delivery leaving much room for improvement in this area. While NC reached a high of 69% in 2019, the percentage of postpartum visits has hovered around 60% for most of the 2017 to 2023 time period. The NC Title V Program is fortunate to have strong partnerships through the Maternal Health Branch, the Perinatal Health Strategic Plan Collective, the HRSA funded Maternal Health Innovation Program, and NC Medicaid's Maternal Health Learning Collaborative working together to improve this postpartum care rate.

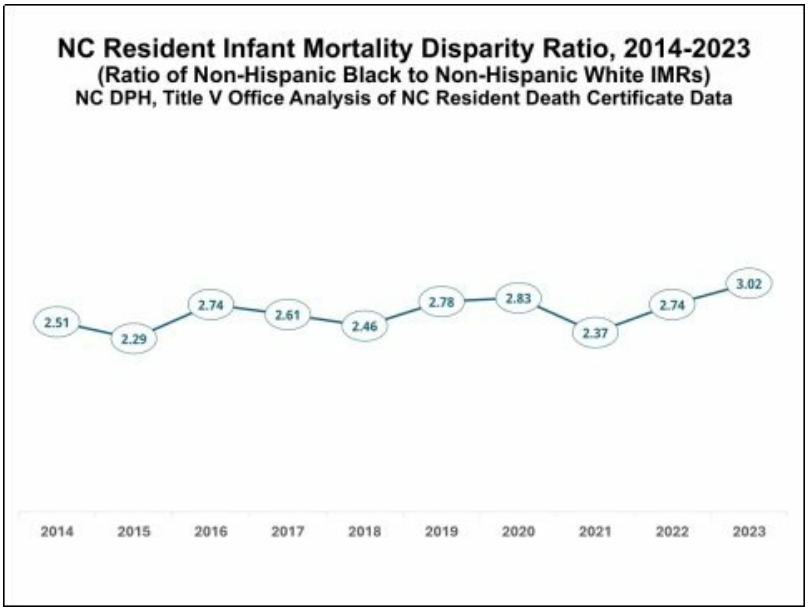
Maternal morbidity and severe maternal mortality rates are also concerning. Findings from the 2018-2019 NC Maternal Mortality Review Committee Report show that of the 181 NC resident deaths occurring from 2018 to 2019 that were reviewed by the committee, 42% (76) were determined to be pregnancy-related. Mental health conditions were the overall leading cause of death, comprising nearly one-third of all cases (31.6%). Twenty deaths were attributed to overdoses and eight were homicides. The committee determined that the majority (85.5%) of pregnancy-related deaths were preventable. Since maternal mortality (SMM) rates can be challenging to report due to small numbers and other issues, severe maternal complications can help provide similar information regarding risk factors associated with maternal mortality. SMM rates increased significantly after the pandemic, both in NC and nationwide. In 2024, NC recorded its highest SMM rate, with 112.7 deliveries experiencing complications per 10,000 deliveries. For the 2020-2024 five-year time period, the total SMM state rate was 99.7 per 10,000 deliveries, and rates were as follows by racial/ethnic groups of women: NH Black –147.5; NH Asian or Pacific Islander – 92.7; NH American Indian or Alaskan Native – 80.3; Hispanic – 90.1; and NH White – 83.4.

Perinatal/Infant Health

In 2023, North Carolina's infant mortality rate remained stagnant at a rate of 6.9 infant deaths per 1,000 live births, which means that 828 infants (a figure equal to about 46 classrooms of 18 students each) died before reaching their first birthday. While the state has experienced declines in overall infant mortality over the last two decades, racial disparities in infant mortality persist. Consistent with national reporting standards, racial classifications were modified in 2023 to include a multi-racial classification and single race reporting. Files were modified dating back to CY2014, the first year the North Carolina death certificate included multi-racial reporting options through the revised

death certificate. The disparity ratio between NH Black and NH White infant death rates rose from 2.51 in 2014 to 3.02 in 2023 (Figure 8). While NC is fortunate to have several federal and state funded programs aimed at reducing infant mortality and improving birth outcomes among all populations and has developed the NC Perinatal Health Strategic Plan (PHSP), there is still much more work to be done.

Figure 8



Increasing the percentage of infants who are ever breastfed or are breastfed exclusively through six months is a goal of the NC Title V Program as one means of reducing infant mortality. The latest data available from the National Immunization Survey (NIS) data for NC births occurring in 2021 reported that 83.5% of infants were ever breastfed, yet by 6 months of age only 28.3% of infants were exclusively breastfed. These are increases from the previous years' rates of 81.4% and 23.1% respectively. State rates are comparable to national rates for infants born in 2021. Breastfeeding initiation data obtained from birth certificates through NVSS for infants born in 2023 reveal that 81.5% of all infants were breastfed at hospital discharge. These data also mirror national trends of racial/ethnic disparities in breastfeeding, as Hispanic infants had an 86% initiation rate, NH white infants had a rate of 84.1%, and NH Asian/PI infants had a rate of 87.3%. In contrast, NH Black had a lower rate of 71.7%, and NH American Indian had the lowest rate at 56.4%. Per 2022-23 results of the National Survey of Children's Health (NSCH), in NC, 33.5% of children, ages 6 months through 2 years, were breastfed exclusively for 6 months, as opposed to 28.7% nationally.

NC has also experienced an unprecedented increase in congenital syphilis cases in recent years, with a 28.1% increase between 2022 (57 cases) and 2023 (73 cases), and a 7,200% increase in cases from 2012, when there was just one case) to 2023. The WICWS is working with the Epidemiology Section to improve access to syphilis testing and treatment and to increase awareness of the problem.

Additional priorities that surfaced from the qualitative data for the Perinatal/Infant Health domain included improving access to timely and quality prenatal care as well as quality health care during the infant's first year, addressing socioeconomic and other conditions affecting health, preventing and limiting substance use, including alcohol and/or tobacco use/vaping, improving access to mental and behavioral health services, and ensuring coordinated access to appropriate level of care at birth. Many of these items are highlighted in the work of the PHSP Collective.

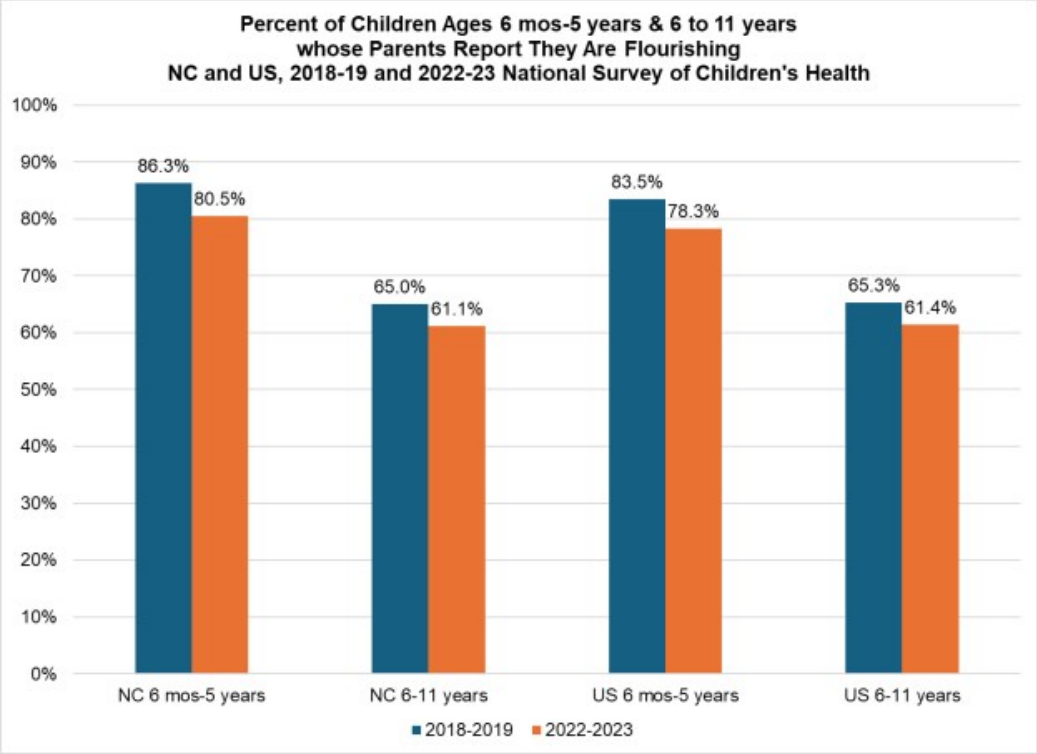
Child Health

The qualitative data collection process overwhelmingly highlighted the priority needs in the Child Health domain to be to promote safe and nurturing relationships, improve access to mental and behavioral health programs as well as access to health care and dental care, and improve community health factors. Quantitative data also support these priorities. While child deaths have declined 12% since 2003, rates rose every year from 2018 (54.5/100,000 children) to 2022 (63.3) and decreased only slightly to 61.5 in 2023. Over the past decade, child mortality rates are

consistently higher among NC's American Indian and Black children. In 2023, injuries were the leading cause of death among children ages 1 to 17, comprising 55% of all (non-infant) child deaths.

Children thrive in safe, stable, and nurturing environments. One measure from the NSCH, flourishing, collects information from parents about their child's curiosity and discovery about learning, resilience, attachment with parent, contentment with life, and self-regulation. Results from the 2022-23 NSCH show that 80.5% of parents with children age 6 months-5 years in NC indicate their children are flourishing (met all four flourishing items), while 61.1% of parents of children age 6-11 years respondent that children were flourishing (met all three flourishing items). These percentages are consistent with the 2022-23 NSCH national rates (78.3% and 61.4% respectively). Rates for both age groups in NC have declined since the 2018-19 NSCH, when the younger age group rate was 86.3% and rate for the 6-11 year old age group was 65%, but these don't appear to be statistically significant declines as the confidence intervals overlap for those two survey periods (Figure 9).

Figure 9



Increasing the number of children who receive appropriate developmental, psychosocial, and behavioral health screening tools is another way to determine if children are being raised in a safe, nurturing environment. While 2022-23 NSCH data indicate that NC has a higher percentage of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year than the nation as a whole (47% vs. 35.6% with confidence intervals not quite overlapping), too many children are still not receiving developmental screening. Through a variety of programs, the WCHS not only offers training opportunities on developmental screening to providers but also assists parents in child health clinics and home visiting programs as well as the Triple P – Positive Parenting Program.

Adolescent Health

Not surprisingly, the qualitative data results for the Adolescent Health domain were very similar to the Child Health domain as improving access to mental and behavioral health services and promoting safe and nurturing relationships ranked at the top along with preventing teen suicide and injuries. In addition, preventing substance use, including alcohol and tobacco/vaping ranked highly along with preventing bullying. Ensuring that youth receive well visits inclusive of mental and behavioral health screenings and related referrals continues to be a priority for the

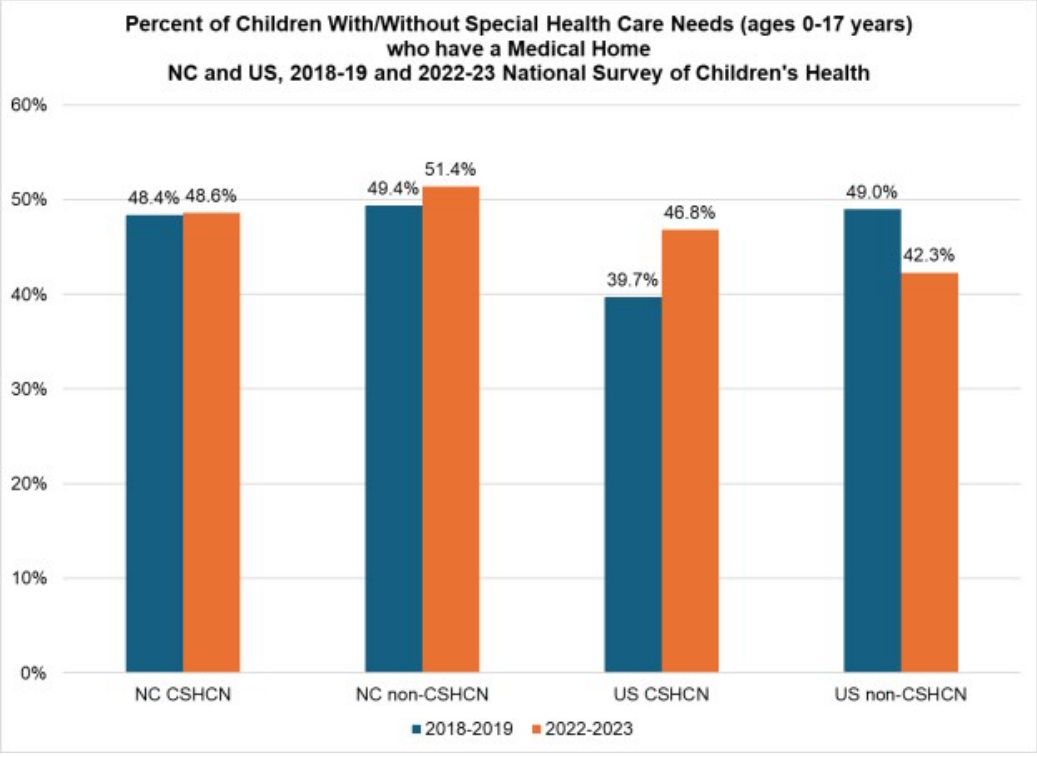
WCHS. According to the 2022-23 NSCH, 81.5% of adolescents in NC received a preventive medical visit in the past year which is higher than the national rate of 71.4% and almost identical to the 2019-2020 NSCH rate for NC of 81.6%. Slightly more males (82.9%) than females (80.1%) had a preventive medical visit, (although confidence intervals overlap) and more YSHCN (94.3%) had a visit than non-YSCHN (75.6%). Additionally, 2022-23 NSCH data did show that 50.9% of NC adolescents age 12-17 had a medical home while only 43.8% did nationwide. Teen suicide rates for NC have risen over the past decade just as they are for the nation, with NC rates for youth ages 10 to 17 increasing from 4.4 per 100,000 youth population in 2014 to 5.4 per 100,000 in 2023. Older teens – ages 15 to 17 – have experienced the largest increase in suicides, and they comprise the largest proportion of suicides throughout the last decade, averaging 32 deaths per year, compared with an average of 16 deaths per year among younger teens ages 10 to 14.

In addition to supporting local health departments and school health centers to provide youth health care and behavioral health services, the WCHS will continue to provide technical assistance to school health nurses, partner with the Department of Public Instruction, promote and connect parents to the Triple P Teen parenting support intervention, and engage youth and hear their voices through the Youth Health Advisor Team.

Children and Youth with Special Health Care Needs

Ensuring that CYSHCN receive coordinated, comprehensive, ongoing medical care was the top priority identified through the qualitative portion of the needs assessment, along with other related items such as improved access to mental and behavioral health services, dental care, respite care, and community-based services. While having a medical home should help ensure that CYSHCN receive coordinated, comprehensive care, data from the 2022-23 NSCH (Figure 10) indicate that CSHCN in NC are less likely to have a medical home (48.6%) than non-CSHCN (54.4%), although the confidence intervals overlap so there is probably not a statistically significant difference. This is true for NC and the nation, although NC had higher rates than the US for both groups of children. Percentages for both NC groups increased slightly between the 2018-19 and 2022-23 surveys while in the US, the non-CSHCN group decreased. Another important part of coordinated care is making sure that CSCHN are receiving care in a well-functioning system. NSCH data for 2022-23 indicate that only 15.6% of CSHCN in NC received such services, leaving lots of room for improvement.

Figure 10



The WCHS has a very active Family Partnership which enables families with CSHCN to voice their challenges and successes routinely to Section staff members. Work to ensure coordinated, family-centered care in a well-functioning system will continue through them, the Family Liaison Specialist, the CYSHCN Help Line and outreach team, with CMARC care managers and Home Visitors, and the Innovative Approaches Initiative, as well as through the Commission for CSHCN. The WCHS is also exploring how to best update the WCHS Strategic Plan for CYSHCN with meaningful engagement with system partners to include the six core outcomes that serve as indicators of a well-functioning system of services for CYSHCN.

III.C.1.b.ii. Title V Program Capacity

III.C.1.b.ii.a. Impact of Organizational Structure

The strengths, opportunities, and challenges associated with the placement of the Title V Program within the WICWS under the Title V Director in its efforts to respond to MCH needs are outlined below.

Strengths

- The placement of the work of the Title V Program across two divisions that work across the lifespan allows for a whole person approach for program implementation, monitoring, and evaluation
- Expansive background experience among staff in both divisions including knowledge of other state MCH programs, federal level funding, and local health department programs
- Monthly and quarterly meetings have been established including a quarterly MCH Steering Committee which reviews budget expenditures and future spending, programmatic successes and challenges, and plans for innovative changes to activities
- Deep community integration across both divisions allowing for participation and feedback during needs assessment data collection and other public input opportunities

Opportunities

- Development and execution of an interagency memorandum of agreement between the DPH and DCFW to ensure expectations are consistent across divisions
- Creation of new documents to track expenditures and future budget requests that will pave the way for a more robust understanding of the MCH Block Grant itself across both divisions which will allow for more thoughtful programmatic planning
- The new location of the Title V Office will allow for better integration of the Title V staff to the daily work of the WICWS which will facilitate improved communication about Division and Department updates and changes and allows the Title V staff to be a part of a larger team which will boost morale
- Leverage interest and knowledge of new staff to consider shifting current practices and processes around the needs assessment including first ever Spanish speaking focus group and immigrant and refugee population focus group

Challenges

- Ensuring coordination across the DPH and DCFW as the CYSHCN Director and many other program staff are in a separate division from the Title V Director
- Staff turnover has resulted in a loss of institutional knowledge, leaving new staff without many resources to orient to the complexity of state government and federal grant reporting

The Title V program is able to partner with other state programs and agencies and leverage the ongoing work of both the DPH and DCFW to ensure a robust presence across the Department. The promotion of Dr. Kimple to the DPH Division Director will assist with ongoing communication regarding changes at the division and state level as well as the promotion of MCH issues given her background and previous role as Title V Director.

III.C.1.b.ii.b. Impact of Agency Capacity

The NC Title V Program's capacity to promote and protect the health of all mothers and children, including CSHCN, is strong, but the Program continually strives to improve this capacity. The 2025 Needs Assessment process helped pinpoint areas of strength, opportunities, and challenges, and in the development of the 2026-2030 Priority Needs

and State Action Plan, staff members were encouraged to create strategies that would increase the Program's capacity to protect the health of all North Carolinians, not just to continue to do the work currently being done. More complete descriptions of agency capacity can be found in other sections of this application, but a summary of strengths, opportunities, and challenges are found below.

Strengths

- The Title V Program coordinates, leads, or participates in numerous collaborative efforts that bring together partners from other state agencies, health services entities, and private organizations to support health services delivery at the community level. Examples (not an exhaustive list) of these efforts include the Perinatal Health Strategic Plan Collective, the Perinatal Health Committee of the NC Child Fatality Task Force, the NC Commission on CSHCN, the Improving Outcomes for Maternal and Child Health Advisory Committee, the Parent Training Cadres, the NC Home Visiting Consortium, and the NC Association of Local Health Director's.
- A primary way to provide and assure services across the five population domains is through the funding that goes to local health departments, federally qualified health centers, and other community-based organizations. Qualified, experienced staff members conduct numerous program implementation efforts and monitoring and evaluation activities to ensure that this funding is being used appropriately. Pre-natal care, child health, and family planning services are available at these locations.
- Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in NC. In fact, NC provides Medicaid coverage to all elderly, blind and disabled individuals receiving assistance under SSI. The Title V program continues to assure that all SSI beneficiaries receive appropriate services. Each month, WCHS receives approximately 100 referrals of newly eligible SSI children. Infants and children under five years of age are referred to the CMARC program. The parents of those ages 5 and older are contacted by letter to let them know about our toll-free Help Line. The purpose of both contacts is to make families aware of the array of services offered under Medicaid, as well as other programs for which their child may qualify.

Opportunities

- Priority Need 6 found in the Cross-Cutting/System Building domain states: Engage individuals and families with lived experience, as well as community-based organizations, as partners in the development and implementation of people-centered programs and policies that reduce health disparities and address community health factors. The strategies developed to meet this need highlight multiple opportunities where the Title V Program is eager to build agency capacity in authentic community engagement and ensure that Title V programs offer compensated family engagement and leadership opportunities.
- Many opportunities for improvement in agency capacity were found during the focus group held with leaders of organizations serving immigrants and refugees These include a recurring theme for systemic changes to improve access and affordability of services for marginalized populations and the fact that better collaboration among various sectors was seen as essential for creating lasting improvement along with the provision of more holistic solutions that encompass affordable housing, job opportunities, vocational training, and language support.

Challenges

- Ongoing challenges in agency capacity somewhat overlap with challenges mentioned with the organizational structure of the Title V Program, namely staff recruitment and retention.
- The uncertain landscape of both state and federal funding negatively impacts agency capacity in many ways. Sustaining evidence-based programs that improve health outcomes is going to be challenging and trying to expand efforts will be very difficult.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

The capacity of the Title V workforce to address Title V priorities is strong. The WICW and WCH section, branch, and unit managers are experienced and knowledgeable leaders. There is a good mix of staff with historical knowledge as well as new staff who bring new energy and ideas. Many of the staff bring a variety of lived experiences with them as they work on MCH activities which allow staff to contribute both their professional and personal knowledge to their work and boosts morale for all staff. This lived experience is inclusive of individuals of reproductive age utilizing the services locally, pregnant and postpartum women who have experienced positive birth outcomes as well as more challenging ones, to individuals parenting children and youth with special health care needs. Some of the Title V staff

have also worked in other sectors prior to joining the NC team. These individuals leverage their experience to contribute new ideas which include the local and federal levels, other states, and even different areas of public health.

While the creation of the new DCFW has been an adjustment, having the work of the Title V office bridge two divisions also brings greater possibilities for streamlining work to meet the populations most in need. This organizational change has highlighted the need for specific and intentional time that is needed to review Title V activities and consider strategic plans for future years and programs. With the Title V Director and the CYSHCN Director now sitting in different divisions, a new approach to gathering information for discussion was needed. The MCHBG Steering Committee was formed following the creation of the DCFW which allows for programmatic and financial leaders to come together quarterly and discuss the MCHBG. There is also a monthly MCHBG application and reporting meeting with the Title V leadership team. The opportunities to streamline reporting on both the programmatic and financial side abound, and the team will continue to work together to achieve reporting goals, strengthen communication, and ensure that the relationships remain strong across the divisions.

The Title V Program continues to support a full-time Family Liaison Specialist (FLS) position in the WCHS who is a parent of a CSHCN to train and support family engagement in WCHS programs and maintains an active group of Family Partners. The roles of the FLS and the Family Partners are described in the Family and Community Partnerships section of this document. Also described there is the work of the Perinatal Health Strategic Plan Collective's Village 2 Village work group, which provides the Collective with feedback from persons with lived experiences. The State Action Plan for the next five years includes examining the number of compensated opportunities for families and individuals with lived experiences. The Title V office will lead the collection of this data as well as explore how to increase these numbers across programs in the WICWS and WCHS.

The Title V Program is committed to recruiting and maintaining qualified staff members. At the state level, the Office of State Human Resources (OSHR) is under the legal direction of NC General Statute chapter 126 in the provision of personnel policies and procedures. The OSHR manual outlines systematic recruitment, selection and career support programs that identify, attract, and select from the most qualified applicants for employment. Employment is offered based upon the job-related qualifications of applicants for employment using fair and valid selection criteria. Selection decisions are made with the aid of federal and state anti-discrimination laws.

We currently are operating under a temporary hiring freeze for positions that are funded in whole or part with state appropriations based on the NC General Assembly Operations Appropriations Act. We continue to fill federally funded positions as we await further guidance on the timeframe for the hiring freeze.

The Title V Program follows OSHR policy and procedures for evaluating employees' performance. The performance management system consists of a process for communicating employee performance expectations, maintaining ongoing performance dialogue, development plan, and conducting annual performance appraisals. There are also procedures for addressing performance that may fall below expectations and for encouraging employee development. Priority consideration is given when a career state employee applies for a promotion and the eligible employee is in competition with outside applicants.

The OSHR maintains a compensation plan which provides a salary rate structure to appropriately compensate all positions subject to the State Personnel Act. Historically, state employees were classified and compensated under two different systems: salary graded and career banded. In 2013, the OSHR was directed by the NC General Assembly to conduct a Statewide Compensation System Project to address the problems caused by having two outdated systems. Implementation of the new Statewide Classification and Compensation System began in June 2018 with the number of job classifications reduced from 2,300 to 1,400. As with the rollout of any major systems change, there were some errors in how positions were classified and delays in hiring and processing reclassifications. A new revision to the Statewide Compensation System became effective June 1, 2022. The revisions and enhancements to the pay plans are an effort to make compensation fair, modern, and aligned with the State's objectives, and updates salary ranges to align with the labor market. Benefits for state employees also include many types of leave (vacation, sick, community service, holiday, military, family medical), retirement system contributions, medical insurance, voluntary supplemental retirement plan contributions, and supplemental insurance coverage. Some state employees also became eligible for up to eight weeks of Paid Parental Leave on September 1, 2020, when Governor Cooper's Executive Order No. 95 went into effect. Originally this was a benefit just for

employees of state agencies under the Governor's oversight, but some other state agencies opted to cover their personnel. This was further strengthened by S.L. 2023-14 effective July 1, 2023, which now requires rules and policies to provide paid parental leave for full-time, permanent employees of State agencies, departments, and institutions, including the University of North Carolina, to public school employees, and to community college employees.

NCDHHS makes it a priority to assure that new employees are adequately oriented to and trained for their positions. There are online courses required of every NCDHHS employee covering topics such as new employee orientation, performance management, orientation to the timekeeping system, and workplace harassment. DPH new employee orientation includes information about the three core functions and ten essential services of public health. Supervisors are provided with opportunities for numerous management trainings and are also required to attend Equal Employment Opportunity training. In response to staff feedback, DPH also developed a division-wide orientation offered quarterly for all new employees to enhance the knowledge of the varied and complex work of public health and promote a collaborative approach. DPH, in partnership with the NC Institute for Public Health, has also developed an orientation for new Local Health Directors, given the fact that around a third of all LHDs have transitioned leadership over the last few years.

In January 2025, the NC DPH approved and adopted the NC DPH Workforce Development Plan 2024-2029 which serves as the foundation of the Division's ongoing commitment to the training and development of its workforce. The plan provides a current workforce profile and the plans for the future workforce and training needs and workforce development goals. To assess workforce needs, NCDPH uses the three following workforce assessments:

1. Foundational Capabilities Opportunities Analysis – This assessment, which uses the eight Foundational Capabilities within the Foundational Public Health Services framework, is executed annually with an academic partner, NC Institute of Public Health through a quantitative survey and qualitative focus groups.
2. Data Modernization Workforce Assessment – This annual assessment is devised and executed by an academic partner, NC Agricultural and Technical State University to assess the expertise and capacity of data science staff to perform key capabilities in assessment and surveillance.
3. Public Health Workforce Interests and Needs Assessment – This assessment will be done every three years to determine key issues in recruitment, retention, training, and funding of the governmental public health workforce.

The DCFW and DPH both promote the NCDHHS leadership development coaching program and several staff have been selected for participation. The CYSHCN serves as a director-at-large on the AMCHP board and encourages applications to the AMCHP leadership lab among their staff. There is also support for staff to serve as LEND faculty or guest lecturers and to attend/present for trainings. WICWS staff have also participated in panels encouraging students to consider public health, inclusive of maternal and child health, as their professional path.

The most recent in-person priority setting meeting in December 2024 included a brief survey requesting staff indicate specific training or professional development topics that they were interested in. The most popular topics included improving health outcomes for all, data analysis, and monitoring and evaluation. The Title V team will take the lead on organizing specific trainings or opportunities for learning specific to these topics in FY26.

The Title V Program strives to invest in its workforce in not only knowledge and expertise, but also personal and professional development. Leadership training is available to Title V Program staff members through the NC Public Health Leadership Institute, as well as other programs through NCDHHS, AMCHP, ASTHO, National Healthy Start Association, and CityMatCH. Staff members are assessed for perceived training needs and education and training resources are matched to those areas when possible. Excellent training resources are brought to the NC Title V Program through partnerships with Area Health Education Centers (AHECs), UNC's Leadership Education in Neurodevelopmental Disabilities and Related Disorders (LEND) program, National Implementation Research Network (NIRN), and through partnerships with communities, universities, and medical schools, etc. Staff hold peer-to-peer trainings for NC Title V Program staff members as well. Trainings are often recorded and offered to new staff as they come on board or to key partners as needed. Examples of subject matter included in trainings are motivational interviewing, results-based accountability, systems development and integration, how to implement and sustain evidence-based programs with model fidelity, data analysis, quality improvement assessments, community engagement, and trauma-informed services. As much as possible, staff members participate in national

conferences and annual meetings. The NC Title V Program will continue to promote the MCH Navigator and the UNC MCH Workforce Development Center training opportunities among staff.

The WICWS has held a regular Reading Circle focused on cultural awareness for many years. The Reading Circle, a completely voluntary group, was reinstated in FY23 and is currently held at least twice a year. The objectives of the Reading Circle discussions are to:

- Engage critically and constructively in discussions that foster the exchange of information
- Clarify and broaden their own points of view by examining and building on the ideas of others
- Analyze cross-cultural communication issues
- Actively participate with a group of peers exploring cultural awareness and acceptance

WICWS and WCHS staff members host a number of student interns, both graduate and undergraduate, throughout the year in partnerships with local universities such as the NCDHHS Historically Black University and Colleges (HBCUs) and Minority Serving Institutions (MSIs) Internship Program. In addition, class practicum projects provide university and college students with real world experience. Most recently, DPH has established a Fellowship Program which assigns a recent graduate to work with a section or program. The goal is to engage early career professionals in building the confidence and expertise needed for thriving public health careers in NC. The Fellows work alongside other staff and are given the opportunity lead programmatic and epidemiology efforts. The NC Institute of Public Health provides leadership with e-learning opportunities, monthly educational sessions, monthly coaching sessions, and supporting them in developing an annual skills application project. While participating in the Fellowship, fellows are encouraged to apply for positions that become available. WICWS is in year 2 with a fellow that has been instrumental in providing leadership in several program efforts and even assisted with covering a vacant position for a short while. This Fellowship program has been a critical innovative collaboration as we continue to work to elevate our MCH workforce.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

The NC Title V Office uses State Systems Development Initiative (SSDI) funding to maintain the current SSDI Project Coordinator's position. The primary role of this position is to help increase the Office's capacity to utilize and analyze data to assess, plan and evaluate maternal and child health services provided by the Title V Office, the WICWS, and the WCHS. The following goals of the SSDI grant complement the work of the NC Title V Office as a whole:

Goal 1 - Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming

The SSDI Project Coordinator is responsible for coordinating the completion of the MCH Block Grant narrative by working with the Title V Director, CYSHCN Director, Title V Initiatives and Operations Manager, and staff members of DPH and DCFW. The Coordinator provides rationale for the MCH Block Grant national and state performance measure objectives and assists with the development of the evidence-based or -informed strategy measures (ESMs) and the State Action Plan. The Coordinator works with data stakeholders, epidemiologists, and evaluators within DPH and DCFW to compile the necessary data for the Block Grant. The Federally Available Data (FAD) Excel workbook facilitates comparisons from one year to the next and across demographic and other subgroups. In addition to uploading the narrative to the Title V Information System, the Coordinator gathers all the information for and completes all the forms for the Block Grant application and provides necessary field notes, working with the Title V Initiatives and Operations Manager to complete the budget forms.

Goal 2 – Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability

It is fortunate for the Title V Office that the NC State Center for Health Statistics (SCHS) has a long history of collecting vital statistics data, linking data with infant birth certificates, and in conducting statewide surveys; thus, the work of the SSDI Project Coordinator is to promote data utilization and provide better means of data dissemination, including assuring data-driven programming within the Title V MCH Block Grant.

The Title V Office partnership with the SCHS supports accessible, timely and linked MCH data systems, as

documented on Form 12. Since 1985, NC has linked Medicaid newborn hospitalization records to live birth certificates to identify births occurring to families enrolled in Medicaid. This birth file with added health services data is referred to as the NC Composite Linked Birth File. Aggregate data from this birth file are posted on the SCHS website in a variety of ways. Data that are linked annually to the live birth file include:

- Medicaid newborn enrollment records
- Medicaid maternal delivery records
- Summary of Medicaid newborn costs in the first 60 days of life
- Summary of Medicaid infant costs in the first year of life
- Prenatal WIC records
- Infant death records
- Maternal death records
- Birth defects cases identified through the Birth Defects Registry surveillance system
- Pregnancy Assessment System (PAS) data which is NC's Pregnancy Risk Assessment Monitoring System (PRAMS) like survey data

Linkages with hospital discharge records for newborns and for mothers/delivery records are currently under development.

The Perinatal Epidemiologist, a position supervised by the SSDI Project Coordinator, has direct electronic access to the NC Composite Linked Birth File as well as to other vital statistics data, hospital discharge, and emergency department data. In addition, she can access newborn hearing screening data from WCSWeb Hearing Link. Staff members within the Genetic Newborn Screening Unit in the WCHS have access to newborn bloodspot screening data, and the epidemiologist in the DCFW/CNSS has access to additional WIC data.

While the Title V Office has had consistent access to PRAMS data for many years (and access to the electronic data source on an as needed basis), an application for CDC funding was not submitted by SCHS in 2020. The SCHS rolled out a pilot state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which included questions identical to the 2020 NC PRAMS survey and began data collection in 2024 using PRAMS Phase 9 questions. During the first year of data collection under PAS (2024), the response rates were insufficient for meaningful analyses of the data. However, 2025 data collection is currently underway, and SCHS has initiated data collection and monitoring improvements that should result in increased response rates.

The SSDI Project Coordinator and Perinatal Epidemiologist serve on the Maternal Health Innovation (MHI) Evaluation Team and have helped provide data for annual reports and the 2024 competing continuation grant application. The Perinatal Epidemiologist supports the work of the Maternal Mortality Review Committee (MMRC) by identifying pregnancy-associated deaths through multiple data sources including vital statistics data linkages, literal cause(s) of death recorded on death certificates, diagnoses record on hospital discharge and emergency department data, and pregnancy checkbox information on the death certificate. She also prepares data reports on severe maternal morbidity for use by the Title V Office and WICWS and collaborates with academic and HRSA colleagues. In addition, she makes annual presentations to the Child Fatality Task Force and relevant committees regarding infant and child deaths. She also continues to collaborate with the SCHS to identify birth and fetal death data quality issues and develop solutions to improve data quality. In addition, the SSDI Project Coordinator, the Perinatal Epidemiologist, and the Title V Initiatives and Operations Manager meet monthly with the SCHS Director and the SCHS Statistical Services Branch Manager to discuss progress of the PAS.

Goal 3 – Enhance the development, integration, and tracking of community health factors to inform Title V programming

One of the NC Title V 2026-2030 MCH Block Grant State Action Plan Priority Needs is to "Engage individuals and families with lived experience, as well as community-based organizations, as partners in the development and implementation of people-centered programs and policies that reduce health disparities and address improved health outcomes for all individuals," and the NC Title V Program and NCDHHS have a strong commitment to SSDI Goal 3. The SSDI Project Coordinator has been involved in a number of activities to reduce health disparities and to ensure that demographic data are used appropriately, and she will continue in these roles and take on others as

needed.

The SSDI Project Coordinator has served as chair of the PHSP Collective Data and Evaluation Work Group (DEWG) since its inception in 2014 to help develop the initial strategic plan and serves on the PHSP Collective Leadership Team. The DEWG has evolved over time to include participants from Title V, SCHS, and partner organizations such as NC Child, March of Dimes, Collaborative for Maternal and Infant Health, Tobacco Prevention and Control Branch/CDIS, and the NC Coalition Against Domestic Violence at its monthly meetings. The Work Group's purpose is to compile data annually for the PHSP data indicators and monitor new data sources. In addition, they promote data quality improvement and assist other PHSP Collective workgroups to move data to action. The Work Group was instrumental in helping the Collective identify performance indicators for the updated version of the plan released in August 2022 which includes four overarching and thirty-four strategy specific data indicators. The overarching indicators are: 1) to eliminate the Black/white disparity in infant mortality, 2) to eliminate the Black/white disparity in severe maternal morbidity 3) to decrease the percentage of preterm births to 8.3% or less for all racial/ethnic groups, and 4) to increase health insurance rates to 90% or above for all racial/ethnic groups. While these PHSP indicators do not constitute a full community health metrics for all MCH populations, it provides a good basis from which to start.

The second annual update on the indicators took place during the September 23, 2024, PHSP Collective meeting, titled *Stories Behind the NC 2022-26 Perinatal Health Strategic Plan Data Indicators*. Approximately 50 people attended in person and another 108 participated via Zoom. The DEWG planned the agenda for the meeting and helped produce the 2022-2026 Mid-Plan Report that was released at the meeting. Along with including baseline and most recent data for each of the PHSP indicators, the report also included results of the PHSP Collective Impact Survey conducted in spring 2024 that was analyzed by the DEWG and a narrative of PHSP Collective Accomplishments. Two members of the DEWG presented an overview of the overarching indicator data and Impact Survey results using slides that the SSDI Project Coordinator created. This was followed by a community panel discussion by three speakers highlighting qualitative successes stemming from their attempts to implement sections of the plan that would not be readily identified in the quantitative indicators. The DEWG members were able to identify these speakers from their responses to the PHSP Collective Impact Survey. During a Stretch and Connect Break, attendees were encouraged to talk to someone that they did not already know and share stories about the ways they were working to advance the work of one of the three goals of the PHSP. Lastly, the WICWS Chief led a discussion about what strategies and activities are missing from the current plan. Attendees were then invited to participate in two calls to action: 1) to check their voter registration status and 2) create a calendar entry for 2:30pm on October 21, 2024 (a month after the PHSP Collective meeting), titled "How have I helped improve a PHSP Collective data indicator in the last 4 weeks?"

In June of 2024, the SSDI Project Coordinator and Perinatal Epidemiologist launched the NC Maternal & Infant Health Data Dashboard. The dashboard is comprised of data visualizations for key maternal and infant indicators disaggregated by year, maternal race/ethnicity, age, education level, region, and county of residence. In conjunction with the dashboard, the Title V website was also updated to include an Appendix with more information regarding the data sources and a separate page with additional MCH data resources. The dashboard is frequently updated to include the latest data, new visualizations, as well as new indicators of interest to maternal and infant health programs. In August of 2024, additional county-level data visualizations were added to the indicators. As 2023 birth data became available in September 2024, all of the birth indicators were updated on the website and infant mortality data was updated after mortality data became available in February 2025. In January 2025, a new indicator, Perinatal Mental Health Conditions, was added, and two additional indicators, Birth Defects Prevalence and Critical Congenital Heart Defects Prevalence, are to be added in summer 2025. The Perinatal Epidemiologist collaborated with the NC Birth Defects Monitoring Program of SCHS to ensure that the birth defects indicators met their reporting standards. Additionally, in May 2025, a Maternal Medicaid Status tab was added to all the MIH birth and infant death indicators. The Perinatal Epidemiologist analyzed the NC Composite Linked Birth File to aggregate the data and obtained approval from the Quality and Health Outcomes Cross Functional Team in the Division of Health Benefits (NC Medicaid) for these additions. Since the initial launch in late June 2024, the dashboard has received over 6,000 views (n=6,399 as of June 17, 2025).

The SSDI Project Coordinator continues to serve as chair of #impactHEALTHNC, a group made up of representatives from DPH, DCFW, NC Child, and the NC Chapter of the March of Dimes. #impactHEALTHNC was

initially started to create and promote the use of a Health Impact Assessment (HIA) tool. The SSDI Project Coordinator worked with a subgroup of #impactHEALTHNC members to revise and release an updated version of the HIA in November 2021, and work to promote uptake of the tool continues. The HIA consists of a series of action steps intended to focus discussions and document proposals for modifications to the policy or program being assessed. The primary action steps are completed jointly by an implementation team consisting of stakeholders, community experts, content experts, providers, etc. who are knowledgeable about the policy/program being assessed on the day(s) of the assessment. These steps include creating a clear description of the current or proposed policy or program, examining the community data profile, identifying changes to the policy or program that will make it more consistent, and developing a monitoring plan for measuring changes to the policy or program. Use of the HIA tool is required by the Improving Community Outcomes for Maternal and Child Health (ICO4MCH) and Reducing Infant Mortality in Communities (RIMC) programs managed by the WICWS. The SSDI Project Coordinator serves on the ICO4MCH Evaluation Team which evaluates the use of the HIA, and that team continues to look for additional funding to help evaluate the effectiveness of the HIA. In July 2022, the HIA was accepted as an Emerging Practice in the Association of Maternal and Child Health Programs Innovation Hub, with the SSDI Project Coordinator listed as the contact for questions about the practice and practice replication. #impactHEALTHNC held a HIA facilitator training in September 2024 and is planning to revise the tool with input from some of these trained facilitators and people with lived experience using the tool in their communities in August or September 2025.

One additional tool that helps the Title V Program and local health departments track non-medical drivers of health is the North Carolina Data Portal which was released in 2024. Using the portal, users can quickly access data visualizations, maps, and tools to support community health assessments. The portal pulls data from a variety of credible data sources for over 120 indicators covering a wide range of categories including demographics, economic stability, employment, education, neighborhood and built environment, healthcare/clinical care, health behaviors, health outcomes, physical environment, and social support. Plans to link indicators from the NC Maternal & Infant Health Data Dashboard to this portal are underway.

Goal 4 – Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19

As previously described, NCDHHS is fortunate to have extensive data capacity with numerous surveillance systems already in place which enable quick response to emergencies and emerging issues/threats to MCH populations as well as the general population of North Carolina. The SSDI Project Coordinator and Perinatal Epidemiologist continue to provide support as needed to DPH and other divisions within NCDHHS in developing and implementing new surveillance systems, providing support for ongoing data collection needs, and participating in analysis and/or reporting of data. Past examples of this include the Perinatal Epidemiologist working as a member of the Epi COVID Data Team from May to December 2020, assisting with daily, weekly, and ad hoc statistical analysis and reporting, providing on-boarding training to new Epi COVID Data Team members, and developing reports demonstrating the burden of the COVID-19 pandemic on women, infants, and children, all while continuing to provide data support to the NC Title V Program as needed. In 2021, the SSDI Project Coordinator and MCH epidemiology workforce members of the WICWS helped with data entry efforts for the COVID-19 Vaccine Management System.

In addition, during 2021, the PHSP Collective DEWG instituted an Emerging Threats/Issues Discussion at the PHSP Collective meetings in an effort to move data to action. The following topics were covered between 2021 and June 2025:

- COVID-19 and Women of Reproductive Age
- Pediatric COVID-19 Vaccinations
- Maternal Mental Health and the Ongoing Pandemic
- Perinatal Mental Health – Collaborative Care and Perinatal Services and Maternal Mental Health Hotline
- Prevent Violence NC - Application of a Shared Risk and Protective Factors Framework
- Bridged vs. Non-Bridged Population and Vital Statistics Data
- NC Senate Bill 20 (Abortion Law Revisions)
- Congenital Syphilis in North Carolina
- NC Family Engagement Report

- NC Smart Start Data Dashboard
- Restoryation Storytelling Project (North Carolina Coalition Against Domestic Violence)
- NC Maternal & Infant Health Dashboard
- Birth Defect Surveillance in North Carolina
- Maternity Care Deserts in NC

III.C.1.b.ii.e. Other Data Capacity

In addition to those data and information systems mentioned previously, there are several others employed by the NC Title V Program and throughout NC DPH and NCDHHS that help support access to up-to-date MCH data. Again, the SCHS is a key resource as it provides so many different data reports and analyses based on vital statistics data. In 2018, LHD clinical service data reporting and analysis moved to a secure, direct file upload format called the Local Health Department Health Services Analysis (LHD-HSA) system and located at the SCHS. Data analysis now occurs by SCHS statisticians using SAS. Quarterly and ad hoc custom reports are available on program-specific data and cross-cutting public health issues. Some of these data are used by the WICWS in their LHD agreement addenda Outcome Objectives Data Reports and in the Family Planning Annual Report (FPAR).

The SCHS website also hosts the Healthy North Carolina 2030 (HNC 2030) report and the 2023 State Health Improvement Plan which includes a HNC 2030 Data Indicator Table. The HNC 2030 Scorecard supports the 2020 State Health Improvement Plan (SHIP) as LHD and other partners link their local scorecards to the state scorecard to show the collective impact occurring statewide on 21 population indicators. Results-based accountability drives the HNC 2030 plan (asking how much did we do, how well did we do it, and is anyone better off), and the scorecard shows change over time as well as providing the story behind the data. There is also an annual NC SHIP Community Council Scorecard posted that monitors progress on state-level priorities aimed at improving quality of life in NC. The new Community Council structure was adopted in 2023 which convenes 18 workgroups around 21 indicators. The NC Title V Director serves as the co-lead for the PHSP Collective Policy Workgroup and, in addition, WCHS and Early Intervention staff members co-lead the Short-Terms Suspension Work Group and the Third Grade Reading Proficiency Work Group.

Additionally, the Perinatal Epidemiologist routinely collaborates with statistical staff at the SCHS on a variety of Vital Statistics data quality improvement projects to help ensure the accuracy of NC MCH data. SCHS and NC Title V Program collaborations have included resolving errors in prenatal care information in the birth file, generating facility level birth data quality reports, and verifying the accuracy of pregnancy checkbox information on the death certificate through data linkages and certifier confirmation of pregnancy.

In addition to the NC Composite Linked Birth File described earlier, each month a subset of the birth file is shared with the Early Hearing and Detection Intervention (EHDI) program which is matched with newborn screening data through the WCSWeb Hearing Link data system to ensure proper follow up. The Perinatal Epidemiologist works closely with EHDI program staff to enhance access to birth data and improve EHDI/birth data linkage rates.

The NC Early Childhood Integrated Data System (ECIDS), a system integrating early childhood education, health, and social services data from state agencies, is now in use and continues to be updated. The Early Childhood Action Plan website added the Early Childhood Action Plan 2024 Update in March 2024 providing updated data and three key NCDHHS strategies to support progress of the plan specific to four goals that address highly urgent needs for families with young children. The NC Title V Program also relies heavily on NC Child, a non-profit founded in 2014 to “advance public policies to ensure that every child in North Carolina has the opportunity to thrive – whatever their race, ethnicity, or place of birth” (https://ncchild.org/about-us/) in using data from their NC Child Health Report Card, published biannually in partnership with the NC Institute of Medicine, and in using KIDS COUNT data which is available through NC Child’s partnership with the Annie E. Casey Foundation.

The NC Violent Death Reporting System (NC-VDRS) is a CDC-funded statewide surveillance system that collects detailed information on deaths resulting from violence (homicide, suicide, unintentional firearm deaths, legal intervention, and deaths for which intent could not be determined) that occur in NC. NC-VDRS began collecting data in January 2004 from a number of data sources such as death certificates, medical examiner reports, and law enforcement reports. In 2021, the IVPB released the NC-VDRS Data Dashboard visualization tool, providing key takeaways on the metrics page and providing more detail including data at a county and demographic level where

available on individual pages of the dashboard covering overall violent death, suicide, homicide, and firearm-related deaths.

The IVPB also provides other data through its NC Overdose Epidemic Data website which provides integration and visualization of state, regional, and county-level metrics for stakeholder across the state to understand the impacts of the overdose epidemic in their communities. The NC Alcohol Data Dashboard presents data on excessive alcohol use, alcohol outlet density, and alcohol consumption rates as well as related public health strategies, immediate- and long-term impacts of excessive use, and cost to communities.

The WCHS helped lead an effort to establish the NC Child Behavioral Health Dashboard. Effectively and equitably addressing the child and youth behavioral health crisis requires being able to quickly gain insights into where progress is being made and where more must be done. The dashboard includes prioritized measures to inform data-driven decision making for policy and service development and care delivery. Previously, data related to children's behavioral health in North Carolina existed in siloes, but the dashboard facilitates more timely data transparency and shared accountability within NCDHHS and with our partners, including providers, payers, schools, child welfare system, and policymakers. The Perinatal Epidemiologist was a member of the initial planning team for this dashboard and continues to participate in meetings to update the data. An updated version of the dashboard is expected in the summer of 2025.

Modernization efforts to enhance the technology health care partners rely on to share data, track vaccines, and make informed decisions using the NC Immunization Registry (NCIR) are ongoing.

During the pandemic, the Title V Program was also fortunate to have continuous access to COVID-19 surveillance and vaccine data for women and children in the state. The NC COVID-19 Dashboard was launched in May 2020 as an interactive data dissemination tool that provides an overview of COVID-19 metrics and healthcare capacities that the state is following to inform decisions. The dashboard continued to evolve over time and grew into a dashboard that provided weekly updates focused on seven metrics: wastewater testing; COVID-like illness in hospital EDs; COVID hospital admissions; COVID reported cases; vaccine and booster rates; variant surveillance; and CDC's COVID-19 community levels by county. As of April 26, 2023, however the COVID-19 Vaccinations Dashboard has been archived and is no longer being updated. NCDHHS will continue tracking vaccination data which will be available from the CDC. Similarly, the COVID-19 Cases and Deaths Dashboard was archived on May 17, 2023, as doctors and labs were no longer required to report COVID cases to NCDHHS. The NC Respiratory Virus Summary Dashboard still exists, however and tracks information about North Carolinians with contagious respiratory viruses including COVID-19, the flue, and Respiratory Syncytia Virus (RSV). The dashboard contains information on emergency department visits and hospital admissions for respiratory viruses as well as COVID-19 wastewater monitoring data.

The WICWS is also making great strides with its Maternal Mortality Review Committee and implementing the MHI Program, and data sharing partnerships and quality improvement initiatives will continue. The NC 2018-2019 Maternal Mortality Review Report was released in February 2024 and a report on data from 2018-2020 is expected to be released during the summer of 2025.

The NC Title V Program is also working with NCDHHS to refine its data use and data sharing agreements throughout the Department. The NCDHHS Data Sharing Guidebook was released in May 2022.The purposes of the Guidebook are to:

- establish clear pathways for data sharing and integration, for requestors and data owners
- establish a common legal framework for data sharing and integration across NCDHHS
- support data use that leads to improved data quality, insights, and improvements, and
- clarify processes to reduce burden on staff requesting and granting access to data, increase efficiencies, and ensure privacy and security safeguards.

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination

The NC Title V Program's relationship with other MCHB investments (e.g., SSDI, MIECHV, ECCS, etc.), HRSA programs, and other federal investments (e.g., Title X, PREP, WIC, Immunizations, etc.) is very strong. With the Title V Director also serving as the Chief of the WICWS, she supervises staff involved in several other MCHB investments

such as the Maternal Health Innovation, Maternal Mortality Review Committee, and Healthy Start grants as well as Title X grants. Likewise, the CYSHCN Director supervises staff involved in MEICHV, newborn screening, epilepsy, and genetic grants and works directly with the Exceptional Children's Assistance Center (ECAC), which is NC's Family-to-Family Health Information Center (F2F). Both the WICWS and WCHS partner with community health centers and Area Health Education Centers on various projects and programs.

The weekly DPH Division Management Team meetings provide an avenue for the Title V Director to partner with administrators of other HRSA programs and other federal and state programs within DPH.

The NC Association of Local Health Directors (NCALHD) meets monthly, and, on the day prior to each of these meetings, committee meetings are held which include staff members from DPH/DCFW Sections which enable the Title V Program to work collaboratively with NCALHD on matters that pertain to all LHDs. The Title V Director and other Title V Program staff present regularly to the NCALHD. NC Title V Program staff members, particularly the Regional Nurse and Social Work Consultants, also visit the LHDs regularly to perform monitoring and consulting duties and to provide technical assistance. The MCH Steering Committee will continue to meet to ensure continued collaboration between the programs in these two divisions. This committee includes leadership from the WIWCS, the WCHS, and the Title V Office. The quarterly meetings include standing agenda items to discuss Block Grant budget and activities as well as updates from other federal investments housed within the DCFW including WIC, EI, and Behavioral Health.

Additionally, the DPH is signatory to a formal written agreement with the Division of Vocational Rehabilitation (assumes responsibility for Supplemental Security Income eligibility determination). Programs within the NC Title V Program also collaborate with the Division of Public Instruction (DPI); Office of Rural Health (ORH) which works with federally qualified health centers and other primary care providers; and Division of Child Development and Early Education (DCDEE). The NC Title V Program also collaborates with the Department of Insurance closely on ACA and the Department of Corrections around incarcerated parents and other issues.

According to the Council on Education for Public Health, there are eight accredited schools of public health in NC and the NC Title V Program maintains close working relationships with many of them, particularly the UNC-Chapel Hill Gillings School of Global Public Health, but also with the Departments of Public Health at UNC-Greensboro and East Carolina University. The NC Title V Program also works with the Department of Public Health Education at NC Central University. Division staff members serve as adjunct faculty members and are frequent lecturers, in addition to serving on advisory committees. Faculty members are asked to participate in DPH/DCFW and NC Title V Program planning activities to provide review and critique from an academic and practice perspective.

The NC Title V Program also collaborates on a number of activities with several professional organizations in the state including: NC Medical Society: NCPS; NC Obstetrical and Gynecological Society; Midwives of NC; NC Friends of Midwives; and the NC Academy of Family Physicians. The NC Title V Program also partners with the NC Institute of Medicine, the NC Healthcare Association, and the NC Area Health Education Centers. The Section works closely with the NC Partnership for Children (SmartStart), Prevent Child Abuse NC, NC Child, the NC Chapter of the March of Dimes, CCNC, and the Perinatal Quality Collaborative of North Carolina (PQCNC), along with many other organizations.

DPH has a Quality Improvement Council that provides guidance to Continuous Quality Improvement (CQI) efforts across the division, and NC Title V Program staff members have been involved in various projects to improve customer service and business office processes. Individual programs have also used CQI tools at different times to improve services to LHDs, providers, and clients. While there is a long way to meeting the longer-term vision for QI at DPH to achieve a culture of quality, the NC Title V Program strives to continually evaluate if the work that is being done is meeting the needs of women, infants, children, and families in NC. HNC 2030 and the accompanying 2020 NC State Health Improvement Plan both incorporate the principles of results-based accountability which should also help drive quality improvement. Examples of specific quality improvement and innovation efforts by the NC Title V Program are provided in the State Action Plan narratives.

III.C.1.b.iv. Family and Community Partnerships

dThe NC Title V Program is committed to building the capacity of women, children, and youth, including those with

special health care needs, and families to partner in decision-making about state Title V activities and programs. There are several NCDHHS advisory councils and commissions that are in place and involve family members including, but not limited to: the Commission on CSHCN, Newborn Metabolic Committee, Newborn Hearing Advisory Committee, , NC Baby Love Plus Community Consortium (T.H.R.I.V.E. (Together Helping to Reach Improved Vitality and Empowerment), Council on Developmental Disabilities, and the Governor's Council on Sickle Cell Syndrome. The WCHS has families represented on all advisory councils and working groups, and its direct care programs such as newborn hearing, metabolic, and genetic counseling all provide satisfaction surveys for each family served. The WICWS receives feedback from its family partners in a variety of ways: through Community Advisory Councils/Networks in TPPI, Healthy Beginnings, ICO4MCH, and NC Baby Love Plus; and through work with PPE counselors at universities and community colleges. Family partners are asked for input on grant applications, including the MCH Block Grant, and on educational materials, trainings, and public awareness campaigns. LHDs are required to routinely survey their clients for feedback which is reviewed during monitoring visits by WICWS and WCHS Regional Consultants.

One of the priority needs highlighted by the PHSP Collective was to increase family-driven service provision. One response to this need was the creation of Village 2 Village (V2V), a community and consumer engagement work group whose members provide feedback on the PHSP strategies, publications, and services. Participants are NC residents between 18 to 44 years old from rural and urban counties who must have children no older than one year of age. Participants are compensated for time, travel, meals, and lodging according to NC state government reimbursement guidelines. Over time, V2V has made some key changes to shift its focus toward community engagement instead of just providing feedback on the plan. V2V is now co-chaired by people with lived experience who also serve on the Collective Leadership Team in an effort to share power. V2V has moved away from working on single outputs and instead wants to improve the system of community engagement.

The WCHS Family Liaison Specialist (FLS) position was reclassified, and a new person started in that position in April 2023. This employee has a CSHCN and is able to utilize their lived experience and acquired knowledge to support the family engagement efforts of the WCHS. The FLS has worked to institutionalize family engagement in all areas of the WCHS and uphold the WCHS family engagement philosophy: 1) Build and maintain relationship with families to ensure DCFW/WCHS programs and services are family centered; 2) Recognize, respect, and support the knowledge, skills and expertise that families possess; and 3) Assure that families are actively engaged in program planning, implementation, and evaluation. The WCHS has developed a multi-faceted framework that offers a variety of opportunities to empower parent and youth partners to share their knowledge and expertise, including those who serve as FPs. The WCHS FP Engagement and Leadership Committee meets quarterly and is comprised of ten parents of CYSHCN with a full range of experience with systems of care, the Assistant Director for the WCHS, five Unit Managers, a Child Mental Health Program Consultant, the FLS, and the CYSHCN Access to Care Specialist. These parents are a part of a collaborative process to make decisions regarding program development, implementation, and evaluation and to provide consultation and feedback regarding programming, services, and strategies. In addition, these parents often represent the WCHS and model family engagement on various state and regional groups. The WCHS continues to use Title V funding to provide travel assistance and stipends to compensate family members for their time and effort. One recurring task of the FP Engagement and Leadership Committee is to provide input on the MCH Block Grant by reviewing the application and attending the annual review. Parent Trainers are trained to implement both the *Parents as Collaborative Leaders* curriculum as well as the *Teaching Parents of Children and Youth with Special Healthcare Needs about Sexual Health* curriculum. The WCHS also is in the process of developing an additional training curriculum titled, *Teaching Parents of Children and Youth with Disabilities About the Medical Home Approach*. This newly developed curriculum embeds the national CYSHCN Blueprint for Change framework and is scheduled to launch in Fall 2025. Both the sexual health and medical home parent trainings were developed in collaboration with core workgroups that included parents of children with disabilities, youth with disabilities, WCHS staff members, community partners, a subject matter expert, and healthcare providers. The training cadre utilizes a peer-to-peer training model to support and build knowledge, increase confidence and leadership skills of parents of CYSHCN. Trainings are held virtually or in person, reaching both English and Spanish speaking parents and caregivers across the state. Family partners are included in educational opportunities alongside staff including attending national and state conferences, and in planning and participating in WCHS meetings and other trainings hosted by the WCHS. WCHS staff members also continue to partner with the Exceptional Children's Assistance Center (ECAC), which is NC's Family-to-Family Health Information Center (F2F). The WCHS remains committed to continue seeking out opportunities to strengthen

relationships with families and to ensure meaningful input into all services for children and their families delivered through programs at every level.

The WCHS continues to sponsor family representation in Title V-supported state advisory councils. Supported families actively participate in the NC Triple P Partnership for Strategy and Governance and the NC Triple P State Partners Collaborative. FPs co-chair the Genetics and Genomics Advisory Council (GGAC) and play a key role in promoting and operationalizing the GGAC's strategic plan.

The Early Hearing Detection Intervention (EHDI) Program also prioritizes supporting families of deaf and hard of hearing (DHH) children. Parents of children who are DHH engage with the EHDI program to assure that our services meet the needs of families. The EHDI Program website provides a wealth of resources for families including parent-to-parent support groups across the state. NC EHDI provides technical assistance, resource development, and training to parent-to-parent support group leaders. Depending on funding levels, the EHDI Program can support parent consultants and family events across the state. The EHDI Advisory Committee retains dedicated family partners attending the quarterly meetings and providing practical vision to the newborn hearing screening and EHDI programming.

Family partners will also continue to attend the CSHCN Commission's four subcommittees – Behavioral Health, Medicaid Community Alternatives Program for Children (CAP-C), Pediatric Home Nursing, and Oral Health. These groups provide feedback and recommendations on services or policies impacting Medicaid populations.

Efforts to empower youth and integrating their voice throughout Title V endeavors continue to broaden, particularly through the Youth Health Advisor Team. The Youth Health Advisors (YHAs) launched a social media account in partnership with NCDHHS communications to help promote healthy living for NC teens through awareness and action. The account has been used to uplift the work of the team as well as share important health messaging and connect with other youth leadership organizations throughout the state. The YHAs continue to build on their Youth Participatory Action Research projects through work such as investigating and attending to mental health stereotypes in schools and gathering and sharing data on the student experiences of youth with special healthcare needs. The YHAs have partnered with various programs to provide guidance on youth messaging related to tobacco and vaping prevention, reproductive health, and the promotion of the 988 suicide and crisis lifeline to teens. One new parent/youth program engagement opportunity will include expanding strategies to embed the national CYSHCN Blueprint for Change framework into DCFW initiatives.

Staff members of the NC Title V Program, as state employees, cannot advocate directly to the state legislature or US Congress on behalf of their programs; however, they can educate and provide information to family partners to help them in their advocacy work.

III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

As noted earlier, the NC Title V Priority Needs Meeting was held in December 2024 which was attended by Title V program staff as well as state and family partners. The results of the needs assessment findings, both quantitative and qualitative, were shared through slide presentations along with a handout with recent data trends for each of the National Performance Measures. A preliminary set of twenty potential priorities that had been identified through the needs assessment activities (partner survey, focus groups, and data analyses) was distributed and discussed, and meeting participants were given a chance to add or modify these potential priorities. After a brief review of the prioritization criteria (see Figure 7), an anonymous vote was held using Mentimeter to select the top priorities. Participants were encouraged to vote for seven to ten priorities with the Prioritization Criteria shared earlier in mind and were required to vote for at least one priority in each of the population domains. After the vote, the list was narrowed to ten priority needs which, after more discussion, got reduced to seven priority needs with some of the priorities being merged into a broader priority (e.g., the priorities "to improve access to timely and quality prenatal care" and "to promote postpartum care and support" became one priority which was "to promote comprehensive reproductive health care including postpartum care and support").

The priority "to prevent maternal deaths and complications related to pregnancy" received a majority of votes, but during the discussion this priority was removed from consideration as participants felt like with was being covered in other priority areas and because several funding from sources outside of the MCH Block Grant were supporting this

work. This was the only frequently cited need that did was not included directly in the final list of priority needs.

Overall, NC's 2026-2030 priority needs do not differ drastically from the 2021-2025 priority needs as access to comprehensive, quality health care services across the life course, promoting safe and nurturing relationships, improving access to mental and behavioral health services, and ensuring health for all while engaging people with lived experiences remained the state's top priorities. The biggest change was the deletion of the priority need to improve immunization rates. While increasing those rates remains an important priority of NC's Title V Program, during the creation of the DCFW in 2022, the Immunization Branch was moved to the DPH Epidemiology Section to allow better coordination with other branches in that Section, so the Title V Director no longer supervises that Branch.

The development of NC's 2026-2030 State Action Plan took place over a series of meetings by seven separate domain work groups. These work groups, who were made up of mostly Title V Program staff members, but also included family partners, finalized the wording of each of the seven priority needs which had been agreed upon during the Title V Priority Needs Meeting and determined the National and State Performance Measures, the Evidence-Based or -Informed Strategy Measures, and the objectives and strategies for the plan. The Leadership Team reviewed and finalized the State Action Plan in early March. Table 2 lists the seven priority needs and the accompanying performance measures by population domain.

Table 2 – MCH Priority Needs Linked to Performance Measures

NC Priority Needs by Population Domain	National/State Performance Measures
Women/Maternal Health	
1. Promote comprehensive reproductive health care including postpartum care and support	Postpartum Visit NPM
Perinatal/Infant Health	
2. Prevent infant/fetal deaths	Breastfeeding NPM
Child Health Domain	
3. Promote safe and nurturing relationships for children and adolescents	Developmental Screening NPM
4. Improve access to quality whole child and adolescent health care	Medical Home for Non-CSHCN NPM
Adolescent Health	
3. Promote safe and nurturing relationships for children and adolescents	SPM 1: Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance
4. Improve access to quality whole child and adolescent health care	Adolescent Well-Visit NPM
CYSHCN	
4. Improve access to quality whole child and adolescent health care	Medical Home CSHCN NPM
5. Ensure all CYSHCN receive care in a system that works well and ensures health for all, family and child well-being and quality of life, access to services, and financing of services	SPM 2: Percent of children with special health care needs who receive care in a well-functioning system
Cross-Cutting/Systems Building	
6. Engage individuals and families with lived experience, as well as community-based organizations, as partners in the development and implementation of people-centered programs and policies that reduce health disparities and address community health factors	SPM 3: Percent of Title V programs that offer compensated family engagement and leadership opportunities
7. Improve access to mental and behavioral health services for maternal and child health populations	SPM 4: Percent of counties who have providers who have utilized the NC-PAL or NC MATTERS psychiatry access lines

III.D. Financial Narrative

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$18,806,308	$16,451,537	$18,871,732	$16,711,237
State Funds	$37,169,426	$45,802,293	$45,189,526	$49,684,655
Local Funds	$0	$0	$0	$0
Other Funds	$65,371,749	$57,707,314	$65,311,808	$186,253,574
Program Funds	$73,859,576	$70,327,753	$67,155,895	$75,179,067
SubTotal	$195,207,059	$190,288,897	$196,528,961	$327,828,533
Other Federal Funds	$456,342,218	$390,961,113	$413,861,107	$337,108,529
Total	$651,549,277	$581,250,010	$610,390,068	$664,937,062

	2024		2025	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$18,871,732	$16,501,293	$18,871,732	
State Funds	$46,722,582	$49,684,655	$54,811,949	
Local Funds	$0	$0	$0	
Other Funds	$65,322,845	$1,128,601	$0	
Program Funds	$70,327,754	$87,292,481	$75,179,067	
SubTotal	$201,244,913	$154,607,030	$148,862,748	
Other Federal Funds	$435,531,229	$448,981,414	$69,890,335	
Total	$636,776,142	$603,588,444	$218,753,083	

	2026	
	Budgeted	Expended
Federal Allocation	$18,401,714	
State Funds	$46,722,583	
Local Funds	$0	
Other Funds	$0	
Program Funds	$87,292,481	
SubTotal	$152,416,778	
Other Federal Funds	$24,211,468	
Total	$176,628,246	

III.D.1. Expenditures

The NC General Assembly (NCGA) approves all block grants as distinct parts of the state budget. However, because the state fiscal year is July 1 – June 30, there is a difference in the amounts of Title V funding in the approved state plan from the annual Maternal and Child Health Block Grant award to the state. All budget and expenditure actions relating to Title V funds occur within the approved state plan as determined by the NCGA. The amounts of expenditures reported in the annual report therefore are within the state fiscal year. Because the same period is used year after year, the amounts reflect a consistent 12-month period of performance. The budgeted amounts are based on the previous year's funding at the time of the MCHBG application/report preparation and submission. In FY24, federal Maternal and Child Health Block Grant expenditures were $16,501,293 which is a slight decrease of $209,943 from the previous year.

The conceptual framework for the Title V Maternal and Child Health Block Grant services is envisioned as a pyramid with three tiers of services and funding levels that provide comprehensive services for mothers and children with the ultimate goal of improving health for these populations. Based on the Maternal and Child Health Bureau's definition of direct health care services, North Carolina's MCH program does not fund any direct services with Title V dollars, nor does the MCHBG fund any services that are eligible for Medicaid reimbursement. A majority of expenditures (~82%) went to enabling services, with a smaller proportion (~18%) going towards public health services and systems.

North Carolina is in compliance with the reported expenditures for the 30%-30%-10% requirement as specified in Section 504(d) and Section 505(a)(3), see Form 2 and Form 3 for the details.

- Federal Allocation FY24 Expended compared to Budget; this remains a variance each year due to our State Budget Process. The NC General Assembly (NCGA) approves all block grants as distinct parts of the state budget. However, because the state fiscal year is July 1 – June 30, there is a difference in the amounts of Title V funding in the approved state plan from the annual Maternal and Child Health Block Grant award to the state. All budget and expenditure actions relating to Title V funds occur within the approved state plan. The amounts of expenditures reported in the annual report therefore are within the state fiscal year. Because the same period is used year after year, the amounts reflect a consistent 12-month period of performance. The budgeted amounts are based on the previous year's funding at the time of the MCHBG application/report preparation and submission. Since we have two years to spend, funds are not left unexpended.
- There were several position vacancies at different points in the year which were difficult to fill, resulting in underspent funds for these categories. Staff worked to utilize the funding for temporary staff to complete the duties of the vacant positions as well as other allowable expenses including equipment (laptops, printers, etc.) and professional development for existing staff (trainings, conference attendance, etc.)
- Several contracts with external partners were delayed in execution, resulting in underspending as well. The NC General Assembly was delayed in approved a budget in FY 24. Given that the MCHBG budget must be approved by the General Assembly, the delay impacted when contract work could begin. These excess amounts were awarded in fiscal year (FY24-25) and spent in alignment with the two-year allowance for spending Block Grant dollars.

We have previously covered our process to ensure these set aside requirements are met.

Section 503 (c)

Administrative costs are identified in specific cost centers called segments. Typically, these are costs that are charged in the division's cost allocation plan, and certain direct costs for administrative offices. Budgets for these cost centers are summed and compared to the total budget to assure they are not more than 10% of the total grant amount.

Section 505 (a) (3) (A & B)

The state budget's available funds are in a series of cost centers called segments. These cost centers are used to group dollars intended for certain types of programs and services. They are assigned to one or both of the 30% "set aside" categories and are assessed a percentage of the budget that can be attributable to services in the category.

III.D.2. Budget

The FY26 Application Budget for the MCHBG is $18,401,714, a majority (86%) of which goes to support local women's and children's health programs and services. Funding for local programs goes to all local health departments, community-based organizations, and health care systems to carry out the programs described in the narratives and is a critical source of funding for LHDs to provide or assure maternal and child health services in NC. A smaller portion (12%) is used to support NCDHHS infrastructure, which is not only used to carry out critical statewide MCH work but also leveraged to bring in additional funding to expand initiatives and improve MCH outcomes in North Carolina. The remainder of ~2% of budget goes towards NCDHHS administration, which has consistently stayed below the maximum of 10%.

Per the Maternal and Child Health Bureau's definition of direct health care services, North Carolina's MCH program does not fund any direct services with Title V dollars, nor does the MCHBG fund any services that are eligible for Medicaid reimbursement. Most of this funding goes towards enabling services (~86% of budget), with the remainder (14% of budget) going towards public health services and systems and administration.

NC's Maternal and Child Health Block Grant financial management plan assures the compliance with the Title V fiscal requirements as follows:

Section 503 (a)

The state requires that all state match for the grant be budgeted in the same cost center with the relevant federal dollars. Upon expenditure of those pooled dollars, the state draws the appropriate number of federal dollars to reflect the 4:3 federal to state match rate. There are some cost centers in which federal dollars are not matched to state dollars; in other words, 100% of the budgeted funds are federal. For these dollars, the state designates with special codes the proper amount of state dollars elsewhere in the budget as match.

Section 503 (b)

The state applies annually for the MCH Block Grant funding, however, has two years in which to expend the federal MCH Block Grant allocation awarded in any fiscal year.

Section 503 (c)

Administrative costs are identified in specific segments. Typically, these are costs that are charged in the division's cost allocation plan, and certain direct costs for administrative offices. Budgets for these segments are summed and compared to the total budget to assure they are not more than 10% of the total grant amount.

We have covered our process below on our procedures to ensure these set aside requirements are met. The Budget is reported for the 30%-30%-10% requirement as specified in Section 504(d) and Section 505(a)(3), see Form 2 and Form 3 for the details.

Section 505 (a) (3) (A & B)

The state budget's available funds are in a series of cost centers called segments. These segments are used to group dollars intended for certain types of programs and services. They are assigned to one or both of the 30% "set aside" categories and are assessed as a percentage of the budget that can be attributable to services in the category.

For example, the AMU 1271 5351 consists of allocated funds to local health departments for child health services. We determine the proportion of the funds that are attributed to preventive and primary care services and services for children with special health care needs, then multiply the percentages by the allocation to come up with the respective amounts for each category. This assessment is performed for each AMU segment in which Title V funds are budgeted, and the sums for the two categories are compared to the total budget award to determine compliance.

Section 505 (a) (4)

The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs for FY25 as shown in Form 2 is $54,811,948. This includes state funds used for matching Title V funds, which for the FY25 application is $129,991,016.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: North Carolina

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

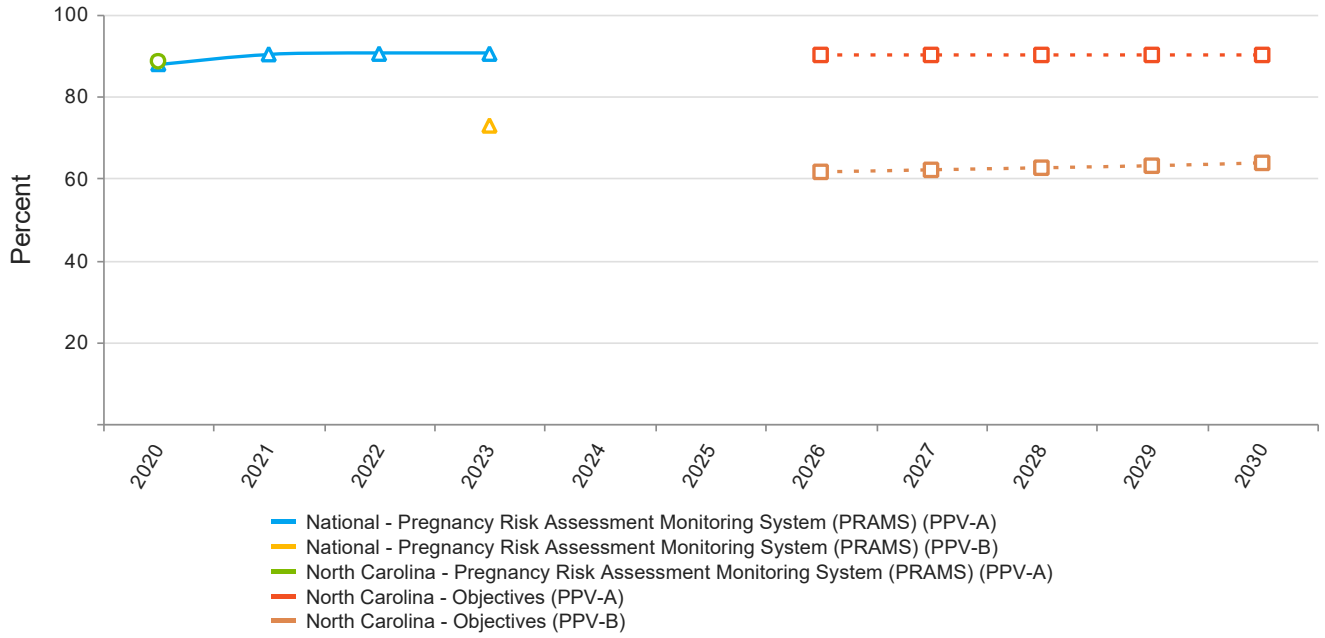
III.E.3 State Action Plan Narrative by Domain

If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.

Women/Maternal Health

National Performance Measures

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	88.6
Numerator	98,465
Denominator	111,078
Data Source	PRAMS
Data Source Year	2020

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	90.0	90.0	90.0	90.0	90.0

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2024
Annual Objective	
Annual Indicator	60.7
Numerator	
Denominator	
Data Source	NC Medicaid
Data Source Year	2023
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	61.5	62.0	62.5	63.0	63.7

Evidence-Based or –Informed Strategy Measures

ESM PPV.1 - Comprehensive postpartum visits in local health departments

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0

State Action Plan Table

State Action Plan Table (North Carolina) - Women/Maternal Health - Entry 1
Priority Need
Promote comprehensive reproductive health care including postpartum care and support
NPM
NPM - Postpartum Visit
Five-Year Objectives
WMH Objective 1 By 2030, increase the percent of Medicaid deliveries that had a comprehensive postpartum visit on or between seven and 84 days after delivery from 60.7% (2023 Baseline) by 5% to 63.7%. WMH Objective 2 By 2030, the unduplicated number of people in NC receiving patient-centered reproductive health services, including contraception, will increase from 57,414 (2024 Baseline) by 2% annually.
WMH Objective 2 By 2030, the unduplicated number of people in NC receiving patient-centered reproductive health services, including contraception, will increase from 57,414 (2024 Baseline) by 2% annually.
WMH Objective 3. By 2030, increase the unduplicated number of adolescents in NC receiving adolescent-centered reproductive health education, including contraception, through NC DHHS Teen Pregnancy Prevention Initiatives (TPPI) funded programs from 3,844 (FY24 Baseline) by 2% annually.

Strategies
WMH 1.1 Participate in NC Medicaid's Maternal Health Internal Alignment Meetings and the Maternal Health Learning Collaborative, strengthening collaborations and ensuring alignment of activities and resources.
WMH 1.2 Leverage home visiting programs (Healthy Beginnings, Healthy Start, Nurse-Family Partnership, Healthy Families America, and local health department (LHD) Women's Health Services Home Visitors, among others) to provide education and support to ensure that participants: (1) receive comprehensive postpartum clinical visits and (2) are informed about Medicaid 12 month extension and Medicaid expansion.
WMH 1.3 Improve LHD data reporting and data quality for documenting postpartum visits by: - Providing training and technical assistance to LHD maternal health providers and support/billing staff on appropriate billing and coding for postpartum visit completion - Creating custom data form in each LHD's electronic health record to report out the data; (3) Creating a reporting template to share back EHR services and claims data, inclusive of data related to postpartum care; and (4) Selecting one or two LHDs to implement QI processes to improve the quality of the postpartum visit and the number of completed postpartum visits during FY26 and scaling up promising practices as possible statewide.
WMH 1.4 Establish a "community of practice for postpartum care" inclusive of physicians, midwives, nurse practitioners, nurses, home visiting nurses, behavioral health providers, etc., providing care at NC LHDs or federally qualified health centers to share knowledge, best practices, and experiences to provide optimal postpartum care to new mothers.
WMH 1.5 Provide postpartum navigation through the Perinatal Nurse Champion program in Perinatal Care Region 3 who will conduct culturally and linguistically appropriate phone calls to encourage non-English speaking Atrium Health patients to complete their comprehensive postpartum visit.
WMH 1.6 Provide postpartum simulation training to OB practices related to postpartum best practices and evidence-based maternal mental health screening in Perinatal Care Region 1.
WMH 1.7 Serve on the PRAMS/PAS steering committee established by the NC State Center for Health Statistics.
WMH 2.1 Work with LHDs/agencies to increase access to services by offering extended clinic hours; utilizing mobile units or alternate locations; promoting pharmacist-initiated contraception; and educating around over the counter contraception.
WMH 2.2. Assist local agencies with offering same-day contraceptive services by providing technical assistance; creating template policies and flowsheets to aid clinic flow; and connecting agencies to share success/barriers.
WMH 2.3 Offer webinars and/or office hours to LHDs/agencies on variety of topics to increase patient-centered services (trauma-informed, weight stigma, shared decision making, etc.).
WMH 2.4 Provide technical assistance/training to local agencies on reviewing/updating policies to promote patient-centered services.
WMH 2.5 Create resources for local agencies to promote patient-centered, accessible reproductive health services, such as social media ads, waiting room slides, advertisements, etc.
WMH 2.6 Promote best practices and provide technical assistance for home visiting and care management program staff members to discuss pregnancy intention.
WMH 3.1 Create a workgroup comprised of individuals from TPPI funded agencies to discuss applying adolescent-centered reproductive health practices to program implementation.
WMH 3.2 Provide webinars/trainings around adolescent-centered reproductive health educational programs to youth-serving agencies.
WMH 3.3 Create regional-based youth leadership councils to provide opportunities for young people to voice their opinions and ideas around reproductive health work in NC

ESMs	Status
ESM PPV.1 - Comprehensive postpartum visits in local health departments	Active

NOMs

Maternal Mortality

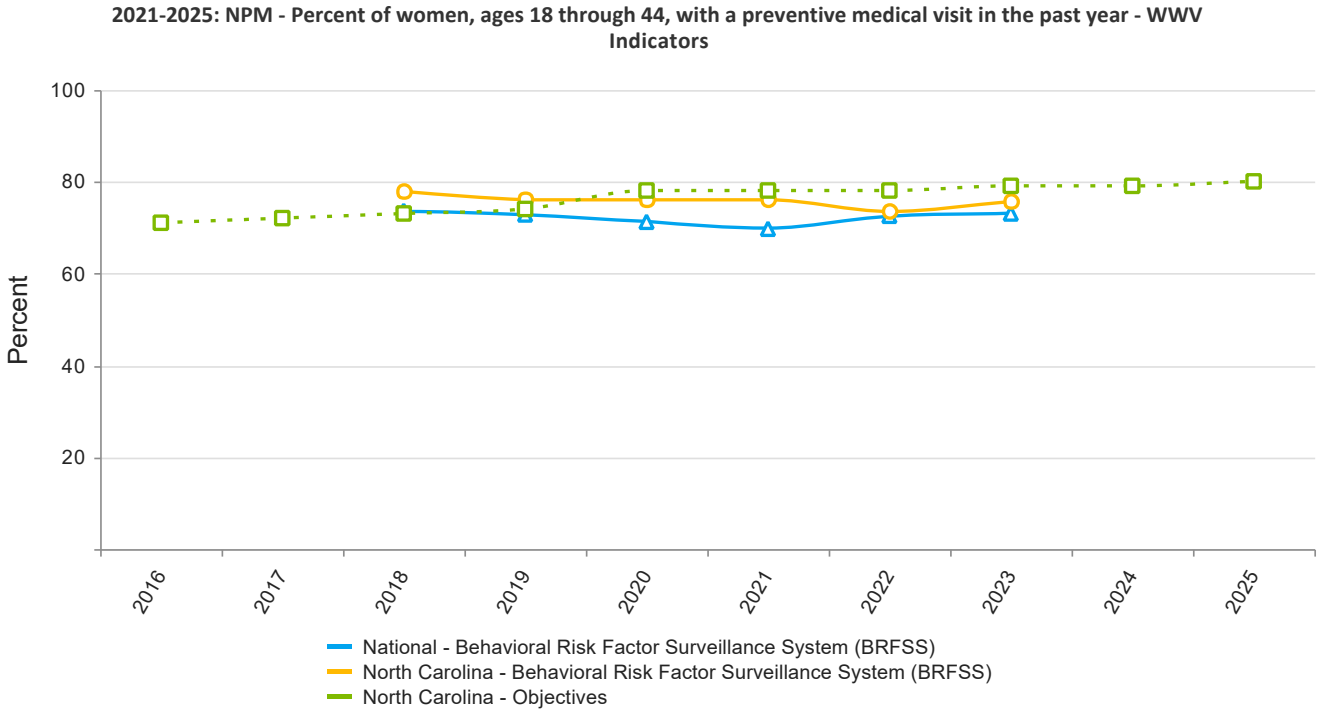
Neonatal Abstinence Syndrome

Women's Health Status

Postpartum Depression

Postpartum Anxiety

2021-2025: National Performance Measures



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	78	78	78	79	79
Annual Indicator	76.1	75.9	75.9	73.4	75.5
Numerator	1,386,809	1,383,829	1,383,829	1,360,288	1,419,381
Denominator	1,823,266	1,822,669	1,822,669	1,853,350	1,879,778
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2021	2021	2022	2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM WWV.2 - Percent of WICWS programs that utilize the PCH Outreach and Education Toolkit

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		0	0	10	15
Annual Indicator		0	0	0	0
Numerator					
Denominator					
Data Source		WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM WWV.3 - Percent of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and reproductive life planning (RLP).

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		30	40	75	95
Annual Indicator		32.9	82.1	95.2	97.6
Numerator		28	69	80	82
Denominator		85	84	84	84
Data Source		WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year		FY20-21	FY21-22	FY22-23	FY23-24
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM WWV.4 - Percent of LHDs offering same day insertion of both contraceptive implants and intrauterine devices (IUDs)

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		74	85	86	86
Annual Indicator		84.5	73.7	59.2	56.1
Numerator		82	73	58	55
Denominator		97	99	98	98
Data Source		NC FP LHD Clinical Practice Survey	NC FP LHD Clinical Practice Survey	NC FP LHD Clinical Practice Survey	NC FP LHD Clinical Practice Survey
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM WWV.5 - Percent of LHDs that offer extended hours for Family Planning services.

Measure Status:	Active	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	28.6	33.3
Numerator	24	28
Denominator	84	84
Data Source	NC Family Planning Program Service Site Info.	NC Family Planning Program Service Site Info.
Data Source Year	2023	2024
Provisional or Final ?	Final	Final

2021-2025: State Performance Measures

2021-2025: SPM 1 - Percent of PRAMS respondents who reported that their pregnancy was intended

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		59.7	60	60.3	60.6
Annual Indicator		58.6	58.6	58.6	58.6
Numerator					
Denominator					
Data Source		NC Pregnancy Risk Assessment Monitoring System	NC Pregnancy Risk Assessment Monitoring System	NC Pregnancy Risk Assessment Monitoring System	NC Pregnancy Risk Assessment Monitoring System
Data Source Year		2020	2020	2020	2020
Provisional or Final ?		Final	Provisional	Provisional	Provisional

Priority Need 1 – Improve Access to High Quality Integrated Health Care Services

The NC Title V Program is committed to assuring that people in NC have access to high quality integrated health care services across the life course. For individuals of reproductive age, much of this work is operationalized within the Women, Infant, and Community Wellness Section (WICWS). The WICWS develops and funds programs and services that protect the health and well-being of individuals during and beyond their child-bearing years. This includes programs for individuals before, during and after delivery of their baby, and for their infants as well. Strategies directly related to the work of Title V within the Women/Maternal Health Domain are included here, and others can be found in the Perinatal/Infant Health Domain section.

Postpartum Visit NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components.

Well-Woman Visit Standardized Measure – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Increasing the percentage of women who received a postpartum checkup within 12 weeks after giving birth who received recommended care components and increasing the percentage of women with a past year preventive medical visit are critical pieces of the work of the WICWS. While PRAMS data are only available for NC up to 2020, results from 2020 show that 88.6% of respondents said they had received a postpartum checkup, and 91.5% of those respondents stated that during the checkup, a doctor, nurse, or other health care worker asked if they were feeling down or depressed. Per FAD data from the 2023 BRFSS, 75.5%% of women ages 18 to 44 surveyed had received such a service which is similar to the national rate (73%) and is slightly lower than the 2019 NC rate of 76.1%. Of the women who responded to the 2023 survey, those with higher income, higher educational attainment, and higher rates of health insurance coverage were more likely than other women to receive a preventive medical visit. Non-Hispanic Black women (80.6%) and non-Hispanic American Indian or Alaskan Native (90.5%) were more likely to have had a visit than Hispanic women (67.2%) or non-Hispanic white women (76.8%). The Affordable Care Act (ACA) has ensured that the majority of health plans offer women coverage for well-woman visits without cost-sharing, but many women and/or their providers are not aware of this coverage.

To increase the percent of women with a past year preventive medical visit, local health departments (LHDs) provide family planning core services that include contraceptive services, pregnancy testing and counseling, achieving pregnancy services, basic infertility services, sexually transmitted infection (STI) services, preconception health services, and related preventive health services. LHD maternity clinics also provide maternal health services inclusive of clinical care, referral for Medicaid and WIC services, provision of tobacco cessation counseling, screening for intimate partner violence, depression screening, and provision or referral for nutrition consultation. In addition, maternal care skilled nurse home visits are provided for women with high-risk pregnancies. Home visits for newborn/postpartum and newborn assessment and follow-up care home visits are also provided by nurses. LHDs are also able to provide childbirth education services.

Title V funding, along with Title X, TANF, and state funding, was allocated to 84 LHDs for the delivery of family planning services in FY24. According to the 2024 Family Planning Annual Report, 57,414 female patients were seen in these LHDs. Female patients were able to choose an appropriate method of birth control from among a range of options.

In addition, the Division of Child and Family Well-Being's Whole Child Health Section (WCHS) used Title V funds to support training and technical assistance to include how to more effectively provide confidential reproductive health services as part of annual adolescent preventive visits as part of the Division's emphasis on whole adolescent health up through age 21 years in LHD child health clinics. LHDs are encouraged to implement approved evidence-based strategies to improve health outcomes for adolescents.

The WICWS houses the Teen Pregnancy Prevention Initiatives (TPPI). TPPI provides funding opportunities for local agencies to implement teen pregnancy prevention programs utilizing evidence-based/informed curricula. Local agencies are funded utilizing state and federal funds, including Title V, for adolescent pregnancy prevention

programs and adolescent parenting programs. Title V funding supported five local adolescent parenting programs (AP2). The programs focus on delaying a second teen pregnancy, completing high school or GED, developing effective parenting skills, and building positive self-image for the pregnant/parenting adolescent. The programs utilize the Parents as Teachers home visiting curriculum. In order to impact adolescent reproductive health programs across the state, the WICWS partnered with South Carolina based Fact Forward through a Request for Applications (RFA) process completed in FY23. Fact Forward's contract started in October 2023, and during FY24 they hosted listening sessions with adolescent-serving professionals to determine training needs. Based on this information two trainings (*Teaching Techniques* and *Askable Adult*) were held and were open for any youth-serving individual interested to attend. Additionally, Fact Forward hosted an Adolescent Health Spring Summit in April 2024 in Chapel Hill with 98 attendees. The conference was 1.5 days and held a variety of breakout sessions as well as an overview of the state of adolescent health in NC. Attendees reported the conference was a valuable resource for their professional work and appreciated the quality of the breakout sessions and speakers. Another focus of Fact Forward's work in NC was to recruit youth to serve on a Youth Leadership Council (YLC). Seventeen youth candidates were interviewed and fourteen were confirmed as members of the new YLC. An introductory meeting was held in May along with a retreat during the summer.

Provide Guidance and Support to LHDs to Offer Family Friendly Clinical Services

Throughout FY24, the WICWS Regional Nurse Consultants (RNCs) provided LHDs monitoring and technical assistance to assure that the family planning and maternal health clinical services offered met the needs of their community. RNCs routinely reviewed LHD policies/procedures/protocols and evidence related to community engagement and community participation in determining the services offered/provided in their family planning and maternal health clinics. Consultants also worked with agencies to provide technical assistance regarding the required annual informational and educational material review; this process assures that publications are reviewed by existing family planning clients to assure that they are appropriate to the needs of the community.

The Community Engagement, Education, and Quality Improvement (CEQ) Plan is an annual mandatory requirement for all LHD Title X sites. In August 2023, a CEQ office hours webinar was held. During this webinar session, the main components of the CEQ were summarized. In addition, LHDs were allowed to ask questions and provide feedback regarding their CEQ process (challenges, successes). A review of the CEQ template, submission instructions, and additional resources were also provided. In February 2024, an additional CEQ office hours webinar was held. The webinar highlighted the following: identifying manageable steps of the QI process, available resources to help improve the QI process, and identifying key strategies to promote continued community participation. During the webinar, Rockingham County Health Department's Family Planning Program was highlighted. They aimed to increase client satisfaction by implementing a client-chosen measure to improve client experience over the fiscal year. They created a survey on clients' input on clinic improvement areas. The agency surveyed the clients in a 3 to 4 month period and summarized the suggestions for options that could be feasible and affordable for their clinic. After careful evaluation of the results, the clinic could easily implement physical changes in the clinic (i.e. sound machines, colorful wraps for overhead lights).

As staff turnover continued at higher levels than in the past, the RNCs continued to implement the LHD staff orientation process that was revised in FY23. The process requires the local staff to complete pre-requisite work designed to familiarize them with their local policies/procedures/protocols including those around community engagement and informational/educational material review. This revised orientation process allowed the RNCs to focus time during orientation discussing the individual staff person's role in assuring the clinic is assessing and addressing the overall reproductive health needs of their community. Feedback from all 17 individuals oriented through this process in FY24 reflected that their understanding of the Family Planning and Maternal Health programs was better or much better after completing the orientation process than it was before their orientation.

In February and March 2024, the Reproductive Health Program Consultant collaborated with the Family Planning Medicaid Program Manager to host an interactive two-part webinar series based on social media. Part One of the series reviewed the importance of brand voice/goal setting in social media outreach, understanding specific priority audiences, and developing messaging and engaging social media content. Although this webinar was made available to all LHDs and community-based agencies, sections of the webinar were developed with Title X agencies and requirements in mind. It was highlighted that the use of social media can be utilized to promote reproductive

health care in Title X clinics, and it can help family planning agencies provide opportunities for education, engagement, and quality improvement which is part of their CEQ. Social media can be used as a powerful tool for engaging current and potential clients and connecting them with health information and family planning resources. Part Two of the series focused on helping agencies develop social media campaigns, utilizing social media data and evaluation to gauge program success, and selecting the appropriate media channels for the promotion of Family Planning services. The training series had over 60 attendees.

On June 20, 2024, the State Family Planning Nurse Consultant and the Regional Nurse Consultant Supervisor presented a webinar for local family planning nursing staff on implementing client-centered care practices in their family planning clinics. Seventy-one respondents completed an evaluation that they agreed or strongly agreed that, as a result of the webinar, they understood the importance of client-centered care in reproductive health services.

Extended Hours for Family Planning Services

WICWS created ESM WWV.1 (number of LHDs that offer extended hours for family planning services) which would help provide an opportunity for more individuals to access a preventive medical visit outside regular business hours. Offering extended clinic hours allows agencies to provide services to populations that are not able to access them during standard clinic hours. It is an opportunity for clinics to increase the number of patients as well as flexibility in patient appointments and staff scheduling. Based on feedback from the MCH Evidence Center, this ESM was revised and strengthened during FY24 and turned into measuring the percentage of LHDs that offer extended hours for family planning services (ESM WWV.5). With 84 LHDs providing direct family planning services, this means that the percentage jumped from 17.9% in FY20 up to 33.3% in FY24.

In November 2023, a survey was sent to thirteen Title X agencies that had previously stated during the February 2023 Regional Family Planning Nurse's Meeting that they were interested in providing extended clinic hours. Several agencies expressed in the survey that their primary reasons for providing an extended hours schedule were to increase patient accessibility and staff flexibility. In addition, these agencies stated they would provide comprehensive reproductive health services during those times, which includes preventative health services, referrals to other providers, pregnancy testing, and STI screenings and treatment. In May 2024, the Reproductive Health Program Consultant and Reproductive Health Branch Head met with staff from the Reproductive Health National Training Center to discuss strategies around an extended hours schedule. They discussed the following strategies and steps: community support, advertising/social media, clinical staff buy-on, logistics, and sustainability. The extended hours one-pager will be re-developed for agencies and LHDs to highlight the benefits, lessons learned, and effective tips for extending clinic hours while taking these several strategies/steps into consideration. The document will serve as a resource for agencies considering offering different hours.

Improving Preconception Health and Creation of Outreach and Education Toolkit

The Preconception Health Team (PCH Team), which includes the Infant and Community Health Branch (ICHB) Head, the Nutrition Consultant, and the Preconception Health and Wellness Program Manager, in collaboration with the Family Planning Nurse Consultant and an intern from a local university, completed the draft of the Preconception Health Outreach and Education Toolkit (ESM WWV.2). Internal review of the toolkit was extended through FY24, and submission to the NCDHHS Office for Public Affairs is in process.

The ICHB continued to enhance the implementation of preconception efforts within NC using the NC Preconception Health Strategic Plan Supplement for 2014-2019 as a guide. As work began on updating the NC Perinatal Health Strategic Plan (PHSP), it was decided to merge the work of the Preconception Health Strategic Plan Supplement into the PHSP. A Preconception Health Workgroup is being considered as part of the Perinatal Health Strategic Plan Collective. The ICHB implements the Preconception Peer Educator (PPE) program in collaboration with Historically Black Colleges and Universities, community colleges, other universities, and a high school around the state. Students continue to be trained in preconception health, reproductive life planning, HIV/STIs, tobacco use, healthy weight, and other wellness areas. The PPEs share this information on their college campuses and in surrounding communities. A total of 20 two- and four-year colleges remain on the NC PPE roster. Guilford County Division of Public Health, in collaboration with North Carolina Agricultural and Technical State University and the ICHB, hosted two hybrid PPE trainings on September 22-23 and November 11-12, 2023. A third virtual PPE training was

conducted in collaboration with Albemarle Regional Health Services, Elizabeth City State University, and Martin County Innovation Center (a magnet high school) on March 12-13 and March 18-20, 2024. More than forty students attended the training along with advisors and volunteers from Guilford County's community ambassador program. Each institution launched a range of activities highlighting preconception health and wellness on their campuses and in surrounding communities.

Additional Activities to Improve Access to High Quality Integrated Health Care Services

During FY24, Improving Community Outcomes for Maternal and Child Health (ICO4MCH – described more fully in the P/IH Domain Annual Report) sites implemented efforts focused on improving preconception and interconception health among individuals of reproductive age. Durham County Department of Public Health, Guilford County Division of Public Health, and the Mecklenburg-Union and Sandhills Collaboratives conducted outreach events focused on preconception and interconception health, reaching 3,225 women of reproductive age. Forty-five staff members from four grantee sites were trained to facilitate the Mothers & Babies (MB) Program. This program focuses on screening for postpartum depression and support during the interconception period. They delivered 49 group and 291 individual sessions of the program to 124 women.

During FY24, the federally funded Healthy Start program, NC Baby Love Plus (NC BLP), continued to provide case management services using evidence-based tools for risk assessment and screening, provide education on pregnancy intendedness using the Ready, Set, Plan! toolkit, and facilitated access to health services for preconception women. The Family Outreach Workers (FOWs) in NC BLP served as the primary source of engagement in preconception outreach. The NC BLP program continued to engage with participants using virtual platforms. Several sites held in-person sessions on topics such as stress management, healthy relationships, financial management, and nutrition. The NC BLP program continued to share information with participants via social media (Facebook and Instagram) posts with tips on achieving and maintaining optimal health and determining next steps whether or not a baby is in their future. NC BLP continued to partner with the March of Dimes' Preconception Health Community Ambassador program to support participant knowledge of reproductive life planning and folic acid consumption.

During FY24, the WICWS RNCs, via monitoring and technical assistance, assured that LHDs had policies/procedures/protocols related to referrals for medical services identified during a health care visit that are beyond the scope of the family planning program. Consultants assured that the LHDs had lists of referral providers within their community, and that the lists clearly identified the kinds of health care services provided to ensure continuity of care. Additionally, RNCs assured that agencies had Memoranda of Understanding in place with primary care providers for their family planning clients to help assure access to and continuity of care. Finally, RNCs assured that visit documentation reflected that clients are assessed to ensure access to a primary care provider during family planning clinic visits.

The Reproductive Health Branch (RHB) continued to partner with substance use treatment programs to provide reproductive life planning to their clients. In FY24, an asynchronous online training was released for staff at substance use disorder clinics to complete related to reproductive life planning. This training had been held in-person and virtually prior, but after over a year of development, was released. LHD staff could also complete this training for anyone interested. Two hundred and sixteen people completed the training as of July 2024.

Priority 2 – Increase Pregnancy Intendedness Within a Client-Centered Care Framework

Another NC Title V priority is to increase pregnancy intendedness within a client-centered care framework. This would include providing services and supporting individuals whether they choose to have children or not.

SPM#1 - % of PRAMS respondents who reported that their pregnancy was intended (wanted to be pregnant then or sooner)

In Phase 7 of the Pregnancy Risk Assessment Monitoring System (PRAMS) survey, the question regarding pregnancy intendedness (Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?) was modified to include a choice of "I wasn't sure what I wanted" to go along with the

responses that the person wanted to be pregnant later, sooner, then, or not then or at any time in the future. With this change, data prior to 2012 are not comparable to data from more recent years. Low participation has been a substantial problem for NC PRAMS from 2012 to 2020, with overall weighted response rates ranging from 45% to 57%. The 2020 PRAMS responses, which are the most recent available, were similar to previous years, as 17.8% of respondents wanted to be pregnant later, 16.5% wanted to be pregnant sooner, 42.2% wanted to be pregnant then, 7% did not want to be pregnant then or any time, and 16.5% were not sure what they wanted. As reported in other sections of this application, PRAMS data will not be available for 2021 and 2022, but the SCHS piloted a state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which included questions identical to the 2020 PRAMS survey. PRAMS Phase 9 questions were instituted into PAS beginning in 2024, but the response rates were insufficient for meaningful analyses of the data for 2023 and 2024.

Providing Services Within a Client-Centered Care Framework

In order for local partners, including LHDs, to provide services within a client-centered care framework, they need to have a full understanding of the framework and the implications on the services provided. To that end, the WICWS adopted ESM WWV.3 (Percent of LHDs who had staff complete training on client-centered care framework, contraceptive methods, and reproductive life planning) and collected baseline data that 33% of LHDs had staff complete such trainings (FY21). Based on data from trainings that occurred in FY24, 61% of LHDs had staff complete a training during FY24 and 98% of LHDs have completed a training over the last four years.

In order to enhance capacity to advance client-centered care, the RHB started offering training opportunities and resources to address the top training areas that LHDs identified wanting more information on in both the Improving Health Outcomes Training Survey (February 2023) and annual clinical assessment (December 2023). This includes three virtual, interactive webinar trainings: Exploring the Non-Medical Drivers of Health (December 2023), Client-Centered Care (June 2024), and Trauma-Informed Practices: Enhancing Your Clinic's Physical Environment (June 2024). A total of 221 participants from 55 LHDs attended these live webinar opportunities. Additionally, these webinars are available on the WICWS website for agencies to view at any time. The Non-Medical Drivers of Health webinar defined the drivers, discussed common drivers among people of reproductive age, and considered ways to address the drivers within the family planning clinic setting. The Client-Centered Care webinar defined client-centered care, why it is important in reproductive health, and how shared decision making prioritizes clients' needs. The Trauma-Informed Practices webinar defined trauma-informed care, discussed common elements of trauma-informed design, and described small, manageable changes in the clinic physical space as trauma-informed. The webinar highlighted the importance of integrating trauma-informed practices into LHDs CEQ plans. Several benefits of implementing trauma-informed practices into CEQ activities were discussed. A mock CEQ plan was developed and shown during the webinar. Several resources were highlighted to help agencies support trauma-informed quality improvement plans (including the WICWS RHB Patient Satisfaction Survey). Guilford County Division of Public Health Family Planning Program's Just Teens Clinic, a clinic staffed with health professionals who are experts in addressing teens-specific issues, reproductive health, and sexual health in a trauma-informed way, discussed the importance of creating a clinical environment specifically for the youth and underrepresented groups. For many years, this clinic has been helping fill the gap in health for adolescents in a trauma-informed way.

During FY24, the WICWS sponsored several additional trainings for LHD staff. In early 2024, the RHB held two Family Planning Statewide Virtual Meetings for LHDs to discuss differences between Title X and NC Family Planning Medicaid requirements, follow-up of abnormal lab findings, adding new clinical service sites, and utilizing community health workers in family planning. The meetings combined had 208 attendees from 73 of 84 different LHDs.

An additional resource for LHDs to further their learning on various health for all topics, the Title X "Patient-Centered Practice" Newsletter, was launched in 2024. This is a quarterly newsletter sent out to all Title X subrecipient agencies and is a way to disseminate information, highlight the work a subrecipient agency is doing, and promote additional trainings from the RHB or other trusted sources. The two issues sent out this year (March 2024 and June 2024) focused on different aspects of trauma-informed care – workforce development and physical environment.

In FY24, the RHB staff members furthered their journey on improving health outcomes and reflected on how the work is impacted. Staff completed an assessment from the National Family Planning and Reproductive Health

Association to identify areas of strength and growth within the work of the Branch. Additionally, they attended a facilitated meeting in June 2024 where they reflected on a recent *Time Magazine* article about the importance of offering individuals access to all methods of birth control. The article highlights how client-centered care can be compromised when patient needs and preferences are not put first. The RHB staff walked away from the time together with a commitment to provide training around client-centered care and additional ideas of how to update state Title X policies and the Agreement Addenda with client-centered language.

In FY24, TPPI focused on issuing an RFA for secondary prevention sites offering home visiting and support services to adolescent parents through AP2. This step fully transitioned programs to offering the Parents as Teachers home visiting curriculum. Additionally, secondary pregnancy prevention sites continued to apply a client-centered care framework to program implementation and assessing local policies and practices. TPPI also hosted a virtual graduation for AP2 graduates. The theme of the graduation was *Lighting the Future*, featuring a slide presentation highlighting each graduate and a keynote speaker. At least 30 individuals were in attendance (graduates, local agency staff, TPPI staff).

TPPI continued its longstanding partnership with the North Carolina School Health Training Center at East Carolina University (ECU) to provide reproductive health training, technical assistance, and resources to funded programs. This supported the implementation of the Rights, Respect, and Responsibility (3Rs) and FLASH curricula for primary prevention sites. TPPI identified training and competency development as key focus areas for sites in year one of the new funding cycle, a Positive Youth Development Training was held in August 2023 with over 20 attendees.

Another objective is to increase access to highly effective contraceptive methods.
In June 2023, the NC Legislature allocated $3.5 million of state dollars towards increasing access to contraceptives and/or improving infant and maternal health outcomes. Beginning in FY24, eight LHDs and ten federally qualified health centers (FQHCs) were awarded funding to increase access to contraceptives by offering extended clinic hours or offering services in a satellite location under the Supporting Women's Health Services program. This program operates under WICWS. During the short FY24 funding (Feb/March to May 2024), 217 individuals were seen through this program across the funded agencies and staff completed a Client-Centered Contraceptive Counseling training sponsored through the Reproductive National Training Center.

During FY24, the WICWS continued to tri-chair the NC Reproductive Life Planning Stakeholders Workgroup which has representation from 16 different agencies all focused on Reproductive Life Planning for all North Carolinians. Agencies represent state government, Title X subrecipients, FQHCs, nonprofits, private funders, hospital systems, universities, consumers, Medicaid, and substance use disorder treatment programs. The group met in August 2023 (17 attendees); November 2023 (22 attendees); February 2024 (15 attendees), and May 2024 (18 attendees). The topics during these meetings included expanding access to contraceptives through pharmacies and Opill, expansion of Fact Forward into NC, updates to Family Planning Medicaid, adolescent-focused reproductive health, and updates on Upstream's work in NC. The group received regular updates on the implementation of pharmacists trained to offer oral and transdermal contraceptives and marketing of this work. As Fact Forward moved to spread their adolescent work in NC, the group assisted in making connections, encouraging attendance at their first Adolescent Summit, and lifting up the importance of the adolescent voice in reproductive health.

NCDHHS continued to partner with the nonprofit Upstream USA as they work to provide sustainable training and technical assistance to health centers to ensure same-day access to birth control methods at low or no cost. During FY24, Upstream reported working with 18 different agencies, eight of those being LHDs. Upstream directed their focus on assisting FQHCs and healthcare systems over the year. During 2024, they completed training for Atrium Healthcare system staff with 750 participants and representing 35 clinic locations.

Upstream continued their policy efforts in NC by supporting the roll out of the NC pharmacy prescribing efforts by providing training on patient-centered contraceptive care for pharmacists. They also partnered with the Carolina Complete Health Network (CCHN) to enhance contraceptive care. They started work on a patient-centered approach to promoting contraceptive screening within the CCHN and hope to expand that work next year.

During FY24, the WICWS RNCs assisted agencies in understanding Medicaid billing rules around same-day

insertion in conjunction with an annual preventive visit to dispel any misconception that it is economically advantageous to separate LARC insertion from a preventive visit. This information was shared during the monitoring process and, where appropriate, in response to requests for technical assistance. Additionally, when monitoring and providing technical assistance, the RNCs routinely shared best practice information and connected agency staff to training resources as needed. Further, the RNCs continue to support agencies working with Upstream to enhance access to LARCs and delivery of quality contraceptive services. The RNC Supervisor and the RHB Head met with Upstream staff monthly to provide the best support for agencies working with Upstream. During the Statewide Virtual Meetings in January 2024, the RNCs helped local staff distinguish between Title X requirements and Medicaid requirements to further elucidate billing requirements and dispel misconceptions around billing and reimbursement for same-day LARC insertion.

In the Spring of 2024, the State Family Planning Nurse Consultant researched best practices, potential barriers, sample policies, and clinic procedures related to same-day LARC insertion. Existing policies from LHDs with established protocols for same-day insertion were also collected for review. Based on this research, a survey was developed to assess potential barriers and gauge LHD's interest in receiving technical assistance, as well as in developing policies and clinic workflows related to this practice. The percentage of LHDs offering same day insertion of both contraceptive implants and intrauterine devices (ESM WWV.4) according to results of the 2024 FPAR Survey was 56%. This was a slight decline from the 59% reported previously. The survey indicated that 95% of LHDs offer IUD insertions on site and 98% offer implant insertions on site.

For the last two years of the project period, the NC MHI program moved from offering the March of Dimes Implicit Bias training to working with Eastern AHEC to develop RJ trainings to medical and nursing graduate students. Eastern AHEC partnered with faculty within the East Carolina University Brody School of Medicine (ECU BSOM) to author the curriculum with the vision to integrate the training in the medical school curriculum in the future. This was an upstream effort to influence the practice of future health care providers during their training program. The RJ training consisted of didactic lectures, group activities and patient simulations. The ECU BSOM offered the RJ training twice to a total of eight medical and/or nursing students. Based on unanticipated low registration for the first two trainings and feedback from participants, Eastern AHEC staff and the BSOM faculty decided to shorten the training to a hybrid course, consisting of pre-recorded videos to review prior to the one-day in person session.

Priority Need 1 – Promote comprehensive reproductive health care including postpartum care and support

As stated in the WMH Domain Annual Report, the NC Title V Program is committed to assuring that people in NC have access to high quality integrated health care services across the life course, but during the development of the 2026-2030 State Action Plan, the priority need for this domain was updated to encompass comprehensive reproductive health care with an emphasis on postpartum care. The WICWS leads the majority of work detailed in this domain, partnering with local agencies and also the WCHS to ensure quality services are available to all North Carolinians. While the Postpartum Visit NPM was selected for this priority need, since NC does not have current PRAMS data, SPM 1 (Percent of deliveries to women receiving Medicaid that had a postpartum visit on or between seven and 84 days after delivery) was also selected. By increasing the number of women who receive a comprehensive postpartum visit on or between seven and 84 days after delivery in LHDs (ESM PPV.1), the WICWS hopes to improve both the SPM and NPM.

WMH Objective 1 By 2030, increase the percent of Medicaid deliveries that had a comprehensive postpartum visit on or between seven and 84 days after delivery from 60.7% (2023 Baseline) by 5% to 63.7% by 2030.

During FY26, staff members from the WICWS will participate in regular meetings with the Division of Health Benefits/Medicaid team related to maternal health. The Medicaid Maternal Health meetings will occur monthly and the DHHS Maternal Health Learning Collaborative meetings will be held bi-monthly. The meetings are designed to strengthen collaboration and alignment related to maternal health. NC is currently performing below the national average for Medicaid health maintenance organizations on the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)® Prenatal and Postpartum quality measure, While global billing codes may be able to account for some data quality issues, both WICWS and NC Medicaid staff want to strengthen collaboration and improve this objective.

The NC Healthy Start Baby Love Plus (BLP) and Southeastern NC Healthy Start programs will continue to educate on and emphasize the importance of attending postpartum visits with women who recently delivered. BLP and SENCHS Family Care Coordinators (FCCs) will refer program participants to their provider and arrange for facilitating (i.e., transportation) services if there are access to care concerns. To strengthen postpartum support efforts, FCCs and FOWs will conduct one-on-one and group education sessions focused on Medicaid 12-month extension and Medicaid expansion. Representatives from each Medicaid prepaid health plan will be invited to present at group education sessions conducted at least once annually.

Case managers working in the Healthy Beginnings program will provide care coordination services to at least 400 minority pregnant and interconception women through monthly contacts primarily conducted through home visits. Program participants are enrolled during pregnancy or up to 60 days postpartum and receive services until the baby reaches two years of age. Program participants receive individual and group education on the importance of attending postpartum visits and are linked to transportation resources if needed.

In FY26, all HFA and NFP home visitors will continue to assess pregnant mothers upon enrollment and during subsequent visits to educate them on the importance and benefits of postpartum visits and inform them about the Medicaid 12-month extension and expansion. One measure that MIECHV funded programs are required to report is the percentage of mothers enrolled in HFA or NFP prenatally or within 30 days of delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery.

Additional strategies to promote the importance of postpartum visits include offering calendars/phone apps to track appointments; encouraging mothers to schedule and reschedule missed visits; educating fathers and family members; providing gas cards and transportation vouchers to clients with transportation barriers; and screening for maternal depression as this can be a barrier to postpartum visits.

CMHRP CMs will refer all patients to the local DSS for ongoing Medicaid extension coverage regardless of the pregnancy outcome. CMHRP CMs will educate all patients on the importance of scheduling and attending the postpartum clinical visit and promote and encourage all patients to receive a clinical postpartum visit with their provider. CMHRP CMs will assess transportation needs for postpartum clinic visits and refer to appropriate resources, as applicable. Patients will be educated by CMHRP CMs on the 4th trimester care, inclusive of post-birth signs and symptoms of when to reach out to provider/Emergency Department in the postpartum period.

The MHI program will focus on enhancing and improving data reporting and quality for those women who begin prenatal care at a LHD. MHI will provide training and technical assistance to LHD maternal health providers and billing/support staff on appropriate billing and coding for entry into prenatal care. Additionally, a custom data form will

be created in each LHD's electronic health record to collect maternal health service data. This data will be analyzed by the Maternal Health Epidemiologist, and county specific data will be shared with each LHD. The Maternal Health Epidemiologist will provide technical assistance to those LHDs needing data quality improvement.

To improve postpartum care access and quality of care with the goal of increasing postpartum care visit completion, the MHI team will establish a community of practice (CoP) for postpartum care during FY26. To establish the CoP, the MHI team will work with a subject matter expert who will provide technical assistance throughout the planning and implementation. This involves drafting a mission statement, identifying the CoP's core purpose and stakeholders, creating a communication plan, developing a recruitment strategy with clinical champions, and establishing the CoP's structure and format. In FY26, the Postpartum CoP will meet regularly to share best practices and drive actionable learning that aligns with the maternal health efforts and policies to improve quality and access to comprehensive postpartum care. As a result of the participation in the Postpartum CoP, providers at NC LHDs or federally qualified health centers will conduct comprehensive postpartum visits of mothers with deliveries covered by Medicaid.

The Perinatal Care Region 3 Perinatal Nurse Champion program will utilize postpartum navigators to coordinate culturally and linguistically appropriate phone calls to non-English speaking Atrium Health patients. The postpartum navigator will encourage patients to complete their comprehensive postpartum visit and/or provide assistance in scheduling postpartum visits. In this perinatal care region, the PNC is will work with health systems to implement an initiative to reduce maternal morbidities and mortalities within the first 42 days after giving birth. The I Gave Birth initiative trains first responders, emergency department personnel and postpartum nurses about post-birth warning signs. To measure outcomes of the I Gave Birth initiative, the PNC will conduct surveys at pediatric clinics to assess whether postpartum patients are wearing their hospital-issued bracelets and have been educated on post-birth warning signs.

An essential part of the postpartum visit is screening for maternal mental health. The Perinatal Care Region I Perinatal Nurse Champion located at the Mountain Area Health Education Center (MAHEC) will provide educational materials focused on postpartum best practices and maternal mental health screenings to OB providers. These educational materials will be developed as a collaborative effort between MAHEC and the NC Maternal Mental Health MATTERS Program. A simulation training that emphasizes effective screening techniques will be implemented. The Perinatal Nurse Champion will lead five simulation trainings across Perinatal Care Region I, to equip OB/ GYN practices with the knowledge and resources necessary to identify and address maternal mental health concerns.

WICWS team members utilize PRAMS/PAS data for a host of programs and initiatives, inclusive of tracking the Perinatal Health Strategic Plan, pregnancy intendedness data, and the MCHBG national performance measures. Members of WICWS have served on the PRAMS/PAS Steering Committee in the past and this expectation will continue.

WMH Objective 2 By 2030, the unduplicated number of people in NC receiving patient-centered reproductive health services, including contraception, will increase from 57,414 (2024 Baseline) by 2% annually.

Reproductive health is a critical part of every individual's overall health. While NC works to improve postpartum care through specific strategies involving the postpartum period, the entire span of reproductive health impacts health outcomes leading up to and after the postpartum timeframe. Patient-centered care prioritizes the patient's needs, preferences, values, and ensures they are actively involved in their care and wellbeing. Much of this work is happening through the WICWS's RHB.

One strategy to impact reproductive health services is for WICWS to work with LHDs and federally qualified health centers to increase access to services by offering extended clinic hours; utilizing mobile units or alternate locations; promoting pharmacist-initiated contraception; and educating about over the counter contraception. Offering extended clinical hours and utilizing mobile units (alternate locations) allows the family planning agencies to deliver family planning and reproductive health care services directly to local communities in need. This is especially beneficial for individuals who encounter barriers to accessing reproductive health care. Since 2022, the RHB has been working with the LHDs to increase access to services by offering extended clinic hours.

In December 2024, the RHB gained insight from LHDs and federally qualified health centers participating in the state-funded Supporting Women's Health Services (SWHS) program who reported offering varied clinic hours. Through a survey, staff reported that additional funds and medical staff (provider, nurse staff, front desk, and Pharmacist Tech (depending on agency)) were required on site to offer extended hours. These agencies offered this schedule 1-2 times a week, providing reproductive health services to individuals of reproductive health ages.

Agencies reported several challenges such as staffing, Hurricane Helene, and lack of program promotion and advertising. With this additional information from local agencies, the RHB continued the redevelopment of the Extended Hours informational document, emphasizing advantages to varied hours, practical recommendations, and steps for extending clinic hours. During FY26 this go-to guide will be distributed to LHDs and federally qualified health centers. In addition, the SWHS agencies will be highlighted via a webinar which will allow them to share their experiences, processes, and implementation of an extended hour schedule. The WICWS RNCs also share best practices among LHDs and connect agency staff with other agencies who have successfully implemented extended hours or alternate clinic strategies to increase access to services. In FY26, the State Family Planning Nurse Consultant will work with the RNCs to develop a complete set of checklists to help agencies ensure programmatic requirements are met while implementing these strategies. The RNCs will also share best practices information at regional meetings with local nurse administrator staff, through a quarterly newsletter, and during monitoring activities with the 26 agencies scheduled to be monitored during FY26.

In Spring 2025, the RHB's Family Planning Medicaid Program Manager launched a toolkit to assist agencies in improving outreach, education, and ultimately the utilization of Family Planning Medicaid-covered services. This toolkit includes strategies on using social media, training staff and partner organizations, and distributing existing resources, among other strategies. Among the resources highlighted are flyers detailing the availability of over-the-counter contraception (Opill) and pharmacist-initiated contraception services, which are both now covered by Medicaid. During FY26, the RHB will provide TA around implementation of the recommendations in the toolkit, keeping record of TA requests and providing office hours and other resources, as needed.

A second strategy to increase the number of individuals receiving reproductive health services is to assist local clinics with offering same-day contraceptive services by providing TA; creating template policies and flowsheets; and connecting agencies to share success/barriers. The RNCs and State FP Nurse Consultant encourage LHDs to offer same-day contraceptive services when providing TA, when monitoring, and during regional meetings. The State FP Nurse Consultant has developed a template policy and flowsheets to share with agencies when they express an interest in initiating or enhancing same-day contraceptive services. The RNCs worked with the State FP Nurse Consultant to pilot the tools that have been developed and identified necessary changes. In FY26, additional templates will be created to build a same-day access toolkit for local agencies to assist in increasing this practice across NC LHDs. WICWS will also continue its collaborative work with Upstream to support LHDs and other health care entities who are engaged with Upstream's training and TA support.

Patient-centered healthcare is about creating a partnership between patients and health providers where shared decision-making is occurring. This type of healthcare leads to better health outcomes as patients feel heard, valued, and demonstrate trust and respect for the patient-provider relationship from both sides. An additional strategy to assist LHDs/agencies providing patient-centered reproductive health care is to offer webinars and/or office hours on a variety of topics to increase patient-centered services (trauma-informed, weight stigma, shared decision making, etc.). In December 2024, LHDs were given the opportunity to respond to an annual clinic assessment, which inquired about their current training needs. The top responses included community engagement and patient-centered care. In the same survey, they also responded to questions about their preferred training modalities, and overwhelmingly LHDs responded that they favor live webinar opportunities.

Over the past year, members of the RHB have developed and facilitated a series of webinars and office hours focused on shared decision-making and client-centered care. This initiative included educational materials, content development, and role play scenarios to support skill-building among LHD staff. Building on this work, the RHB plans to continue working with LHDs in FY26 through a new series of interactive role-play webinars that will provide small groups with the chance to engage and practice in breakout rooms. The upcoming series will be offered in three parts, with the first part building on the previously offered role play webinar and providing additional opportunities for Advanced Practice Providers to attend and further develop their patient-centered counseling skills. The second and third parts of the series will introduce new content tailored specifically for nurses and front desk staff, respectively, focusing on their unique roles in delivering patient-centered care, emphasizing the fact that patient-centered care is the responsibility of the entire agency. To maximize accessibility, multiple dates and times will be offered for each part of the series. To further help participants prepare for these skill-building webinars, the RHB will also record an educational video that introduces the core concepts of patient-centered care and shared decision-making. This video will serve as foundational content to ensure all attendees arrive at the sessions with a shared understanding and context for the role play experience.

In other trainings focused on increasing patient-centeredness, the RHB offered a three-part live webinar series over the past year on different aspects of implementing trauma-informed care in the family planning clinic setting, which all had great turnout. In FY26, staff will plan on offering a similar series, this time focusing on aspects of community engagement and incorporating feedback from family planning clinic patients. Community engagement is a priority

within family planning clinics, as it can improve the quality of service delivery and communication between providers and patients. During FY26, opportunities will be available for LHDs to share, building a strong community network via a series of webinars. LHDs will learn the value of community partnerships, strategies for identifying and building relationships with new community partners, and tips for partnering effectively.

One additional area of patient-centered care that the RHB has been looking at is understanding the relationship between contraception methods and body weight, which have the potential to affect fertility and the effectiveness of some contraceptive methods. The Patient Experience Coordinator will look to provide multiple avenues to explore this topic with LHDs, including through the Patient-Centered Practices quarterly newsletter and a minimum of one webinar in FY26.

Clinical services and practices are driven by the policies that a local agency develops and follows to ensure quality, patient-centered care. To assist local agencies in developing strong policies, a strategy for increasing services is providing technical assistance/training to local agencies on reviewing/updating policies to promote patient-centered services. The North Carolina Title X program last updated their policies in 2022 to align with project monitoring recommendations and the updated Title X rules. Over the past year, several members of the RHB collaborated to further update the Title X state policies and LHD template policies with the goal of enhancing understanding of and ability to provide patient-centered services and improve access to care. In FY26, this team plans to finalize their revisions and submit them for review. They will provide a minimum of one virtual training for LHDs to walk through the updated policy templates and the patient-centered framework that was used in their revisions. A guidance document will be published at the time of the training to further assist LHDs in reviewing and revising their agency policies. This will include strategies that can be included in agency policy with the goal of promoting consistency and quality in service delivery across the state. Based on interest and response, the team will evaluate next steps, which could include office hours or one-on-one TA.

As the RHB focuses on patient-centered care for all individuals in family planning clinics, a strategy to achieve this includes creating resources for local agencies to promote patient-centered, accessible reproductive health services, such as social media ads, waiting room slides, advertisements, etc. The RHB ensures agencies distribute informational materials that are current, patient-centered, and tailored to the patient's needs. In FY26, a media review inventory will be completed to assure that the materials promoted on the WICWS website are current and patient-centered.

LHDs are required to complete an annual Community Education, Engagement, and Quality Improvement (CEQ) plan. The CEQ assists agencies in improving and enhancing the delivery of reproductive health services by utilizing data and input from the community. Identifying key stakeholders, defining clear objectives and outcomes, and establishing program goals are essential before, during, and after the CEQ process. In Spring 2025, work began on developing a CEQ Toolkit to assist LHDs. The toolkit will be an in-depth step-by-step guide to developing a family planning quality improvement plan. This CEQ guide will be distributed in FY26, and the RHB will provide guidance and TA around how to utilize the toolkit.

An ongoing resource for LHDs is the Patient-Centered Practices quarterly newsletter. The newsletter will continue to be published on a quarterly basis and include resources and tools from a variety of reputable sources, including highlighting the work of LHDs and their efforts to provide quality, patient-centered care. Tools that are created by the RHB, such as social media ads, waiting room slides, and advertisements will be featured in the newsletter as well, which is emailed to LHDs across the state and also posted to the WICWS website.

Advertising is always a strong resource for increasing the number of individuals receiving services. In summer 2025, the RHB will launch a social media campaign designed to increase awareness of pharmacist-initiated contraception and how it increases access to obtain reproductive health services. The campaign will include pre-screened social media influencers who contract with NCDHHS to promote health messages, and their content will still be posting and circulating into FY26. The success of the campaign will be determined through frequency of individuals interacting with the ads. This information will help determine what additional media or resources may be necessary to encourage pharmacist-initiated contraception and other reproductive health access initiatives.

The Regional Social Work Consultants provide training to CMHRP Care Managers (CMs) on reproductive life planning during statewide training webinars and provide technical assistance on an on-going basis to ensure patients receive culturally appropriate and best-practice information from their care managers.

CMHRP CMs provide reproductive health education and counseling to all patients who receive CMHRP services. They collaborate with medical providers to ensure pregnant and postpartum women are educated and understand reproductive life planning options, have access to desired methods and/or feel empowered to express the autonomy

to decline a family planning method if that is their desire. CMs discuss the patient's (and partner's) reproductive life plan and review family planning options and ensure the maternity care provider is aware of the patient's desired method of contraception for the postpartum period.

The CMHRP CM conducts a comprehensive biopsychosocial assessment both initially and ongoing which is inclusive of pregnancy intendedness and reproductive life planning. CMs meet with patients at a minimum of once every 30 calendar days and more frequently depending on patient needs. This is instrumental in gaining insight and additional information. Patients may share details or information with the CM that they would not share with provider. The CM can then bridge the communication and share updates with the provider based on what the patient reports. CMHRP CMs emphasize and reinforce the information and education shared by medical providers which promotes appropriate, individually tailored contraceptive use and family planning/birth spacing intendedness. This may include the patient's decision to utilize alternative contraceptive methods or not to access contraceptive methods at all. This information and education increase patient understanding and compliance which in turn leads to improved contraceptive use, family planning, birth spacing and pregnancy intendedness.

CMHRP CMs also identify and reduce barriers that may prohibit the patient from attending their postpartum follow-up appointment. Attendance at this appointment is vital to ensuring a method of contraception is chosen and available if that is the patient's desire.

NFP home visitors use the Strengths and Risks (STAR) framework to assess and score prenatal visits, postpartum visits, and postpartum plans for birth control. HFA and NFP home visitors work with clients to develop a plan for planning/spacing of subsequent pregnancies. Home visitors follow up with postpartum moms within six weeks of birth. They also help clients obtain gas cards and transportation vouchers to reduce transportation barriers.

WMH Objective 3. By 2030, increase the unduplicated number of adolescents in NC receiving adolescent-centered reproductive health education, including contraception, through NC Teen Pregnancy Prevention Initiatives (TPPI) funded programs from 3,844 (FY24 Baseline) by 2% annually

Working towards improving reproductive health care through quality and access includes highlighting and elevating the work happening with adolescents. Much like the descriptions of patient-centered care and services, it is critical that young people receive adolescent-centered services. Adolescent-centered services meet the specific needs and interests of young people. The services/programs empower adolescents by providing them with knowledge, skills, and resources to support their health; ultimately improving mental health, self-esteem, and overall wellbeing. Ensuring services/programs are utilizing an adolescent-centered lens is an important step in creating successful and sustainable youth programs, including reproductive health programs. Three strategies have been developed to work towards the objective to increase the number of adolescents receiving adolescent-centered reproductive health education, and this work is led by the TPPI team that is part of the RHB in the WICWS.

The first strategy is to create a workgroup comprised of individuals from TPPI funded agencies to discuss applying adolescent-centered reproductive health practices to program implementation. The goal is for this workgroup to help inform curricula discussions/adaptations, training opportunities, and determine other areas that need more focus or research to ensure successful adolescent-centered programs. Recruiting members from TPPI funded agencies brings a range of backgrounds and experiences to the discussion. During FY26, a training will be held around adolescent-centeredness for programs to better understand this work. After the training, TPPI will determine what local agency staff are interested in being on a workgroup to continue these conversations. The workgroup will be comprised of at least eight different individuals from local sites.

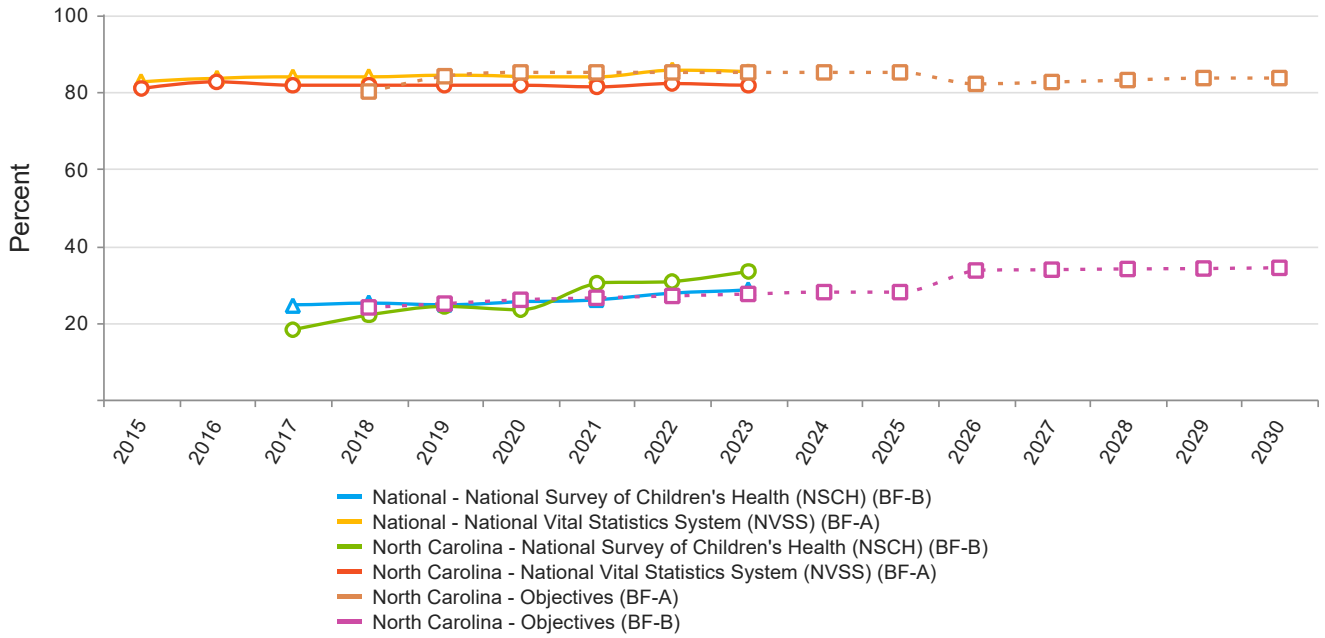
Part of this adolescent-centered focus is for TPPI agencies to understand the term and how it connects to the programs in a variety of ways. As mentioned, first is a training around the topic in FY26. Additionally, TPPI staff will plan for a networking meeting to combine the three TPPI programs (Adolescent Parenting Program, Adolescent Pregnancy Prevention Program, and Personal Responsibility Education Program). During this networking meeting, local agency staff will have the opportunity to discuss adolescent-centered programming and learn from one another about how this is already happening in their work or ways to easily lift this to ensure youth are connected. Another training opportunity will be offered to local agency staff around facilitation skills. This training opportunity will engage curricula facilitators to enhance their skills during program sessions to optimize adolescent-centered practices. This includes utilizing effective evidence-based practices and meeting the different needs of young people, including those with disabilities. The final anticipated training during FY26 is specifically for adolescents and local agency staff participating in the Adolescent Parenting Program. A Senior Conference will be held to highlight the success of the young pregnant or parenting teens who are seniors, as well as providing continued support to the local program coordinators and gathering input on ensuring adolescent-centered services for AP2.

A final strategy to increase the number of youth served through programming involves NC youth themselves. The WICWS partners with Fact Forward, a nonprofit focused on adolescent reproductive health in North and South Carolina. Fact Forward created a Youth Leadership Council (YLC) to allow young people to build leadership skills and share ideas and concerns around reproductive health in NC. This group has been challenged to meet and determine its focus, with NC being a large state with different communities. The new strategy is to create a regional-based youth leadership council to provide opportunities for young people to voice their opinions and ideas around reproductive health work in NC. Having a regional-based council will provide more opportunities for young people to be engaged and feel connected to addressing the specific needs of youth closer to them. In FY26, Fact Forward will build this regional-based YLC and host six meetings across the state. The YLC will be engaged in an annual project determined by the youth. Projects may include developing a media campaign, creating a resource document or tool for local programs, or hosting cross-regional opportunities to share information and resources.

Perinatal/Infant Health

National Performance Measures

NPM - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF
Indicators and Annual Objectives



NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	85	85
Annual Indicator	82.1	81.5
Numerator	98,631	96,717
Denominator	120,143	118,618
Data Source	NVSS	NVSS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	82.0	82.5	83.0	83.5	83.5

NPM - B) Percent of infants breastfed exclusively through 6 months - BF

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	27.5	28
Annual Indicator	30.8	33.5
Numerator	84,259	97,041
Denominator	273,537	289,343
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	33.6	33.8	34.0	34.1	34.3

Evidence-Based or –Informed Strategy Measures

ESM BF.1 - First Time Breastfeeding Hotline Callers

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0

ESM BF.2 - Number of eligible WIC participants who receive breastfeeding peer counselor services

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		28,350	29,120	29,900	30,660
Annual Indicator	25,020	22,263	22,599	22,987	21,869
Numerator					
Denominator					
Data Source	NC Crossroads WIC System	NC Crossroads WIC System	NC Crossroads WIC System	NC Crossroads WIC System	NC Crossroads WIC System
Data Source Year	SFY19-20	SFY20-21	SFY21-22	SFY22-23	SFY23-24
Provisional or Final ?	Final	Final	Final	Final	Final

State Action Plan Table

State Action Plan Table (North Carolina) - Perinatal/Infant Health - Entry 1
Priority Need
Prevent infant/fetal deaths
NPM
NPM - Breastfeeding
Five-Year Objectives
PIH Objective 1 By 2030, increase the percent of NC infants ever breastfed from 81.5% (2023 Baseline) by 2.5% to 83.5%. (Baseline will come from Federally Available Data provided by MCHB and it will be available later this spring).
PIH Objective 2 By 2030, increase the percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months from 33.5% (2022-23 Baseline) by 2.5% to 34.3%.
PIH Objective 3 By 2030, decrease the infant mortality rate from 6.9 per 1,000 live births (2023 Baseline) by 13% to 6.
PIH Objective 4 By 2030, decrease the Black/white infant mortality ratio from 3 (2023 Baseline) by 10% to 2.7.
PIH Objective 5 Increase the number of women receiving prenatal care in the first trimester as reported on the birth certificate from 72% (2023 Baseline) by 4% to 75%.
PIH Objective 6 Each year, 99% of newborn infants in NC will be screened for metabolic and other hereditary and congenital disorders and receive necessary follow-up.
Strategies
PIH 1&2.1 During FY26, establish a 24/7 breastfeeding hotline and text line staffed by International Board Certified Lactation Consultants and Certified Lactation Counselors to provide accessible, consistent breastfeeding promotion and support to lactating people, their partners, and other support people.
PIH 1&2.2 Support strategies in the NC Perinatal Health Strategic Plan to improve breastfeeding rates.
PIH 1&2.3 Support work of maternity centers to obtain the North Carolina Maternity Center Breastfeeding Friendly Designation from DCFW or full Baby-Friendly Designation from Baby-Friendly, USA.
PIH 1&2.4 Support the work of early educators to receive training in Breastfeeding-Friendly Child Care and encourage them to work with Child Care Health Consultants and other Breastfeeding-Friendly trainers to implement and maintain breast feeding best practices
PIH 1&2.5 Support the work of LHDs who are working toward or awarded the NC Breastfeeding Coalition’s Mother-Baby Award for outpatient healthcare clinics.
PIH 1&2.6 Optimize breastfeeding training for, but not limited to, Care Management for At-Risk Children and Care Management for High-Risk Pregnancy care managers, Healthy Beginnings program staff, Community Health Workers, LHD employees, and home visitors, through coordination with the Regional Lactation Training Centers through the State Breastfeeding Coordinator.
PIH 1&2.7 The Pediatric Nutrition Consultant will provide breastfeeding training to Child Health Program staff at LHDs through virtual, regional, and statewide meetings.
PIH 1&2.8 Support dissemination and use of the revised NC Making It Work Tool Kit to help breastfeeding mothers return to work.
PIH 1&2.9 Promote the WIC Breastfeeding Peer Counseling Program to all women receiving services in LHD/WIC clinics and increase the number of women who enroll in the program.
PIH 1&2.10 Increase the number of NC Breastfeeding Friendly Child Care trainers through a DCFW and NC Child Care Health and Safety Resource Center collaboration.

PIH 1&2.11 Increase the number of Breastfeeding Friendly Child Care trainings delivered to child care providers.

PIH 1&2.12 Promote Breastfeed NC website through all programs in DCFW and WICWS.

PIH 1&2.13 Maintain Title V representation on the DPH/DCFW Breastfeeding Coordination Committee that serves as a collaborative platform for ensuring alignment of breastfeeding services across the divisions.

PIH 3&4.1 Support work by the NC Perinatal Health Strategic Plan Collective, NC Child Fatality Task Force, and the NC Office of Child Fatality Prevention to reduce infant mortality and the Black/white infant mortality disparity ratio.

PIH 3&4.2 Support implementation of programs intended to reduce infant mortality and prevent premature births including the following: Reducing Infant Mortality in Communities; Healthy Beginnings; Healthy Start Projects (NC Baby Love Plus and Southeastern NC Healthy Start); Improving Community Outcomes for Maternal and Child Health; Nurse Family Partnership; and Healthy Families America.

PIH 3&4.3 Continue the work of the Women and Tobacco Coalition for Health (WATCH) to offer and disseminate information associated with women's health and tobacco use prevention and treatment across the lifespan.

PIH 3&4.4 Provide smoking and other tobacco cessation counseling in all WICWS direct service programs and in WCHS's CMARC and home visiting programs inclusive of referrals to QuitlineNC.

PIH 3&4.5 Provide annual training for at least two WICWS programs on women's health and tobacco use, inclusive of QuitlineNC and e-cigarettes.

PIH 3&4.6 Partner with Division of Health Services Regulations, NC Institute of Medicine, Perinatal Quality Collaborative of NC, and other providers to update existing neonatal rules and develop maternal health rules to ensure that all birth facilities will have a designation based on the national maternal and infant risk-appropriate level of care standards.

PIH 3&4.7 Promote awareness about safe infant sleep using consistent messaging from Safe Sleep NC and providing training to providers who work in obstetric, pediatric, or family medicine clinics and, as possible, to first responders.

PIH 3&4.8 Provide annual or as needed safe sleep training/SIDS-ITS to child care providers by Child Care Health Consultants (CCHCs).

PIH 3&4.9 Increase the number of certified CCHC SIDS/ITS trainers by offering train the trainer courses 2 times per year.

PIH 3&4.10 Support the work of the March of Dimes with recruiting and training 50 individuals, i.e., cosmetologists, fraternal organizations and/or CHWs to serve as peer educators/lay health navigators in communities related to reproductive life planning.

PIH 5.1 Improve LHD data reporting and data quality for documenting entry into prenatal care by: (1) Providing training and technical assistance to LHD maternal health providers and billing/support staff on appropriate billing and coding for entry into prenatal care; (2) Creating custom data form in each LHD's electronic health record (EHR) to report out the data; and (3) Creating a reporting template to share back EHR services and claims data, inclusive of data related to entry into prenatal care.

PIH 5.2 Increase the number of LHDs offering group prenatal care to prenatal patients by: (1) Encouraging use of current funding (Supporting Women's Health Services and Reducing Infant Mortality in Communities) and (2) Promoting use of Medicaid reimbursement for group prenatal care.

PIH 5.3 Participate in NC Medicaid's Maternal Health Internal Alignment Meetings and the Maternal Health Learning Collaborative, strengthening collaborations and ensuring alignment of activities and resources.

PIH 5.4 Support recommendations from the NC Perinatal Health Strategic Plan Collective Maternity Care Workforce Action Team to enhance maternal health workforce and care delivery approaches to improve access to maternal care.

PIH 6.1 The Newborn Screening Follow-Up Team, EHDI Team, NC Birth Defects Registry, and NC Sickle Cell Program will continue to ensure that all newborns who screen positive for a particular condition receive timely follow up to definitive diagnosis and are referred to clinical management for their condition.

ESMs	Status
ESM BF.1 - First Time Breastfeeding Hotline Callers	Active
ESM BF.2 - Number of eligible WIC participants who receive breastfeeding peer counselor services	Inactive

NOMs

Infant Mortality

Postneonatal Mortality

SUID Mortality

2021-2025: National Performance Measures

2021-2025: NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		90	90	90	90
Annual Indicator	80.1	75.1	73.9	74.1	75.4
Numerator	1,375	1,253	1,266	1,210	1,250
Denominator	1,717	1,668	1,714	1,632	1,658
Data Source	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM RAC.1 - Percent of birth facilities with level of care documented using the CDC LOCATe tool.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		50	75	100	100
Annual Indicator	37.2	70.9	78.8	80.2	80.2
Numerator	32	61	67	65	65
Denominator	86	86	85	81	81
Data Source	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year	FY19-20	FY20-21	FY21-22	FY22-23	FY23-24
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM RAC.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL)

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25	25	40	60
Annual Indicator	1.2	2.4	16.5	15.3	4.7
Numerator	1	2	14	13	4
Denominator	85	85	85	85	85
Data Source	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: State Performance Measures

2021-2025: SPM 2 - Percent of women who smoke during pregnancy

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		8.1	7	6.8	5
Annual Indicator		6.8	5.6	4.5	3.6
Numerator		7,923	6,756	5,425	4,293
Denominator		116,755	120,501	121,557	120,065
Data Source		NC Vital Statistics/SCHS	NC Vital Statistics/SCHS	NC Vital Statistics/SCHS	NC Vital Statistics/SCHS
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Priority Need 1 – Improve Access to High Quality Integrated Health Care Services

One way of improving access to high quality integrated health care services is to ensure that infants and birthing women are receiving care in a risk-appropriate level of care facility. In FY24, the NC Perinatal Health Strategic Plan Collective (PHSP Collective) concluded the work of the three original action teams (Neonatal Levels of Care, Maternal Levels of Care, and Equity in Practice) and launched a new Doula Action team. The Doula Action Team meetings began in April 2024 and concluded in August 2024. The team focused on drafting policy recommendations for Medicaid reimbursement of doula services in NC. The Neonatal and Maternal Levels of Care Action Teams will be discussed later in this document.

Another project that improved access to high quality health care services was the Perinatal Incarceration project. This project, funded by the CDC, focused on mitigating COVID-19 disparities for incarcerated pregnant and postpartum women. The WICWS collaborated with UNC-CH's Collaborative for Maternal and Infant Health (CMIH) to develop comprehensive training and educational materials to support the provisions of the *Dignity for Women who are Incarcerated Act*. The training and educational materials, consisting of posters, flyers, and a pregnancy health booklet, were designed to improve care and education for incarcerated women, particularly in the areas of perinatal health and COVID-19 risk mitigation, and to be used by correctional officers, healthcare staff, and community birthing hospital personnel. The project developed several educational tools – training programs, booklets, videos, and podcasts – designed to improve understanding of perinatal health within incarcerated populations. A Spanish version of the pregnancy health booklet was created along with a range of video and podcast content. These resources helped inform both healthcare providers and correctional staff about key issues such as trauma-responsive care, substance use stigma, and COVID-19 mitigation. These materials are available for order through the WICWS publications order process or downloadable from https://incarceratedwomenshealth.org/.

In addition to educational materials, the Maternal Health Innovation Perinatal Nurse Champion, based at CMIH, collaborated on the Perinatal Incarceration project to provide training to 50 nursing staff at the NC Correctional Institute for Women. The project also trained over 130 healthcare providers, detention officers, and legal professionals, significantly enhancing their capacity to support incarcerated pregnant and postpartum women. Through continued collaborations and the development of additional wellness initiatives, the project made meaningful progress toward improving the health and wellbeing of incarcerated women across the state.

In tandem with this project, the PHSP Collective Equity in Practice Action Team focused on enhancing the accessibility of resources related to perinatal incarceration in NC. Action team recommendations were categorized into low, moderate, and maximum effort initiatives aimed at addressing gaps in accessibility, usability, and dissemination of existing resources. Key actions included a comprehensive resource inventory to assess materials available on the Incarcerated Women's Health website, restructuring content for better readability, translating materials into Spanish, and adding dedicated pages for family resources. The team adopted a community-centered approach, integrating the lived experiences of incarcerated individuals and stakeholders to inform solutions and develop practical tools, such as educational materials and tailored dissemination strategies, to better support those impacted by perinatal incarceration.

The State Maternal Health Innovation (MHI) Program supported training for health care providers across the six perinatal care regions (PCRs) to improve high quality care. In FY24, Perinatal Nurse Champions (PNCs) in each of the PCRs provided training to more than 4,600 clinical providers, doulas, emergency service responders, and others. Training topics were chosen based on a gap analysis conducted in the region. Some examples of training include Obstetric Emergencies, Electronic Fetal Monitoring, Postpartum Hemorrhage Escape Room, Providing Care for Incarcerated Pregnant Patients, and Post-Birth Warning Signs.

The MHI program provided direct care services to pregnant and postpartum women through two Community Health Worker (CHW) Doula programs, located at Novant Health New Hanover Regional Medical Center and the Young Women's Christian Association of High Point. Each program served at least 30 pregnant clients annually. Clients were enrolled in the program by the CHW, who provided prenatal education and support during pregnancy and after birth. The doula provided continuous labor support to the clients. After birth, the CHW continued engagement with the client for up to one year postpartum. The program aimed to support pregnant women who are from historically

marginalized communities and/or facing barriers to accessing care. From September 2023 – September 2024, the CHW-Doula program served a total of 105 participants by providing free prenatal, labor, and postpartum support.

The Novant Health New Hanover Regional Medical Center CHW-Doula program found that in addition to high vaginal birth rates, the breastfeeding initiation (68%) and continuation (>50%) rates were high among clients served by the CHW-Doula program, with breastfeeding support from the perinatal CHW attributed as the primary reason. The CHW was Black, and 80% of the clients served in the CHW-Doula program were also Black. The clients expressed being more comfortable with the CHW and more confident in the process after learning about and getting lactation support from the CHW. The CHW was trained as a Breastfeeding Peer Counselor through the NC WIC Program. It is also important to note that the hospital at which the CHW-Doula program is based does not have any Black lactation consultants on staff; therefore, the CHW-Doula clients had access to the culturally congruent CHW during postpartum, up to one year.

Risk-Appropriate Perinatal Care NPM – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

North Carolina does not currently have a level of care system for assessing birthing facilities' capabilities to care for pregnant and birthing women but does have neonatal levels of care that do not currently align with the AAP guidelines. Therefore, the state data for the Risk-Appropriate Perinatal Care NPM are based on the current self-designated levels of care which do not align with the AAP guidelines. Data for 2022 show that 74.1% of VLBW infants received care at currently designated Level III+ NICUs, which is similar to data for the past three years. 2022 rates were highest for NH Black (76.2%) births, as compared to NH Asian/PI (71.4%), Hispanic (72.8%), and white, NH (73.1%) births.

Adopting Uniform and Nationally Recognized Neonatal and Maternal Levels of Care Standards

As shared earlier, the PHSP Collective concluded the work of two Action Teams in FY24 which included a focus on updating NC's Neonatal Levels of Care and developing Maternal Levels of Care. The NC Institute of Medicine, who convened the Action Teams, provided summary reports after the conclusion of both the Neonatal and Maternal Levels of Care Action Teams. These reports are being discussed with DHHS leadership and medical societies to determine potential next steps.

The mission of the Perinatal Nurse Champion Program is to improve the state's maternal and neonatal morbidity and mortality rates by ensuring that all pregnant women and high-risk infants have access to the appropriate level of care through a well-established regional perinatal system. To achieve this mission, along with provision of training and TA, birthing facilities were engaged to complete the CDC Level of Care Assessment Tool (LOCATe^{SM}) to determine risk-appropriate levels of maternal and neonatal care. By the end of FY23, 65 birthing facilities had completed the LOCATe^{SM} to determine risk appropriate levels of maternal and neonatal care, with 80.2% of birthing facilities having been assessed at least once (ESM RAC.1). During FY24, no facilities were asked to complete the LOCATe^{SM} tool as the WICWS was waiting on an updated version.

Providing Behavioral Health Support to Maternal Health Providers

The NC Maternal Mental Health MATTERS (Making Access to Treatment, Evaluation, Resources, Screening Better) program exists to support providers in screening, assessing, and treating behavioral health concerns in pregnant and postpartum patients. A strategy to help improve access to high quality integrated health care services is to increase awareness and to promote the services available through the NC MATTERS program. The NC Psychiatry Access Line (NC-PAL) is a provider-to-provider telephone consultation service where providers can receive real-time psychiatric consultation and case discussion with a Perinatal Psychiatrist or providers can consult with a Perinatal Mental Health Specialist and/or Care Coordinator to ask questions around diagnoses, medication management therapy, community resources and counseling. In FY24, NC MATTERS received 498 calls on the psychiatric access line and provided 24 one-time psychiatric assessments. NC MATTERS conducted outreach and provided perinatal health related training to 237 health care providers.

The NC MATTERS Stakeholders Network was developed to help shape and guide provider training, outreach,

toolkits, and collaboration across communities. This advisory group of 19 professionals convened its first meeting in February 2024 to review NC MATTERS initiatives and relevant perinatal Medicaid data.

In March 2024, NC MATTERS launched a Maternal Mental Health Fellowship, an intensive educational opportunity for health care professionals designed to enhance their capacity and confidence in addressing perinatal mental health and substance use disorders. A total of 89 people applied from varying perinatal care regions, and 38 were invited to participate from a range of disciplines (19 ObGyn, 8 Pediatrics, 6 Psychiatry, 5 Family Medicine, 3 Mental Health Counseling, 1 Internal Medicine, and 15 Other). Virtual training started in May 2024 and continued throughout the year. The curriculum focused on 1) Understanding Maternal Mental Health, 2) Screening and Assessment, 3) Partner and Family Involvement, 4) Psychiatric Medications and Therapeutic Interventions, Communication Skills and Building Rapport, Best Practices for Perinatal Substance Use Disorders, Self-Care and Professional Boundaries, Being a Champion in Your Community, 5) Case Discussions, and 6) Fetal/Infant Loss, Birth Trauma, and Medical Complications.

NC MATTERS also partnered with Mountain Area Health Education Center in FY24 to expand the Interactive map for Transitions, Access, and Continuity of Care (ITACC) resource with perinatal mental health listings. The ITACC platform provides an overview of reproductive healthcare and substance use treatment resources across the 18 westernmost NC counties.

ESM RAC.2 (Percent of LHDs who are utilizing NC-PAL) was created to help monitor this strategy. Four LHDs (4.7%) were using NC-PAL in FY24 which is a significant decrease from 13 LHDs who used NC-PAL to address in FY23 to address behavioral health needs of pregnant and postpartum patients. While it is unclear what caused this drop, it may be due to less focused outreach to LHD providers during this time period.

The Regional Social Work Consultant (RSWC) team supported the Care Management for High-Risk Pregnancies (CMHRP) staff, inclusive of behavioral health, in the following ways during FY24:

- Four Regional Face to Face Care Management Trainings were held with 72 CMHRP staff in attendance.
- Each new hire completed a care management training within the first year of being hired which included topics such as infant mortality, community health factors, using Motivational Interviewing (MI) for assessing and care planning, caseload management, sending appropriate referrals for services including behavioral health, and closing the loop on the sent referrals.
- Mental Health First Aid and MI remain requirements for new CMHRP staff within one year of their start date. The RSWCs share pertinent training announcements with CMHRP supervisors, so these requirements can be met.

The CMHRP staff members sought to build collaborative partnerships with LMEs in preparation for Tailored Care Management and Tailored Plan roll out into Medicaid Managed Care. This was done by first educating CMHRP Care Managers (CMs) on the importance of communicating with Tailored Care Managers within the LMEs. Secondly, CMHRP staff and LME staff discussed ways to co-manage members who are pregnant and at higher risk for adverse birth outcomes. The CMHRP Program Manager met with LME Administrators to proactively plan for the transition to Medicaid Managed Care. LME contact lists were distributed to CMs in CMHRP statewide and supervisory webinars and the CMHRP Resource and References Document within the CMHRP Program Toolkit contained the NC LME/MCO Directory to assist CMHRP CMs in maintaining communication.

The CMHRP staff members began emphasizing the importance of assessing members for behavioral health concerns with the CMHRP New Hire Orientation (NHO) process. Motivational Interviewing and Trauma Informed Care are trainings that CMHRP CMs are required to obtain within their first year of being hired. These trainings support the desire for care management services to be delivered in a way that promotes awareness of behavioral health concerns and our opportunity to assist members in accessing the need for additional resources to address behavioral health needs. NHO training also contains information on how to assess and address behavioral health concerns using the Program's Comprehensive Needs Assessment. CMHRP CMs conduct this assessment with each member for whom they provide services. CMHRP referral and follow-up data flow training was developed and provided to all Tailored Plans by the RSWC Team.

The CMHRP RSWC Team continues to emphasize the importance of assessing members for behavioral health

concerns with CMHRP Regional Face to Face Care Management Training. Motivational Interviewing and Trauma Informed Care are training courses that CMHRP CMs are required to obtain within their first year of being hired. These trainings support the desire for care management services to be delivered in a way that promotes awareness of behavioral health concerns and our opportunity to assist members in accessing the need for additional resources to address behavioral health needs. NHO training also contains information on how to assess and address behavioral health concerns using the Program's Comprehensive Needs Assessment. CMHRP CMs conduct this assessment with each member for whom they provide services.

The Patient Health Questionnaire-2 (PHQ-2) is part of the behavioral health assessment; when the PHQ-2 is positive the CM then conducts a Patient Health Questionnaire-9 (PHQ-9) for additional insight. These questions allow CMs to identify members who may benefit from a referral for additional behavioral health services. The CMHRP RSWC Team developed, implemented, and provided training on Perinatal Mental Health Educational Pathway as an additional behavioral health resource for CMHRP CMs. The CMHRP Resource and References document contains Behavioral Health resources such as Postpartum Support International and the LME/MCO Directory.

Perinatal Oral Health

The Perinatal Oral Health Program remains dedicated to educating medical providers, dental professionals, and pregnancy support service providers on the critical importance of oral health during pregnancy. In FY24, Public Health Dental Hygienists successfully conducted 82 perinatal oral health training sessions, reaching 501 participants. Beyond these training efforts, the program also made valuable contributions by participating in a community baby shower and showcasing its work at the 50th Anniversary WIC Conference.

A perinatal oral health training was provided to all CMHRP CMs in collaboration with the Oral Health Section. This training provided information on how pregnancy affects maternal oral health as well as how maternal oral health impacts the child's oral health. Perinatal oral health guidance for pregnant women was given in addition to how collaborative practice between medical and dental providers can improve maternal-child health outcomes.

Newborn Screening Follow-Up Team

Universal newborn screening (NBS) genetic services have been available in NC since 1966. In 1991, provision of such services became a legislative mandate with the passage of House Bill 890 *An Act to Establish a Newborn Screening Program*. The NC State Laboratory of Public Health (SLPH) began its program screening all infants born in NC for phenylketonuria, then added tests for congenital hypothyroidism (CH) and later for galactosemia, congenital adrenal hyperplasia (CAH), and hemoglobinopathy disease (e.g., sickle cell). Beginning in July 1997, screening was expanded to include a broader array of metabolic disorders using tandem mass spectrometry technology. Screening for biotinidase deficiency was added in 2004, and screening for Cystic Fibrosis (CF) was added in 2009. Legislation was passed in May 2013 requiring newborn screening for critical congenital heart disease (CCHD) using pulse oximetry screening. Screening for Severe Combined Immunodeficiency Disorder (SCID) was added to the panel of screening in 2017. Screening for Spinal Muscular Atrophy (SMA) was added to the screening panel in May 2021. In February 2023 Pompe disease and Mucopolysaccharidosis Type I were added to the screening panel. SL 2018-5 amended NCGS 130A-125, which allowed for the Commission for Public Health to "amend the rules as necessary to ensure that each condition listed on the Recommended Uniform Screening Panel (RUSP)…is included in the Newborn Screening Program."

The NBS Follow-Up Team, housed in the WCHS and funded by Title V, ensures that all newborns who screen positive for a particular genetic diagnosis receive timely follow up to definitive diagnosis and are referred to clinical management for their condition. The NBS Follow-Up Team reports abnormal NBS results in a timely manner, monitors follow-up testing, documents final outcomes, provides technical assistance to LHDs and private providers about individual NBS results, and provides information for patients and their families. In FY24, the NBS Follow-Up Team provided services for 1,346 infants with abnormal NBS results for CH, CAH, galactosemia, biotinidase deficiency, SCID, SMA,CF and Pompe disease, 142 of whom were confirmed to be affected and are receiving treatment as determined by the appropriate subspecialist. The NBS Follow-Up Team completed a review of follow-up protocol and educational parent and provider materials for galactosemia and biotinidase deficiency. Along with partners in pediatric endocrinology across the state, the WCHS follow-up staff began a review to update CH follow-

up protocols. In addition, work began to create new parent and provider CH and CAH educational materials. The WCHS follow-up staff, in partnership with SLPH and consulting immunologists, reviewed SCID follow-up protocols and completed changes that will be finalized in FY24.

The WCHS maintains a contract with UNC-Chapel Hill for follow-up and management of infants identified by tandem mass spectrometry (MS/MS), X-linked adrenoleukodystrophy (X-ALD), and MPS I. The team at UNC continued to provide clinical genetic services, genetic counseling services, and genetic testing for just over 2,4000 unduplicated patients from a variety of referral sources with highly complex needs and their families regardless of their ability to pay. Services conducted at medical facilities and outreach satellite clinics include clinical evaluations/services, laboratory studies, genetic counseling, follow-up, and management. Metabolic services were provided to 698 newborns and patients with a potential diagnosis for an inborn error of metabolism identified through MS/MS, X-ALD, and MPS I newborn screening through the DHHS. UNC also provided expertise and consultation to the SLPH on follow-up care for infants identified through NBS and consultation to referring healthcare providers regarding patient diagnosis, care, and management. There were 45 confirmed cases of newly diagnosed inborn errors of metabolism who were cared for immediately and are getting ongoing care through the UNC Genetics and Metabolism service. Additionally, the team had nearly 7,000 phone encounters with all their metabolic patients regarding ongoing management.

The SLPH NBS Program has been planning for the addition of Mucopolysaccharidosis Type II (MPS II), Guanidinoacetate Methyltransferase (GAMT) Deficiency, and Krabbe Disease. This includes the development of method validation plans, and an assessment of infrastructure, equipment, reagent, workflow, follow-up, and personnel requirements. MPS II was added to the RUSP in August 2022, GAMT Deficiency was added in January 2023, and Krabbe Disease was added in July 2024.

The WCHS State Public Health Genetic Counselor (SPHGC) provided additional training, technical assistance, and consultation about children and youth with or at risk for genetic conditions and assist with NBS follow-up in FY24. The NC Genetics and Genomics Advisory Committee (GGAC), made up of professionals, families, and other partners with interest in genetics, met quarterly to discuss genetic issues and implement components of the *2020 NC Public Health Genetic and Genomics Plan*.

The NC Birth Defects Monitoring Program (NCBDMP) continues to work with hospital points of contact to improve enrollment and reporting of CCHD data into the statewide WCSWeb database. NCBDMP staff review screening results for case-finding, to determine false positive and false negative results, and to link screening results to cases identified within the registry to determine timing and method of diagnosis. WCHS Early Hearing Detection and Intervention (EHDI) consultants did outreach with staff while working with birthing hospitals about the CCHD reporting requirements. EHDI staff disseminated a recently developed prenatal information sheet, *North Carolina's Newborn Screening Program*, to help with increasing awareness about several newborn screenings. The sheet contains information about CCHD screening, metabolic screening, and hearing screening.

The EHDI program is primarily funded through other federal grants but housed in the WCHS. All hospitals/birthing facilities in NC provide newborn hearing screening. Newborn hearing screening data are collected through the state's web-based data tracking and surveillance system for newborn hearing screening, WCSWeb Hearing Link. WCSWeb Hearing Link is used to provide data to birthing facilities, audiologists, and interventionists for compliance with reporting requirements and the number of infants meeting EHDI 1-3-6 (screen by one month of age, diagnosis by three months of age, enrollment in intervention by six months of age) goals. The EHDI data system will continue to be enhanced with a long-term goal of integration with other Health Information Technology (HIT) or electronic medical record systems. The EHDI program works to empower and utilize families as partners in the development or improvement of a statewide family support system designed to address the needs of families of newborns and infants diagnosed as deaf or hard of hearing (D/HH). In 2023, a total of 121,258 (99% of 122,463 occurrent live births) were screened for hearing, with 118,694 (97% of live births) screened by 1 month of age.

Priority Need 3 – Prevent Infant/Fetal Deaths and Premature Births

The Perinatal Health Strategic Plan (PHSP) is the driving force for the work in this particular domain. Led by the PHSP Collective, the PHSP is making an impact by continually identifying how collaborative partner organizations'

scope of work/priorities align with the PHSP using an environmental scan survey. The PHSP has continued to support and foster new partnerships. For example, the intersection of substance use and tobacco, as well as perinatal incarceration, has created the opportunity to work with new partners. Regular PHSP Collective meetings now highlight speakers/organizations from various domains to increase awareness of organizations working on different community health factors, but there is still more work to do in branching beyond the public health space to engage more deeply with new partners. The PHSP provides a foundation for coordinated strategy throughout NC and identifies varying organizations' roles in that strategy. When working on proposals or thinking through our larger approach, PHSP Collective partners can turn to the plan to ensure that the work being done addresses the larger goals:

Goal 1 – Addressing Economic and Social Inequities
Goal 2 – Strengthening Families and Communities
Goal 3 – Improving Health Care for All Women of Childbearing Age

Work to reduce the infant mortality disparity ratio continued in FY24 through a variety of methods. The PHSP's adapted framework is designed to focus on community health factors to address infant mortality, maternal health, and the health status of individuals of reproductive age. The Perinatal Systems of Care (PSOC) Task Force recommendations, released in April 2020, were aligned with the original PHSP. The updated 2022-2026 PHSP continued with a focus on community health factors. In addition, work to support the NC Child Fatality Task Force (CFTF) continues. The infant focused efforts have been addressed more thoroughly in the Perinatal Health Committee of the CFTF. As historically about two-thirds of all child deaths in NC are infant deaths, the NC Title V Program works closely with the NC CFTF and the NC Child Fatality Prevention System which is described in the Child Health Domain.

Infant Mortality Reduction Programs/Initiatives

Healthy Beginnings, North Carolina's minority infant mortality reduction program, focuses on improving birth outcomes among minority women, reducing minority infant morbidity and mortality, and supporting families and communities. Healthy Beginnings serves women during and beyond pregnancy and their children up to two years after delivery. Services are provided to all enrolled program participants through care coordination contacts, needs assessments and screenings, home visits, and group educational sessions. Healthy Beginnings program components include early and continuous prenatal care, tobacco use cessation, breastfeeding initiation and maintenance, depression screening, postpartum care, infant safe sleep, reproductive life planning, healthy weight, and well-childcare. All Healthy Beginnings staff are required to complete training and/or utilize educational materials identified by the WICWS for each program component.

The Healthy Beginnings program served 502 minority pregnant and postpartum/ interconception women and their children in FY24. During FY24, there were 474 live births with three infant deaths (6.3 infant death rate). Among all pregnant program participants, 82.4% % received prenatal care within the first trimester. Healthy Beginnings program staff are trained in the Partners for a Healthy Baby home visiting curriculum and UNC CMIH's infant safe sleep training. Pregnant program participants receive monthly assessments for prenatal care and postpartum program participants receive monthly assessments on infant safe sleep practices. Healthy Beginnings program staff provide minority pregnant and postpartum/interconception women with education and support throughout their pregnancy and up to two years interconceptionally.

The Healthy Start Initiative is a federally supported program funded through MCHB. The aim of this program is to improve birth outcomes and the health of women of childbearing age (15-44 years) through the strengthening of perinatal systems of care, promoting quality services, promoting family resilience, and building community capacity to address perinatal health disparities. In FY24, NC BLP continued to focus its efforts in three counties with higher infant mortality rates within the state and enrolled 236 pregnant women. NC BLP program services included outreach, health care coordination for women during the preconception, prenatal, and interconception periods, promotion of fatherhood involvement, perinatal depression screening and referral, and health education and training. WICWS also has a second funded Healthy Start site Southeastern North Carolina Healthy Start (SENCHS), which began in September 2023. SENCHS local health department partners are working to fill direct service positions and expect services to be implemented in FY25.

The Improving Community Outcomes for Maternal and Child Health (ICO4MCH) initiative addresses three aims: (1) improve birth outcomes, (2) reduce infant mortality, and (3) improve the health status of children ages birth to five utilizing a collective impact framework with a health for all lens. The ICO4MCH initiative continued funding to five lead LHDs (totaling nine health departments) in FY24. The LHDs implement one evidence-based strategy (EBS) in each of the three aims. The evidence-based strategies implemented included Reproductive Life Planning; Improve Preconception Health among Women and Men, Interconception Health among Women, and Provide Preconception and Interception Health; Ten Steps for Successful Breastfeeding, with a Focus on Steps 3 and 10; Tobacco Cessation and Prevention; Triple P (Positive Parenting Program); and Family Connects Newborn Home Visiting Program. The ICO4MCH initiative seeks to reduce the rates of infant mortality, unintended pregnancy, preterm birth (including low birth and very low birthweight), child death (age 1-5), substantiated child abuse cases, and out-of-home placement for children (ages 0-5) and increase the birth spacing rates in NC. Four ICO4MCH sites (Durham, Mecklenburg-Union, Sandhills Collaborative, and Wake) conducted reproductive justice training in FY24, reaching a combined total of 134 providers and staff. Durham reached 111 persons of reproductive age through participation in community outreach events. Guilford, Mecklenburg-Union and Sandhills Collaborative reached 3,114 people through outreach events focused on preconception and interconception health. Under the breastfeeding EBS, a total of 1,907 staff were trained in lactation education, peer counseling and related areas across all ICO4MCH sites in FY24. Under Triple P, 59 new practitioners were accredited representing Wake (23), Mecklenburg-Union (30) and Sandhills (6) Collaboratives. In addition, a total of 580 caregivers and 3,842 children ages 0-5 were served in Guilford, Mecklenburg and Sandhills regions. ICO4MCH staff at the Family Connects Durham site conducted 659 in-person and virtual visits in FY24.

Title V funding supported the Reducing Infant Mortality in Communities (formerly Infant Reduction Program) in FY24 by providing funding to 11 LHDs in counties that have experienced some of the highest infant mortality and disparity rates in the state. This program implemented evidence-based strategies that are proven to be effective to improve birth outcomes through addressing pregnancy intendedness, preterm birth, and/or infant mortality. Evidence-based strategies included Centering Pregnancy; doula services; infant safe sleep practices; Nurse Family Partnership expansion; reproductive life planning services, increased access to long-acting reversible contraception; and tobacco cessation and prevention services. During FY24, one LHD implemented Centering Pregnancy and provided services to 82 clients; two LHDs had fourteen community members trained as doulas and 44 clients received doula services; and seven LHDs collectively provided infant safe sleep educational sessions to 892 clients. In addition, three Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funded LHDs served 537 clients and staff completed 6,156 home visits under the Nurse-Family Partnership (NFP) program, and five non-MIECHV funded LHDs served 501 clients and completed 5,349 home visits under NFP. Thirty-three staff representing ten LHDs were trained in reproductive life planning and educated 9,525 clients; and three LHDs trained 30 staff on 5As (Ask, Advise, Assess, Assist, Arrange) and/or as Certified Tobacco Treatment Specialists (CTTS). The four CTTS counseled 94 people and referred 48 clients to QuitlineNC. In addition, staff at the three LHDs screened 12,152 patients regarding tobacco use.

Breastfeeding NPM – Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Increasing the percentage of infants who are ever breastfed or are breastfed exclusively through six months is a goal of the NC Title V Program and a component of the state's Early Childhood Action Plan. The latest data available from the National Immunization Survey (NIS) data for NC births occurring in 2021 reported that 83.5% of infants were ever breastfed, yet by 6 months of age only 28.3% of infants were exclusively breastfed. These are increases from the previous years' rates of 81.4% and 23.1% respectively. State rates are comparable to national rates for infants born in 2021. Breastfeeding initiation data obtained from birth certificates through NVSS for infants born in 2023 reveal that 81.5% of all infants were breastfed at hospital discharge. These data also mirror national trends of racial/ethnic disparities in breastfeeding, as Hispanic infants had an 86% initiation rate, NH white infants had a rate of 84.1%, and NH Asian/PI infants had a rate of 87.3%. In contrast, NH Black had a lower rate of 71.7%, and NH American Indian had the lowest rate at 56.4%. Per 2022-23 results of the National Survey of Children's Health (NSCH), in NC, 33.5% of children, ages 6 months through 2 years, were breastfed exclusively for 6 months, as opposed to 28.7% nationally.

North Carolina continues to evaluate and strengthen its breastfeeding response amid unprecedented challenges,

including pandemics, ongoing infant formula supply chain shortages, and natural disasters that impact the state's families. Each year brings new challenges, but with them come opportunities to adapt, respond, and learn. Through these efforts, NC has built a stronger, more resilient system for addressing breastfeeding support. Lessons learned have fostered the development of a coordinated state office focused on infant feeding and trained local agency staff who provide tailored, culturally competent care to families across the state.

DPH and DCFW have partnered on initiatives to improve access to breastfeeding support through the DPH/DCFW Breastfeeding Coordination Committee. During FY24, a key goal was collaborating with Medicaid Managed Care providers to align breastfeeding support with the requirements of Medicaid expansion. This included creating consistent communication for parents on accessing breastfeeding resources, particularly breast pumps. Two of the six Medicaid Managed Care programs have updated their materials, with plans to make these resources publicly available by the third quarter of F25. This goal was identified through the Breastfeeding Coordination Committee's collaborative efforts to ensure families have clear and consistent guidance for obtaining breast pumps. For under-resourced families, the WIC Program remains a critical avenue for accessing breastfeeding supplies. Before Medicaid expansion, WIC was the primary resource for breastfeeding supplies. While WIC has successfully provided breast pumps to many families, this responsibility placed significant time demands on staff for pump distribution and education. Medicaid expansion has eased this burden, allowing WIC to refocus on its core mission of breastfeeding support.

In FY24, WIC rolled out a multi-level breastfeeding curriculum to ensure consistent, evidence-based support. This four-tier training program provides up to 80 hours of education for the most advanced staff, designated as WIC Breastfeeding Experts. This initiative has resulted in standardized breastfeeding education and strengthened the program's ability to deliver reliable, evidence-based information. The need for such training is critical, as no current academic or credentialing programs provide comprehensive breastfeeding education. The impact of this curriculum, combined with the introduction of a continuing education component in FY24, is evident in the state's breastfeeding rates. Breastfeeding initiation rates have remained strong at 77.5%, slightly below the all-time high of 79.2% in FY23. Additionally, there has been a significant 30% growth in the issuance of WIC breastfeeding food packages, increasing from 29.0% of dyads in FY23 to 37.8% by the end of FY24.

Standardized training and consistent messaging are proven strategies for improving breastfeeding rates. These efforts have been enhanced by a coordinated statewide approach to service delivery. In FY24, the WIC Program launched quarterly community engagement meetings to improve continuity of care and facilitate warm handoffs for breastfeeding support. These meetings, led by International Board Certified Lactation Consultants (IBCLCs) funded through the WIC Program's Lactation Area Training Centers for Health (LATCH). By fostering partnerships between public health staff, local health departments, and healthcare providers, LATCH has strengthened the breastfeeding support infrastructure statewide. This collaborative model ensures that families receive coordinated care across public and private sectors.

Additionally, the Nutrition Program Consultants' management of the Breastfeeding Coordination Committee has created pathways to connect WIC programs with other community programs and resources. Increased awareness of these programs has enabled grassroots networking and strengthened local partnerships, further enhancing the support available to breastfeeding families.

In FY24, the WICWS Nutrition Consultant facilitated discussions with statewide stakeholders to gather concepts for the proposed NC Breastfeeding Hotline. The Stakeholders group included representation from a pediatrician, WIC program staff, representative from statewide breastfeeding coalition, lactation consultants, etc. The Stakeholders provided suggestions on topics such as functionality of and essential components for the hotline, integration of the hotline with currently existing programs and how to market the hotline across NC. The development of the Request for Proposal began in FY24.

In FY24, the CMHRP CMs assessed each of their patients prenatally and in the postpartum period for breastfeeding support needs and provided on-going education and information as part of their care management services. Education was also provided about the benefits of breastfeeding for the pregnant woman and the infant. CMs made referrals to breastfeeding classes and other breastfeeding supports. Moreover, CMHRP CMs educated patients on the value-added benefits related to breastfeeding, provided by Medicaid Managed Care Pre-Paid Health Plans to

promote breastfeeding. If the patient indicated a need for breastfeeding support at any time, the CMHRP Care Manager made an appropriate referral to the necessary support services.

Strategic Plans Prioritizing Breast and Human Milk Feeding

Multiple state strategic plans in NC have prioritized breastfeeding objectives, strategies, and action. These include the NC PHSP; NC ECAP; the NCDHHS State Action Plan for Nutrition Security, NC's Plan to Address Overweight and Obesity – Eat Smart, Move More NC; and Promoting, Protecting, and Supporting Breastfeeding: A NC Blueprint for Action. Breastfeeding strategies in the PHSP were modified and enhanced in FY21 and were revised along with the rest of the PHSP in FY22. Within DPH, the WICWS and CDIS house a variety of health professionals and programs that directly work to increase breastfeeding initiation, duration, and exclusivity. Funding for these positions comes from Title V, Title X, WIC, Preventive Health Services Block Grant, and CDC, plus other agencies. The DCFW houses the Community Nutrition Services Section (CNSS) which includes the Special Supplement Nutrition Program for Women, Infants, and Children (WIC), of which an integral piece is breastfeeding promotion and support through the work of the state and local agency breastfeeding coordinator and Breastfeeding Peer Counseling (BFPC) program. DPH and DCFW prioritize breastfeeding through the establishment and monitoring of breastfeeding metrics within pertinent programs and departmental strategic plans. Each program and plan outline various interventions to positively impact breastfeeding rates in alignment with their goals.

Breastfeeding efforts are coordinated within the department through the DPH/DCFW Breastfeeding Coordination team which is predominately led/supported by the WCHS Pediatric Nutrition Consultant (PNC). NC's Title V MCH Block Grant continued to support 100% of the salary of the WCHS PNC in FY24. The goal of the PNC position is to maximize culturally relevant nutrition and physical activity services, community supports and policies, systems and environmental changes, and outcomes for and with NC children and their families. Areas of expertise and/or focus include: Evidence-based Nutrition & Physical Activity (NPA); NPA Policy, Systems and Environmental Change & Drivers of Health; Food Insecurity/Nutrition Security; Local Foods; and Responsive Feeding & Weight Inclusive Practice. In this capacity, the PNC, a Registered Dietitian Nutritionist (RDN), provides nutrition expertise, training, and technical assistance to multiple internal and external partners. The PNC also regularly mentors nutrition/dietetic students who help support and expand nutrition contributions.

The DPH/DCFW Breastfeeding Coordination team meets on a quarterly basis to ensure integration, communication, and coordination of breast and human milk feeding activities. With the creation of the FY2021-25 MCHBG State Action Plan, the DPH/DCFW Breastfeeding Coordination Team has been more engaged in the monitoring of the included objectives, strategies and measures and preparing the annual MCHBG application.

During FY24, the DPH/DCFW Breastfeeding Coordination Team continued to meet quarterly and also held a strategic planning retreat in May 2024. The team consists of ~27 members in both leadership and programmatic positions. Each year, the team works on several projects together or in small workgroups. In FY24, the PNC co-developed agendas and worked to identify facilitators, recorders, and timekeepers for each meeting; served on sub workgroups which created documents to feature each of the DPH and DCFW programs and staffing focused on breastfeeding; and planned DHHS breastfeeding promotions for August 2024. This included four weekly letters titled Liquid Gold that featured lactation appreciation and success stories among state and local programs.

The initiation and continuation of breastfeeding is a well-researched intervention for the reduction of maternal and child morbidity and mortality. The NCDHHS perinatal and child health strategic plans recognize the public health imperative to support interventions that improve the initiation and continuation of breastfeeding for NC citizens. While a decision to breastfeed is personal, its success is dependent on the mesosystem and exosystem sources of influence on families. Families continue to experience barriers that negatively impact their breastfeeding goals. The NCDHHS strategic plans have focused on implementation activities that reduce the barriers of breast and human milk feeding success.

WIC Breastfeeding Peer Counseling Program

In FY24, the North Carolina WIC Breastfeeding Peer Counseling Program (BPCP) demonstrated steady progress as it adapted to the post-pandemic environment. Despite the challenges of disrupted referral processes, the

program continued to connect with families through innovative approaches such as texting, telehealth, and hospital visits.
The Breastfeeding National Performance Measure, ESM BF.1 (the number of eligible WIC participants receiving breastfeeding peer counseling services), remains central to monitoring progress and ensuring program effectiveness, and during FY24 the program reached 21,869 pregnant and postpartum women, reflecting the BFCP's resilience and stability as it continues to regain momentum after declining during the COVID-19 pandemic.

One of the most significant milestones of FY24 was the hiring of a State Peer Counselor Coordinator, ending a 10-month vacancy. This leadership position has brought renewed focus and stability to the program, enabling enhanced guidance and resources for local agencies. A key accomplishment under this new leadership was the development of comprehensive training for managers of paraprofessionals, an approach that sets NC apart in its dedication to building capacity within the program.

To address the challenges of referrals, the program implemented standardized referral structures across all local agencies, guided by the WIC Program's State Program Manual. This initiative has improved the efficiency and consistency of connecting participants to breastfeeding peer counselor services, ensuring more families receive the support they need. By embracing new methods of outreach, refining referral processes, and providing robust training and leadership, the BPCP remains one of the most effective interventions for supporting breastfeeding initiation and continuation among NC families. As the program continues to adapt and innovate, its steady progress is evident in the sustained engagement of participants, the growth of the breastfeeding food package issuance, and the strong collaboration between local agencies and community partners. FY24 was a year of rebuilding, stabilization, and setting the stage for even greater impact in the years ahead.

Breastfeeding Friendly Designations

In FY24, the North Carolina Maternity Center Breastfeeding-Friendly Designation (NCMCBFD) program continued to grow in its influence and reach, demonstrating its value as a pivotal initiative in supporting breastfeeding families and improving maternal and infant health outcomes. The program has been well-received statewide, with an impressive 37 hospitals now participating, reflecting growing engagement and trust in the program's impact. Established by the NCDHHS, NCMCBFD remains the nation's first state designation program to recognize the incremental implementation of the World Health Organization's Ten Steps to Successful Breastfeeding. Administered by DCFW, the program awards maternity centers one star for every two steps implemented, making it a flexible yet rigorous framework for improving breastfeeding support. Since the program's inception, 75% of North Carolina's hospitals providing obstetric services have earned this designation at various levels. The continued success and recognition of NCMCBFD can be attributed to strong collaborative partnerships. These partnerships elevate the program as a key infant mortality reduction initiative and provide hospitals with the technical assistance needed to implement quality improvements in breastfeeding support.

In FY24, the NC Breastfeeding-Friendly Child Care Designation program continued to demonstrate growth and stability as it gained renewed momentum and focus on its goals. The committee overseeing the designation has shown progress in finding its footing, with a stronger sense of direction and commitment to advancing breastfeeding support for families reentering the workforce postpartum. This year, the program saw continued submissions of applications, reflecting growing awareness and interest in the designation. The development of a new logo and promotional materials has enhanced the program's visibility, making it more recognizable and appealing to childcare centers across the state. The designation, updated in FY22, outlines strategic actions aligned with the Ten Steps to a Breastfeeding-Friendly Child Care, developed by the Carolina Global Breastfeeding Institute. The emphasis on implementing all ten steps provides a comprehensive approach to creating a supportive environment for breastfeeding families, reinforcing the continuum of care during a critical transition period.

CNSS staff collaborate closely with the NC Child Care Resource and Referral Council and Child Care Health Consultants (CCHCs) to provide training, resources, and technical assistance for implementing the program's standards. These partnerships have been instrumental in ensuring childcare centers receive the guidance and support needed to achieve and sustain the designation. In FY24, four new childcare centers achieved the NC Breastfeeding-Friendly Child Care designation for successfully implementing all Ten Steps, bringing the total to 14 designated centers. This steady growth reflects the program's success in encouraging childcare providers to

prioritize breastfeeding support and its alignment with broader public health goals.

Another strategy adopted by NCDHHS to increase breastfeeding is to support LHDs who are working toward or awarded the NC Breastfeeding Coalition's (NCBC) Mother-Baby Award for outpatient healthcare clinics. In FY23, NCBC renamed this award (Family Friendly [Breastfeeding] Clinic Award for outpatient healthcare clinics**)** and updated some of the award criteria. The PNC provided NCBC feedback on their updated application and then worked with internal partners to update our DCFW/DPH Pre-Application Assessment that mirrors the NCBC award criteria. The purpose of the DCFW/DPH Pre-Application assessment is twofold:

1. to collect baseline data (at a state and clinic/local level) of interested/potentially applying outpatient healthcare clinics in NC on their current use of evidence-based, high quality breastfeeding and human milk feeding support practices for pregnant and/or postpartum women, infants, children and their families. Data entered into this Pre-Application Assessment is used by DCFW and DPH to identify and address technical assistance, training and/or resource needs of LHD staff and their partners who have chosen this activity as part of their 353 Agreement Addenda (AA) or other supportive AAs administered in DPH.
2. to assist clinic/local level staff who plan to eventually apply for the NCBC's Family Friendly Clinic Award *for Outpatient Healthcare Clinics* by identifying which award criteria their clinic currently meets and more importantly identifying the criteria they don't meet so that an action plan can be developed.

This is primarily accomplished through the Child Health AA 351 as an optional activity for LHDs to choose and through CDC funding received by the CDIS for work in two branches that also focuses on increasing breastfeeding rates and improving other lifestyle behaviors. Continued promotion, technical assistance, and coordination with the DPH/DCFW Breastfeeding Coordination Team and particularly by the PNC will help to increase the total number of LHDs (and or clinics they are working with) receiving the Family Friendly (Breastfeeding) Clinic Award for outpatient healthcare clinics award. According to the NCBC website, the benefits to those LHDs receiving the award include public recognition of breastfeeding-friendly care, free marketing to the public about their success, increased patient satisfaction, and improved support for breastfeeding initiation, duration, and exclusivity. As of FY24, a total of eight LHDs have received the award. During FY24, no additional health departments worked on this optional activity.

Additional Breastfeeding Efforts

During FY24, the PNC, in partnership with the DPH/DCFW Breastfeeding Coordination Team members, contributed to efforts to enhance breastfeeding resources and practices statewide. The PNC initiated a relationship with the Office of State Human Resources (OSHR) wellness director which resulted in assisting with updating of the OSHR Lactation Policy including use of more inclusive language and consistency with the Federal PUMP Act. Other staff that the PNC engaged in this work included the WIC Breastfeeding Coordinator and the WICSS Nutrition Consultant. In February 2024, the OSP Lactation Policy was approved by Governor Roy Cooper.

In FY24, Healthy Beginnings, NC's minority infant mortality reduction program, served women during pregnancy, birth and up to two years during the interconception period as well as their children. Breastfeeding education/support was an intervention provided to program participants by Healthy Beginnings staff members. Staff provided breastfeeding education and conducted an assessment on the participants' plan to breastfeed, then followed through with more education to support the participants' ability to carry out their plan. Healthy Beginnings staff also provided education and resources to fathers/partners and family members on breastfeeding and ways to support breastfeeding mothers. The Healthy Beginnings program provided breastfeeding education and support to all pregnant and postpartum/interconception program participants in FY24, and 73.8 % of postpartum program participants initiated breastfeeding. All existing and newly hired Healthy Beginnings program staff received WIC Breastfeeding Peer Counselor Core training. In FY24, all breastfeeding program participants received monthly breastfeeding assessments and support to maintain breastfeeding rates for 6 months or longer.

Breastfeeding initiation and duration rates continue to be a challenge among NC BLP participants. In FY24, the NC BLP program enrolled 78 women in the interconception period. Any eligible pregnant woman was also referred to WIC for services and for breastfeeding assistance if they were not enrolled in WIC services. During FY24, NC BLP participants were breastfeeding at a rate of 51% at discharge (a decrease from 60.5% in FY23). The rate for infants breastfeeding at 6 months plummeted to 5.4% from 18.5% in FY23. The NC BLP staff continued to maintain strong relationships with WIC clinics to provide increased education on the benefits of providing breast milk for infants,

including how to maintain breastfeeding when separated from babies in such cases as work or school. Plans to increase community support regarding schools and businesses continue to be discussed.

In FY24, CHWs at ICO4MCH sites continued to assist with implementation of the breastfeeding strategy. LHDs are training and collaborating with health care providers, community-based and faith-based organizations to increase the knowledge and skills to support breastfeeding women; and increasing social media messaging. The five ICO4MCH funded sites are implementing one of three evidence-based strategies around breastfeeding. Durham County is implementing the Breastfeeding-Friendly City program, Mecklenburg-Union and the Sandhills Collaborative and Guilford County are implementing the Making It Work approach, and Wake County Human Services is establishing public lactation rooms.

In FY24, Durham County hosted 32 outreach and education events, reaching 3,002 men and women of reproductive age. They worked closely with Breastfeed Durham, who plays an integral role in the LHD, becoming involved with the community and encouraging Duke Hospital to become Breastfeeding Friendly. They are actively working toward the 10 steps of becoming a Breastfeeding Friendly City. Durham County collaborated with five new partner organizations, with an additional eight businesses that became breastfeeding friendly. In addition, Durham ICO4MCH staff distributed “Breastfeeding Welcomed Here” clings to promote new lactation spaces.

Guilford County started a Breastfeeding Lunch and Learn series, which was wildly successful. Guilford ICO4MCH staff opened its second Baby Cafe in High Point and conducted 3 parent engagement sessions. They also established a Breastfeeding Collaborative.

The Mecklenburg-Union Collaborative hosted 22 outreach events, reaching 332 people in FY 2024. In addition, the Collaborative provided two Making It Work Toolkit trainings to employers on how to make themselves more accommodating for breastfeeding employees.
Sandhills Collaborative collaborated with thirteen new partners and held 1,656 outreach events reaching over 5,391 people in FY24. They also worked with four Walmart locations to establish lactation spaces in the region. Richmond County held their first breastfeeding support group, while the Sandhills’ Breastfeeding Program Coordinator was trained to be a doula.

Wake County secured all furniture and supplies for two of five lactation rooms by the end of FY24 with the remaining rooms to be established at the beginning of FY25.

The MIECHV Program implements Healthy Families America (HFA) and Nurse Family Partnership (NFP) models in NC. These home visiting programs serve women prenatally through children up to five years of age. NFP only enrolls first-time mothers prenatally and HFA enrolls mothers prenatally and those with children up to three months of age. When analyzing MIECHV breastfeeding data the numbers may be lower than data from non-MIECHV NFP home visiting programs due to some mothers in HFA being enrolled after giving birth. In FY23, 25.9 % of MIECHV participants reported any breastfeeding at 6 months of age, while non-MIECHV NFP sites were at 39.7%. In FY24, 32.6% of MIECHV participants reported any breastfeeding at 6 months of age, while non-MIECHV NFP sites were at 44.1%.

Both NFP and HFA programs practiced numerous strategies to promote breastfeeding during FY24. Almost all sites have at least one trained lactation consultant or counselor. When mothers are enrolled prenatally, breastfeeding discussions start early and continue throughout the pregnancy and after the infant is born, as well. Other strategies include resources, incentives, and supplies to encourage breastfeeding, such as developing a breastfeeding success plan, and providing nursing pillows and pumping equipment. Breastfeeding educational materials are provided to families and there is ongoing training for home visitors throughout each year.

Smoking-Pregnancy Standardized Measure – Percent of women who smoke during pregnancy

Decreasing the percent of women who smoke during pregnancy remains a big objective of the NC Title V Program as tobacco use during pregnancy is directly associated with the leading causes of infant mortality in NC. While 2018 baseline data indicated that 8.4% of births were to women who indicated that they smoked during their pregnancy, in 2023, this percentage decreased to 3.6%. Hispanic women (.7%) and NH Asian women (.3%) were least likely to

smoke during pregnancy, and NH American Indian women were most likely to smoke (12.6%) in 2023. NH Black women (3.8%) were less likely to smoke than NH White women (4.6%) and NH multi-race women (5.6%). While the overall decrease is encouraging and actually already meets the 2025 objective of 7.5%, birth certificate data does not include information about the use of vaporizers, e-cigarettes, and other Electronic Nicotine Delivery Systems (ENDS).

The NC BLP program enrolled 236 pregnant women during FY24. Of those pregnant, 83.9% reported abstaining from tobacco during pregnancy, with 93.1% abstaining during the third trimester. NC BLP staff are trained using evidence-based approaches such as motivational interviewing and the 5As (Ask, Advise, Assess, Assist, Arrange) for tobacco use and use these approaches in their visitation model and provide resources and support where needed.

All existing and newly hired Healthy Beginnings program staff were trained to provide evidence-based tobacco use screening and cessation counseling through You Quit, Two Quit or Northwest AHEC's online tobacco cessation course. All program participants received education and monthly tobacco use assessments and cessation counseling when needed. In FY24, 4.8% of program participants who enrolled pregnant reported smoking during pregnancy.

Since tobacco use during pregnancy is a driving factor for preterm birth and low birth weight, CMHRP CMs continue to employ interventions to assist pregnant women with tobacco cessation. All pregnant and postpartum women who are eligible for CMHRP services were assessed by a CMHRP Care Manager, received the 5As, and the appropriate level of tobacco cessation intervention according to the 5As modality. The association between tobacco use and low-birth weight, harm reduction, postpartum relapse prevention, as well as the dangers of infant exposure to second-hand smoke were emphasized. The CMHRP Program continued to promote the use of its Tobacco Cessation Pathway resource for CMs. This pathway is a resource developed in collaboration with UNC Collaborative for Maternal & Infant Health and the You Quit, Two Quit initiative. This Tobacco Cessation Pathway provides guidance for screening, counseling and documentation of care management activity related to tobacco use in pregnancy and postpartum. This Pathway, along with the most updated version of the You Quit, Two Quit Tobacco Cessation Practice Bulletin, which encompasses several other educational resources for CMs and patients continued to be a resource for CMHRP CMs. CMs also support prenatal care providers and patients in implementing care plans related to tobacco cessation initiated by the prenatal care provider.

Preconception Health and Tobacco Cessation Activities

NC continues to maintain partnerships comprised of state and LHD partners, universities, and community-based organizations engaged in efforts to decrease tobacco use and exposure. Efforts center on prevention, education, counseling, and care coordination. Tobacco screening and counseling is infused within all programs supported by DPH. The Women and Tobacco Coalition for Health (WATCH) continues to offer and disseminate information associated with women's health and tobacco use prevention and treatment across the lifespan. Healthcare providers, inclusive of LHDs, remain the key partners in the tobacco cessation efforts for pregnant women. The Preconception Health and Wellness Program Manager, though vacant during part of the reporting period, provided technical assistance and support to program partners via training and technical assistance. The Preconception Health and Wellness (PHW) Program Manager engaged with WATCH members who had not met in more than a year due to the retirement of the previous program manager. Efforts to review and update the *You Quit Two Quit* Practice Bulletin did not take place, but efforts to recruit several WATCH members to form a time limited workgroup to begin the process of reviewing the practice bulletin were renewed in FY24.

During FY24, the WICWS and WCHS continued to partner with the Tobacco Prevention and Control Branch to support continuing education training for health and human service providers and worked with other programs within DPH to ensure that the tobacco cessation and prevention efforts are embedded in their program efforts. In addition, LHD maternity clinics continued to provide prenatal care which is inclusive of provision of tobacco cessation counseling for pregnant women. The staff in these clinics utilize the evidenced-based best practice 5A's method for counseling about smoking cessation. This method includes screening and pregnancy-tailored counseling and referrals for pregnant women who use tobacco, with one of the primary referrals being to QuitlineNC, a free phone service available 24 hours a day, seven days a week to all North Carolinians to help them quit using tobacco. The

www.quitlinenc.com website also has web coaches available and includes resources about helping others quit and secondhand smoke. Pregnant callers to the Quitline continued to be enrolled in an intensive 10-call coaching series provided by a team of dedicated pregnancy quit coaches. Pregnant and breastfeeding women postpartum enrolled in Medicaid who were interested in nicotine replacement therapy continued to be provided standing orders to be able to access 12 additional weeks of appropriate medication after a 2-week starter kit. LHD family planning clinics also utilize the 5A's method in working with women and men of childbearing age, including adolescents.

LHD family planning clinics assess the extent of tobacco use for all patients during the initial visit in the social history, and this assessment is updated at each annual preventative visit. In addition, all adolescents are provided with education and counseling to prevent the initiation of tobacco use. If any patient in the LHD family planning clinic is found to be currently using tobacco products she/he is counseled on stopping tobacco use utilizing the 5A's method approach.

The ICHB Head, the WICWS Nutrition Consultant, and the PHW Program Manager continued to lead and develop an action plan for efforts under the Preconception Health Advisory Council. Plan efforts continued to focus on pregnancy intendedness, mental health, obesity, access to care, and substance use.

Priority Need 2 - Prevent infant/fetal deaths

The NC Title V Program is committed to decreasing infant and fetal deaths in NC. As stated in the PIH Domain Annual Report, the NC Perinatal Health Strategic Plan is one of the main driving forces in this domain, but that work will only be achieved through collective impact with a variety of committed partners. In addition, the NC Title V Program will continue to support the work of the NC Child Fatality Task Force and the NC Office of Child Fatality Prevention. While the Breastfeeding NPM was selected for this priority need along with an ESM to increase calls to the breastfeeding hotline (ESM BF.1), work to decrease infant and fetal deaths is much broader than increasing breastfeeding rates as can be seen by the numerous objectives and strategies in the 2026-2030 State Action Plan.

PIH Objective 1 By 2030, increase the percent of NC infants ever breastfed from 81.5% (2023 Baseline) by 2.5% to 83.5%.

PIH Objective 2 By 2030, increase the percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months from 33.5% (2022-23 Baseline) by 2.5% to 34.3%.

The NC Title V Program has a continued commitment to fostering sustainable, collaborative partnerships that advance breastfeeding outcomes and strengthen maternal and child health systems in NC. The WICWS is in the process of selecting a vendor to implement the statewide breastfeeding hotline. In FY26, the WICWS Nutrition Program Consultant will collaborate with the identified vendor to implement the new statewide breastfeeding hotline and textline which will offer professional lactation support to anyone at any time, day or night. The 24/7 hotline and textline allows flexible and consistent access to comprehensive support regardless of geographic location or financial means at critical times when pediatric and obstetric offices may not be available or have limited expertise to adequately support breastfeeding success. Adequate hotline coverage is imperative to guarantee access to comprehensive lactation support when callers need it most, regardless of the time of day. The hotline will be adequately staffed to provide 24/7/365 coverage that will minimize wait times, missed calls, and callbacks, and offer prompt replies to text messages. The vendor will hire a qualified International Board Certified Lactation Consultant and Certified Lactation Counselor who will offer evidence-based, culturally appropriate, personalized lactation promotion and support to anyone who contacts the hotline via phone or text. Hotline staff will receive adequate training and undergo regular performance evaluations to assess the quality, accuracy, and appropriateness of information provided to callers and texters, and the vendor will consistently track and report demographic data, number of calls and texts received, customer satisfaction, and problem resolution.

Breastfeeding/lactation support is referenced in several areas of the NC PHSP. The NC PHSP provides several strategies and recommendations to improve breastfeeding outcomes for North Carolinians. PHSP strategies include support for lactation and breastfeeding policies in the workplace, lactation consultant training programs and licensure, and breastfeeding education initiatives in community settings. Breastfeeding strategies also focus on support for incarcerated pregnant and breastfeeding women, those experiencing disaster and recovery, as well as trauma-informed breastfeeding support. Based on these strategies, the PHSP offers the following recommendations: 1) establishing a licensure board to license and regulate lactation consultants and lactation counselors, 2) developing educational materials for maternal and pediatric care providers around trauma-informed breastfeeding support, 3) utilizing the Breastfeeding Attrition Prediction Tool-Breastfeeding Control (BAPT-BFC) screening tool, and 4) providing breastfeeding accommodations in the workplace. Discussions will occur during FY26 about the feasibility of establishing an Action Team of the PHSP Collective to elevate health care licensure for lactation consultants and lactation counselors and/or other means to support increased breastfeeding rates in NC.

The NC Title V Program will continue to support the implementation of evidence-based maternity care practices that promote breastfeeding through its ongoing collaboration with the NCMCBFD, administered by DCFW. Title V staff members will contribute to the designation process by serving on the NCMCBFD Review Committee and providing subject matter expertise to support application review and strategic guidance. While the long-term objective of the NCMCBFD is for hospitals to achieve full Baby-Friendly designation through Baby-Friendly USA, the NCMCBFD offers an incremental approach to implementing the Ten Steps to Successful Breastfeeding, with an emphasis on quality improvement and sustained adoption of best practices.

One of the evidence-based strategies that ICO4MCH funded sites can implement is breastfeeding promotion. Five local health departments (representing nine counties- Durham, Guilford, Wake, Mecklenburg and Sandhills Collaboratives) are implementing components of The Ten Steps for Successful Breastfeeding, an evidence-based protocol used by Baby-Friendly, USA. Steps 3 and 10, to “inform all pregnant women about the benefits of and management of breastfeeding” and “foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center” are areas that grantee sites can support as they focus on

broader strategies to increase initiation, duration, and support of breastfeeding. To accomplish this, LHDs train and collaborate with health care providers, community-based and faith-based organizations to increase the knowledge and skills to support breastfeeding women and increase social media messaging. Additionally, grantee sites can choose to implement any of the following: 1) Making It Work: Empowering Employers and Mothers toolkit, 2) Breastfeeding-Friendly City Program, 3) Shared Decision-Making Using Patient Decision Aids, or 4) Establish Public Lactation Rooms.

As part of the current health and safety requirements for childcare facilities, staff must complete the Infant Toddler Safe Sleep/Sudden Infant Death Syndrome (ITS-SIDS) training offered through DCFW and the NC Child Care Health and Safety Resource Center. For FY26, the ITS-SIDS will include an expanded section on infant nutrition and breastfeeding best practices. This incorporation allows the CCHCs to provide training to a larger audience. For example, only twelve Breastfeeding-Friendly Child Care trainings were completed in FY24 by the CCHCs, but they delivered 338 ITS-SIDS trainings during that same period. Information about the childcare designation will be included as part of an effort to increase awareness among the broader audience of childcare facilities. Currently, there are only two certified Breastfeeding-Friendly Child Care train the trainers in the state. The two worked together to provide a train the trainer course in May 2025. This will expand the reach of the CCHCs by increasing the number of trainers. The increased number of trainers working in the field will enhance early educators' understanding and utilization of breastfeeding best practices in their centers.

The MIECHV and non-MIECHV home visiting programs will continue to implement the HFA and NFP models in NC in FY26 and support their ongoing strategies to promote breastfeeding. Most sites have at least one trained lactation consultant or counselor. When mothers are enrolled prenatally, breastfeeding discussions start early and continue throughout the pregnancy and after the infant is born. Breastfeeding educational materials are provided to families. Other strategies include providing resources, incentives, and supplies to encourage breastfeeding, such as developing a breastfeeding success plan, and providing nursing pillows and pumping equipment.

During pregnancy and in the postpartum period, the CHMRP care managers will continue to assess each patient for breastfeeding support needs, while also providing on-going education and information. Education will be provided on the benefits of breastfeeding for pregnant women and their infants, and referrals will be made to breastfeeding classes and other breastfeeding supports. CMHRP care managers will educate patients on the Medicaid Managed Care Pre-Paid Health Plans value-added benefits related to breastfeeding to promote breastfeeding.

The Child Health program will continue to offer and promote an option in the Child Health AA as Attachment C for evidence-based strategies that support working toward or being awarded the NC Breastfeeding Coalition's Mother-Baby Award for outpatient healthcare clinics. The Child Health program and CMARC will collaborate with WIC Lactation Area Training Centers for Health to provide a statewide webinar to promote breastfeeding during FY26. The priority audience for this webinar will be LHD Child Health clinical staff and CMARC care managers. Child Health and CMARC staff members will work with the State Breastfeeding Coordinator to promote weekly resources during the month of August for Breastfeeding Awareness Month. CMARC will continue to promote breastfeeding and provide breastfeeding education from the Patient Education Standard with Matrix and Healthwise located with the Helios platform.
.
The Child Health program and CMARC staff members at the state level will continue to participate in the DPH/DCFW Breastfeeding Coordination Committee, a cross-agency collaboration focused on aligning strategies, sharing resources, and strengthening statewide breastfeeding support systems. Several outcomes and planned activities have emerged from this committee's work that align with Title V priorities and will be supported, as appropriate, in FY26.

One key area of focus will be improving connections between local providers and available breastfeeding resources. The DCFW Breastfeeding Promotion and Support team will offer training to raise awareness of key assets such as the WIC Lactation Area Training Centers for Health, which provide clinical consultation for providers encountering complex breastfeeding situations. These trainings will aim to support integration of high-quality, evidence-based lactation care across maternal and child health programs.

The Early Mental Health Action Team will explore how breastfeeding efforts with WIC can help to build strong, positive and nurturing interactions that support IECMH during breastfeeding. In addition, recognizing the emotional and relational components of breastfeeding as critical to both initiation and duration, the WIC Program's Breastfeeding Peer Counseling Program continues to play a central role in participant-centered breastfeeding support. Child Health and CMARC will be encouraged to collaborate annually with local WIC agencies to review and streamline referral processes to ensure families can easily access necessary breastfeeding support services.

A new area of exploration for FY26, also arising from the committee's coordination efforts, is the development of a basic, entry-level breastfeeding training that is available for all Child Health and CMARC staff members. This training would aim to establish consistent expectations across the workforce for how to recognize, respond to, and support breastfeeding within their roles. The need for this foundational training stems from observed variation in staff confidence and consistency in addressing breastfeeding during encounters with families. Providing a shared baseline of knowledge and support expectations would promote a more unified, supportive approach across programs and improve continuity of care for families.

Finally, the State Breastfeeding Coordinator will continue to contribute to a DCFW guided month-long UNC pediatric resident advocacy rotation, helping future providers integrate breastfeeding promotion into their clinical and community advocacy efforts.

In FY26, the WICWS Nutrition Program Consultant will work with the DPH Communications Lead and the Community and Clinical Connections for Prevention and Health Branch within the Chronic Disease and Injury Prevention Section to develop outreach and digital marketing strategies and materials for the NC Breastfeeding Hotline. The BreastfeedNC website will host a page dedicated to the hotline which will provide information about its purpose and mission, allow access to digital marketing materials, and, in time, allow access to annual reports on caller demographics and usage. As word spreads about the hotline, traffic to its landing page will increase, which will subsequently increase traffic to BreastfeedNC as a whole.

PIH Objective 3 By 2030, decrease the infant mortality rate from 6.9 per 1,000 live births (2023 Baseline) by 13% to 6.

PIH Objective 4 By 2030, decrease the Black/white infant mortality ratio from 3 (2023 Baseline) by 10% to 2.7

The NC PHSP will continue to be implemented under the leadership and guidance of the Perinatal Health Strategic Plan Coordinator and the PHSP Collective. The Policy Workgroup of the Collective collaborates with the NC Child Fatality Task Force's Perinatal Health Committee to support policy efforts. The new Office of Child Fatality Prevention will serve as another collaborative partner to review data and suggest implementation strategies collected both statewide and at the local level.

The Healthy Beginnings program will continue to provide care coordination services to at least 400 minority pregnant and interconception women through monthly contacts primarily conducted through home visits in FY26. Program participants are enrolled during pregnancy or up to 60 days postpartum and receive services until the baby reaches two years of age. Program services include assessments, education and support for receiving continuous prenatal care, breastfeeding initiation and maintenance, infant safe sleep practices, tobacco use cessation, multivitamin consumption, and depression screening. As this program has demonstrated positive outcomes in the past, an external evaluation is planned for FY26 to include lessons learned from implementation.

In FY26, two of NC's four federal Healthy Start Programs housed within Title V - Baby Love Plus and Southeastern NC Healthy Start will continue to provide both direct and enabling services including outreach, recruitment, care coordination/case management, behavioral health screening, referral and counseling, health and parenting education, and linkage to clinical care for enrolled program participants across five counties (Cumberland, Edgecombe, Hoke, Halifax and Pitt). LHD partners will continue to employ Family Care Coordinators, Family Outreach Workers, and Fatherhood Coordinators who are responsible for direct program service implementation. This team will continue to maintain collaborations with WIC lactation consultants and other staff to offer breastfeeding education and support to postpartum participants and fathers/partners engaged in HS services, along with promotion of the breastfeeding hotline. In addition, HS staff will also receive professional development training in breastfeeding so that they continue to be equipped and empowered to aid and educate program participants as they begin and continue to breastfeed for as long as they choose.

The Reducing Infant Mortality in Communities program serves pregnant women and individuals of reproductive age within five different evidence-based strategies that are proven to help reduce infant mortality rates: breastfeeding support services, Centering Pregnancy, doula services, infant safe sleep services, and preconception and interconception health services. The program will be implemented within eight local health departments, serving eleven counties in the state. Each program will implement two evidence-based strategies and work with community partner organizations to provide services to individuals within the counties they serve.

In FY26, NC MIECHV HFA and NFP home visiting programs will work to link enrolled children to medical/health care providers and support parents in utilizing health care appropriately, including ensuring the children attend well-child visits. They will also educate mothers about the importance of prenatal and postnatal health care and encourage and

track mothers' scheduling of and attendance at prenatal and postnatal well check visits. Additionally, home visitors will educate families about the benefits of breastfeeding and encourage and track mothers' breastfeeding.

The Preconception Health and Wellness Program Manager will coordinate and conduct two Women and Tobacco Coalition for Health (WATCH) meetings with an increased emphasis on recruiting statewide and community representatives that serve persons of reproductive age who use tobacco along with individuals with lived experience, Also, at least one tobacco cessation training will be offered to WICWS programs along with CMARC and DCFW home visiting programs about QuitlineNC and resources on e-cigarettes.

In FY26, MIECHV and non-MIECHV home visiting programs will continue to address tobacco use with all participants upon enrollment into the programs. This includes all types of tobacco, such as E-cigarettes and dissolvable tobacco, as some examples. Home visitors will consistently provide tobacco cessation education, resources, and referrals for all participants who indicate any tobacco use upon enrollment. Tobacco cessation referrals will be provided within three months of enrollment, and tobacco use will be assessed routinely for the duration of a caregiver's participation in the home visiting program. Home visitors will work with participants to understand the motivation behind using tobacco and when cravings and urges happen; and work together to establish alternative ways to form new behaviors and routines when participants express a desire to quit. The home visitors will also refer pregnant and postpartum women to YQ2Q for additional support.

In FY 26, CMARC will continue to promote smoking and other tobacco cessation counseling and share QuitlineNC resources. The need for statewide smoking and other tobacco cessation training will be assessed.

NC continues to convene discussions related to updating NC's neonatal levels of care and the development of maternal levels of care. These discussions have included providers and health systems throughout the state along with representatives from the Division of Health Services Regulations, NC Institute of Medicine, and the Perinatal Quality Collaborative of NC. During FY26, these efforts will continue. It is anticipated that legislation will be enacted by the NC General Assembly directing DPH to develop an implementation plan which will likely include a fiscal impact.

The WICWS will continue collaborating with the UNC Collaborative for Maternal and Infant Health (CMIH) to implement a comprehensive, multi-channel approach to promote safe infant sleep practices. In FY26, CMIH will leverage digital platforms, like websites, social media, and print material, to reach a broad audience. Regular updates to the Safe Sleep NC website in both English and Spanish, along with flyers and posters, will ensure consistent, up-to-date messaging. Public service announcements on the IHeartMedia NC podcasts will further amplify the message.

Safe Sleep NC will also create and disseminate toolkits and promotional materials to healthcare providers, LHDs, and first responders. These materials will assist priority populations to integrate safe sleep education into their care models or programmatic activities. On-demand training and technical assistance will be provided to these groups statewide. The NC Safe Sleep Advisory Council meetings serve as an opportunity to share the work of CMIH and other participating organizations and agencies to promote safe sleep practices. CMIH will recruit representative members for the NC Safe Sleep Advisory Council and will convene at least three advisory council meetings.

In conjunction with the NC CCHSRC, the SCCNC will lead the statewide team of 75 CCHCs as they provide ITS-SIDS training for child care providers as mandated by the NC DCDEE health and safety requirements. The training is for all childcare providers working with infants 12 months or younger in licensed facilities within 2 months of hire and every 3 years afterwards. The training provides information for the child care providers about creating and maintaining a safe sleep environment, including avoiding hazards, proper positioning, and safe sleep policies. The course provides information about SIDS and helps the providers identify risk factors and tools to minimize the risk of SIDS in child care settings. The materials required to deliver the training are maintained and updated regularly on the CCHSRC web portal for CCHCs.

In addition to the ITS-SIDS trainings provided by CCHCs to child care providers directly, the CCHSRC and SCCNC will continue to collaborate and provide a bi-annual "Train the Trainer" course for active CCHCs. The course is intended for the health consultants who wish to provide the training directly to child care providers and facilities. The goal of this training is to build a larger network of ITS-SIDS instructors, thereby improving access to essential training for child care providers in NC. This course is delivered asynchronously to expand its availability.

The Preconception Health and Wellness Program Manager will collaborate with the March of Dimes Community Health Champions in FY26. At least 50 individuals will be trained in the Preconception Peer Educator model, and prospective Educators will attend a two-day training that covers topic areas such as preconception health,

reproductive life planning, sexually transmitted infections, healthy relationships and related themes that connect to persons of childbearing age. The Preconception Health and Wellness Program Manager will work with the March of Dimes team to identify and link the Community Health Champions to local organizations who work with the priority population and co-host preconception health and awareness events and share preconception health information and resources in Perinatal Health Regions 3, 5 and 6.

PIH Objective 5 Increase the number of women receiving prenatal care in the first trimester as reported on the birth certificate from 72% (2023 Baseline) by 4% to 75%.

As described earlier in regard to improving the data quality around documenting postpartum visits, the MHI program will also focus on enhancing and improving data reporting and quality for those individuals who begin prenatal care at a LHD by providing training and TA to LHD maternal health providers and billing/support staff on appropriate billing and coding for entry into prenatal care. Additionally, a custom data form will be created in each LHD's electronic health record to collect maternal health service data. This data will be analyzed by the MHI Epidemiologist, and county-specific data will be shared with each LHD. The MHI Epidemiologist will provide technical assistance to the LHDs to improve data quality.

In addition, the Maternal Health (MH) Program Manager will facilitate informational webinars and/or workshops to increase awareness of group prenatal care as an evidence-based model for improving maternal and infant outcomes. The MH Program Manager will host at least two informational sessions that will be open to all LHDs. The MH Program Manager will facilitate the sharing of success stories from LHDs that have effectively used funding to support group prenatal care, showcasing improvements in maternal and infant health outcomes, which can serve as motivation for other LHDs to adopt similar models. The MH Program Manager will track the number of LHDs that apply for Supporting Women's Health Services and Reducing Infant Mortality in Communities funding to support or expand an existing program or to implement a new program, and the MHI Epidemiologist will review county data to track which LHDs are billing the group prenatal care incentive code. In collaboration with the MHI Epidemiologist, the MH Program Manager will share county-specific data with each LHD offering group prenatal care.

WICWS will continue to participate in NC Medicaid's Maternal Health Internal Alignment Meetings and the Maternal Health Learning Collaborative. This will strengthen ongoing collaborative efforts while also ensuring that maternal health efforts are aligned and prioritized within DHHS and the broader state. These meetings will continue to be utilized as a venue for information sharing and discussions of potential new efforts.

As part of the PHSP Collective, the WICWS, in collaboration with the NC Institute of Medicine, has convened an Action Team focused on maternity care workforce. The Action Team is charged with developing recommendations to address maternity deserts in the state and consider the needs of the workforce. A full report will be developed to be shared broadly in FY26, and the MH Branch Head will also share the results of the Action Team with the PHSP Maternal Health Work Group. The Maternal Health Work Group will determine strategies in which to advance the work of the Maternity Care Workforce Action Team recommendations.

PIH Objective 6 Each year, 99% of newborn infants in NC will be screened for metabolic and other hereditary and congenital disorders and receive necessary follow-up

In FY26, the DCFW NBS Follow-Up Team will continue to report NBSs with abnormal results in a timely manner, monitor follow-up testing, document final outcomes, provide technical assistance to LHDs and private providers about individual NBS results, and provide information for patients and their families. The DCFW NBS Follow-up Team will successfully report abnormal results to the primary provider on the day of their release in 99% of cases, always striving for 100%. The DCFW NBS Follow-Up Team will work to develop follow-up protocols, educational and outreach materials relevant to new conditions being added to the NC Newborn Screening Panel in FY26 (Mucopolysaccharidosis Type II [MPS II], Guanidinoacetate N-Methyltransferase [GAMT]), and Krabbe Disease). The DCFW NBS Follow-up team will investigate the possibility of developing a long-term follow-up component.

The NCSLPH NC Newborn Screening Program was awarded HRSA funding opportunity No. HRSA-23-065, State Newborn Screening System Priorities Program (NBS Propel) on June 9, 2023. The goals to be accomplished for FY26 include the following: 1) improving IT data systems and data collection through improvements to the existing laboratory information management system and by creating an infrastructure for the collection and reporting of timeliness indictors and long-term follow-up data; 2) enhancing laboratory and follow-up procedures by refining a continuity of operations plan, reviewing and updating screening algorithms and cut-offs, conducting quality improvement projects, and initiating the assay validation work to support the implementation of two new disorders (MPS II and GAMT) to the existing NC NBS panel; and 3) expanding follow-up and educational activities with providers, including clinicians and birthing facilities, and families to improve health for all.

The team at UNC will continue to provide clinical genetic services (including diagnosis and management), genetic counseling services, and genetic testing for approximately 2500 unduplicated patients in FY26. Metabolic services will be provided to newborns with a potential diagnosis for X-ALD, MPS-I and inborn errors of metabolism identified through MS/MS through DHHS. These services are provided in a time sensitive manner given the critical nature of these disorders. Robust tracking of abnormal NBS is performed with secure record documentation to facilitate communication regarding follow up recommendations for confirmation testing and setting up a visit for evaluation with a metabolic specialist, diagnostic outcomes and transition to clinical care for diagnosed patients. Timely follow up of all abnormal NBS results will involve more than 99% of all abnormal results communicated to the outside medical care team on the day the abnormal result is released from the SLPH. UNC will continue to provide expertise and consultation to the SLPH on follow-up care for infants identified through NBS and consultation to referring healthcare providers regarding patient diagnosis, care, and management of patients with confirmed diagnoses.

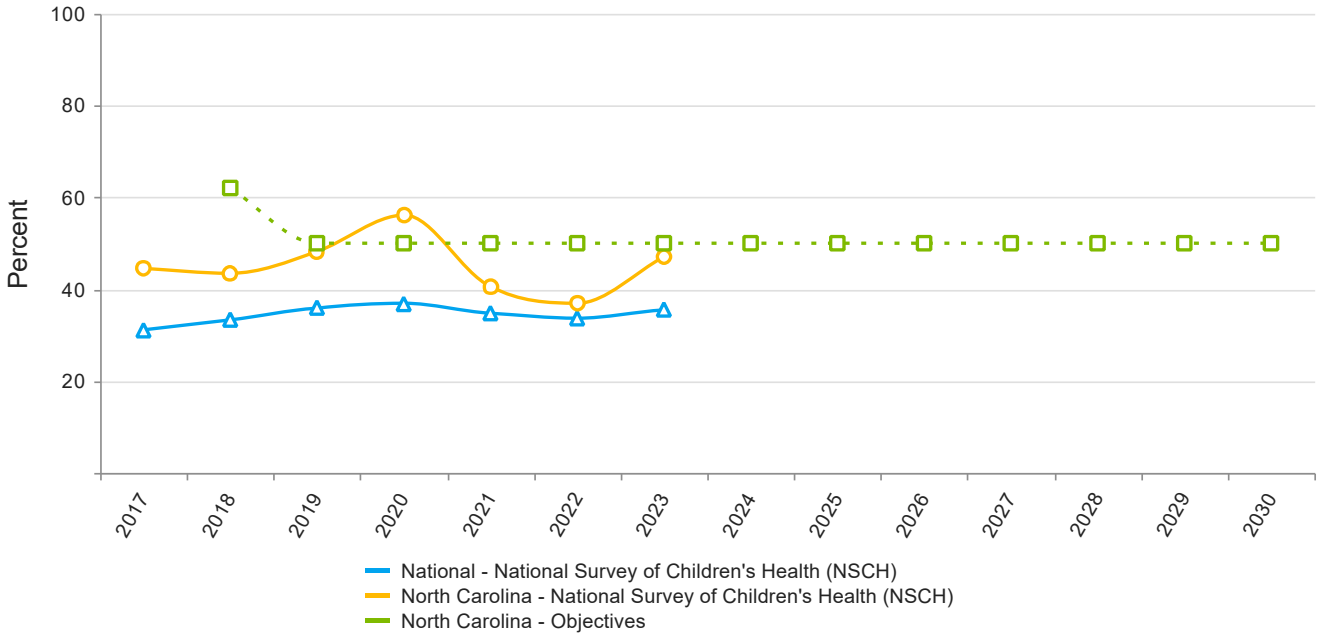
The Sickle Cell Program Supervisor and/or Data Manager will reach out directly to primary care providers of newborns with an abnormal hemoglobin result on newborn screening to ensure proper follow up, inclusive of referral to specialty care (hematology) and confirmatory testing. Sickle Cell Educator Counselors verify that the above steps are taken, then contact the family to share services offered by the NCSCSP, including providing genetic counseling, providing sickle cell disease education, answering questions, and, with verbal consent, conducting an initial assessment of needs.

The EHDI program will continue its activities in FY26. All hospitals/birthing facilities in NC will continue to provide newborn hearing screening and submit screening results through WCSWeb Hearing Link. The EHDI Regional Consultants will continue to provide ongoing tracking, technical assistance, consultation, education, and support to birthing facilities, physicians, audiologists, interventionists, and families. The EHDI program will improve service delivery by reaching out to more families of DHH children across the state to improve early identification and quality intervention. The EHDI program will distribute an updated on-line Residency Training Module to educate medical residents on EHDI 1-3-6 goals. This module will be used to create a 15-minute video training module for primary care providers and other service providers. A newly developed 15-min video training focused on risk factors for late onset and progressive hearing loss will be shared with primary care providers. The successful DHH Heroes program will be expanded, through collaboration with DSDHH, which will allow attendance at more events. The EHDI program will continue to support and sponsor family events around the state in collaboration with The CARE Project and the existing parent-to-parent support groups as funding allows. During FY25, the EHDI program conducted a needs assessment regarding our state's infrastructure to coordinate services across the statewide EHDI system for DHH children to improve language acquisition outcomes. The needs assessment was conducted in partnership with the NC EHDI Advisory Committee members. A workplan including strategies to meet the prioritized needs will be completed in early FY26. The new activities/strategies will begin in FY26 and continue until the end of the grant period (April 2029).

Child Health

National Performance Measures

NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	50	50	50	50	50
Annual Indicator	48.1	39.5	39.5	37.1	47.0
Numerator	119,658	94,883	94,883	92,922	120,834
Denominator	249,001	240,161	240,161	250,771	257,130
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2020_2021	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	50.0	50.0	50.0	50.0	50.0

Evidence-Based or –Informed Strategy Measures

ESM DS.1 - Developmental Screening in Local Health Department During Well-Child Visits

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	75.0	75.0	75.0	75.0

ESM DS.2 - Medicaid-Enrolled Children Receiving Developmental Screening

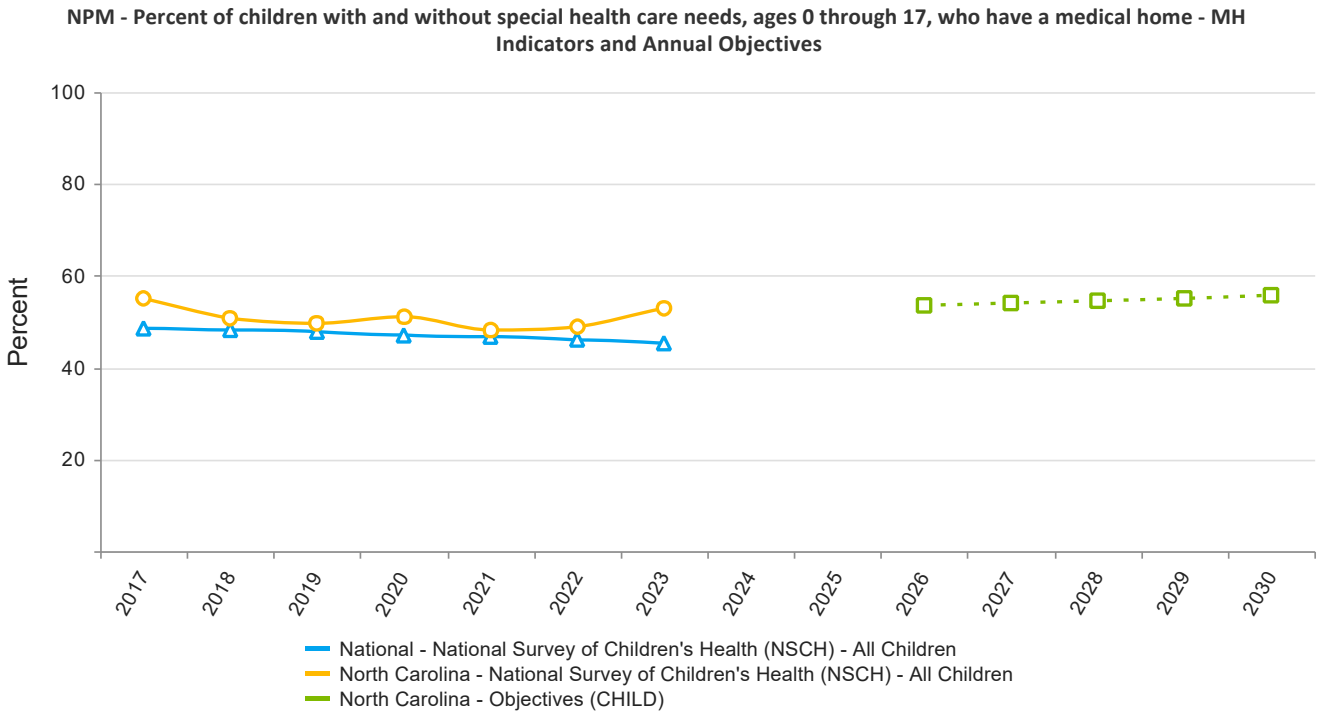
Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	74.7
Numerator	
Denominator	
Data Source	Medicaid Claims Data
Data Source Year	2023
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	76.0	77.0	78.0	79.0	80.0

ESM DS.3 - Percent of LHDs whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children during state fiscal year

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		80	85	90	95
Annual Indicator	75	80.9	75.4	80	80.3
Numerator	51	55	49	52	53
Denominator	68	68	65	65	66
Data Source	DCFW/WCHS staff internal log	DCFW/WCHS staff internal log	DCFW/WCHS staff internal log	DCFW/WCHS staff internal log	DCFW/WCHS staff internal log
Data Source Year	FY19-20	FY20-21	FY21-22	FY22-23	FY23-24
Provisional or Final ?	Final	Final	Final	Final	Final



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	48.9	53.0
Numerator	1,120,042	1,215,395
Denominator	2,292,452	2,291,102
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	53.5	54.0	54.5	55.0	55.7

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Parents who Report That They Understand the Available Tools and Resources Necessary to Access and Maintain Having a Health Care Provider/Team That Uses a Medical Home Approach to Care

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	75.0	75.0	75.0	75.0

ESM MH.2 - Percent of children with special health care needs who received family-centered care

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		88.7	85	87	90
Annual Indicator		80.8	80.3	84.3	83.4
Numerator					
Denominator					
Data Source		2019-20 NSCH	2020-21 NSCH	2021-22 NSCH	2022-23 NSCH
Data Source Year		2019-20	2020-21	2021-22	2022-23
Provisional or Final ?		Final	Final	Final	Final

ESM MH.3 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	12	18	15
Annual Indicator	8	9	17	13	14
Numerator					
Denominator					
Data Source	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

State Action Plan Table

State Action Plan Table (North Carolina) - Child Health - Entry 1
Priority Need
Promote safe and nurturing relationships for children and adolescents
NPM
NPM - Developmental Screening
Five-Year Objectives
CH PN3 Objective 1 By 2030, increase the percentage of children that are screened for developmental concerns using a parent completed tool by 5 percentage points from 47% (2022-23 Baseline NSCH) to 52%.
CH PN3 Objective 2 By 2030, increase the percentage of children, ages 6 months-5 years, whose parents report that they are flourishing by 5% from 80.5% (2022-23 Baseline) to 84.5%.
CH PN3 Objective 3 By 2030, increase the percentage of children, ages 6-11 years, whose parents report that they are flourishing by 5% from 61.1% (2022-23 Baseline) to 64.2%.

Strategies
CH PN3 1.1 WCHS staff members will provide statewide trainings on developmental, psychosocial and behavioral health which include assessing relational health and promoting Safe Stable Nurturing Relationships (SSNRs) to LHD child health clinical staff, child care providers (through Child Care Health Consultants), CMARC providers, home visiting providers, and private providers.
CH PN3 1.2 Enhance early educators' knowledge related to children's development through training and technical assistance provided by Child Care Health Consultants.
CH PN3 1.3 Home visiting programs will complete developmental screenings for children at a minimum at ages 9, 18, 24, and 30 months and provide appropriate referrals.
CH PN3 1.4 Increase awareness and promotion of evidence-based trauma informed therapeutic services (e.g., Child First) for children age birth to five by Title V programs.
CH PN3 2&3.1 Continue to support the Learn the Signs Act Early and early literacy programs and resources for child care facilities, CMARC and MIECHV home visitors, LHD child health clinical staff, and private providers.
CH PN3 2&3.2 Continue to participate in the NC Home Visiting Consortium to ensure all families have access to a range of parenting education supports in early childhood to strengthen parent-child relationships and improve family and child well-being.
CH PN3 2&3.3 Support and participate in several initiatives to align efforts, including, but not limited to, the following: EarlyWell; NC Advancing Resources for Children (ARCh) Project: Connecting NC's Systems to Strengthen Infant and Early Childhood Mental Health Outcomes (SAMSHA Grant); and NC Psychiatry Access Line (NC-PAL).
CH PN3 2&3.4 Continue to collaborate with LHDs and various external partners (including families) to improve services and systems that support safe, stable and nurturing environments for children including but not limited to NC Infant Mental Health Association, NC Partnership for Children, local Smart Start agencies, Child Care Services Association, Exceptional Children's Assistance Center; NC Partnership for Children; Positive Childhood Alliance of NC; NC Child; NC Pediatric Society; NC Academy of Family Physicians; NC Division of Mental Health, Developmental Disabilities, and Substance Use Services; NC Division of Social Services; NC Division of Child Development and Early Education; NC Department of Public Instruction; NC State Office of Child Fatality Prevention, Child Fatality Task Force; NC Early Childhood Foundation, Prevent Blindness NC; Commission on CSHCN; NC Health and Safety Resource Center, and Early Mental Health Policy Action Coalition.
CH PN3 2&3.5 Home visiting programs will continue to assess parent-child interactions using valid tools such as DANCE (Dyadic Assessment of Naturalistic Caregiver-Child Experiences) and CHEERS (Cues, Holding, Expression, Empathy, Rhythm, and Reciprocity).
CH PN3 2&3.6 Increase awareness of and referrals from/to evidence based infant and early childhood mental health-focused home visiting and other therapeutic services,(e.g., Child First) which provide community-based behavioral health care and family support to children ages birth to five and their families.
CH PN3 2&3.7 Triple P LIAs will continue to support practitioners to deliver Triple P to parents and caregivers of children age 0-12 years about promoting their child's development.

ESMs	Status
ESM DS.1 - Developmental Screening in Local Health Department During Well-Child Visits	Active
ESM DS.2 - Medicaid-Enrolled Children Receiving Developmental Screening	Active
ESM DS.3 - Percent of LHDs whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children during state fiscal year	Inactive

NOMs

School Readiness

Children's Health Status

State Action Plan Table (North Carolina) - Child Health - Entry 2

Priority Need

Improve access to quality whole child and adolescent health care

NPM

NPM - Medical Home

Five-Year Objectives

CH PN4 Objective 1 By 2030, increase the percent of children without special health care needs having a medical home by 3% from 54.4% (NSCH 2022-23 baseline) to 56%.

Strategies

CH PN4 1.1 Provide education, training, and support to providers on delivering a medical home approach to care by collaborating with the NC Chapter of American Academy of Pediatrics to promote patient-centered medical home and educate and train providers and by home visitors providing outreach to primary care providers.

CH PN4 1.2 Provide education, training, and support to families on medical home approach to care including: 1) Varied communication strategies (presentations, exhibits, website updates, and targeted email campaigns to parents/caregivers and partner agencies); and 2) Training to equip parents/caregivers with the knowledge and skills to navigate the medical home system effectively.

CH PN4 1.3 Regional School Health Nurse Consultants will promote a whole child health approach when identifying speakers and topics to participate in the annual school nurse conference. Through these efforts, school nurses will be equipped with knowledge to provide quality school health services based on best nursing practices.

CH PN4 1.4 To promote quality whole child care, DCFW home visiting program staff will educate families about the importance of a medical home for their child and inform them of the practices in their community.

CH PN4 1.5 School Health Centers will enhance access to coordinated, preventative healthcare by creating a network of community providers and comprehensive programmatic services that will contribute to the establishment and promotion of a medical home, ensuring students receive consistent, holistic care that supports their overall well-being and academic success.

CH PN4 1.6 Provide statewide monthly Child Health provider webinars, Child Health Training Program, other Nursing Continuing Professional Development contact hours, TA, and monitoring.

CH PN4 1.7 Increase the number of well child visits under 11 years of age provided by Child Health Enhanced Role Registered Nurses (CH ERRNs).

ESMs	Status
ESM MH.1 - Parents who Report That They Understand the Available Tools and Resources Necessary to Access and Maintain Having a Health Care Provider/Team That Uses a Medical Home Approach to Care	Active
ESM MH.2 - Percent of children with special health care needs who received family-centered care	Inactive
ESM MH.3 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion	Inactive

NOMs

Children's Health Status
CSHCN Systems of Care
Flourishing - Young Child
Flourishing - Child Adolescent - CSHCN
Flourishing - Child Adolescent - All

2021-2025: State Performance Measures

2021-2025: SPM 3 - Percent of children with two or more Adverse Childhood Experiences (ACEs)

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		15	15	15	14
Annual Indicator		16.6	17.8	18.5	17.3
Numerator					
Denominator					
Data Source		2019-20 NSCH	2020-21 NSCH	2021-22 NSCH	2022-23 NSCH
Data Source Year		2019-20	2020-21	2021-22	2022-23
Provisional or Final ?		Final	Final	Final	Final

2021-2025: SPM 4 - Percent of NC children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		90	90	90	90
Annual Indicator		75.9	76.5	72.3	69.7
Numerator					
Denominator					
Data Source		2018-20 National Immunization Survey	2019-2021 National Immunization Survey	2020-2022 National Immunization Survey	2021-23 National Immunization Survey
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Priority Need 4 – Promote Safe, Stable, and Nurturing Relationships

An early childhood system of care ensures comprehensive, coordinated, individualized, family-driven services and supports for young children and families. The WCHS promotes the integration and coordination of discrete child and parent/caregiver services across all service sectors into a comprehensive system that "connects the dots" within the service community by participating in or facilitating many collaborative activities at the state, regional, and local levels. Through multiple collaborative opportunities, the WCHS convenes internal and external partners in planning and implementation of programs, including those supported by Title V funds. The Title V Office supports a system of care that uses a public health model to provide a continuum of care, promoting positive well-being, preventing problems in high-risk populations, and intervening/treating in a comprehensive manner when problems do arise. It is the collaborative relationships among the provider agencies, parents/caregivers, human services agencies, schools, child care, and other partners, along with a common set of values and goals that enables providers to see the broader needs of families, set aside turf issues, and utilize existing or build community services to benefit the health and well-being of infants, children, adolescents, and their families.

North Carolina is one of twelve states receiving funding from the Centers for Disease Control and Prevention (CDC) for Essentials for Childhood: Preventing Adverse Childhood Experiences through Data to Action. The current North Carolina Essentials for Childhood (NC EfC) Initiative is funded for five years (9/1/23 – 8/31/28). This is the third iteration of CDC's Essentials for Childhood and is currently emphasizing preventing adverse childhood experiences (ACEs) and promoting positive childhood experiences (PCEs) through upstream strategies; documenting and strengthening state surveillance of ACEs, PCEs, and social drivers of health; and proactively monitoring and using data to inform action such as modifying or developing prevention strategies, outreach to current and new partners, and disseminating data to communities and state-level stakeholders.

NC has been a recipient since the beginning of the CDC Essentials funding in 2013. In FY24, the administrative home for NC EfC in the Division of Public Health moved from the Title V Office to the Injury and Violence Prevention Branch (IVPB), part of the Chronic Disease and Injury Section. IVPB is the recipient of several CDC Cooperative Agreements focused on primary prevention, including Overdose Data to Action, the Comprehensive Suicide Prevention Program, the Rape Prevention and Education Program, and the Core State Injury Prevention Program, which also includes a focus on preventing ACEs. Moving the EfC program to IVPB increases effectiveness by consolidating similar programs together to enhance cross-topic collaboration and increases efficiency of administrative oversight and the support of the IVPS's epidemiology team.

For the current cooperative agreement, NC EfC is continuing to focus on policies that promote financial stability and economic mobility for families, including promoting the establishment of family friendly workplaces, increasing eligible tax filer uptake of the Federal Earned Income Tax Credit (EITC), and educating about the benefits to children and families of a refundable state EITC and a state Child Tax Credit. EfC accomplishments in FY24 included:

- Continued a partnership with the NC Institute of Medicine (NC IOM) to serve as the backbone organization for EfC and to administer subcontracts with four partners who have been supporting EfC strategies for many years: NC Child, Positive Childhood Alliance NC (PCANC, formerly named Prevent Child Abuse NC), MomsRising, and the NC Early Childhood Foundation (NCECF).
- Continued a partnership from previous EfC funding with the University of North Carolina Gillings School of Global Public Health and contracted the time of Dr. Meghan Shanahan to lead the work on establishing a surveillance system for ACEs, PCEs, community health factors, and identifying strategies for using the surveillance data to inform action. Dr. Shanahan also serves as the project evaluator.
- Provided supporting funds for the inaugural 2024 NC State of the Child Summit that was co-led by the NC IOM and NC Child and held on April 30, 2024. The Summit sold out tickets in one day and will be held annually moving forward with the next one scheduled for April 15, 2025.
- Continued to work with the four subcontracted partners to promote family friendly workplace policies, the development of a toolkit with educational information about the benefits of a refundable state EITC, and the refinement of a social norms campaign to prevent ACEs and promote PCEs.
- Partnered with the NCIOM to develop the Essentials State Action Plan to Prevent ACEs and Promote PCEs by revisiting and updating key priority recommendations from the 2015 North Carolina Institute of Medicine's

Task Force on Essential for Childhood and developing new recommendations to address current contexts, needs, and strengths. Work started during this reporting period but will conclude with the publication of the new state action plan in February 2025.

- Began planning alongside Dr. Shanahan and the NCIOM for a series of meetings with a data working group to define and identify the surveillance system for ACEs, PCEs, and community health factors as well as thresholds to guide data to action. The meetings will be held in the fall of 2024.

Infant Early Childhood Mental Health

DCFW is charged with working to meet the health, social and emotional needs of children, youth, and families in NC. Behavioral health is one of the Division's priority areas. DCFW programs and other efforts fall along a promotion, prevention, and treatment continuum to provide parents and caregivers and their young children with different levels of supports and resources to promote social and emotional development and prevent, mitigate, and improve timely access to evidence-based screening, assessment, management, and treatment for mental health concerns.

Infant early childhood mental health (IECMH) has been infused into NC Psychiatry Access Line (NC-PAL) efforts. NC-PAL completed a pilot with three CDSAs to implement IECMH educational and case-based curriculum about identification and support of social emotional development of children and families. The DCFW SMD assisted NC PAL's early childhood lead physician in the planning and debriefing of the CDSA pilot efforts which were used to plan for future CDSA pilots.

DCFW has many additional programs and efforts that are addressing IECMH. However, many programs and staff are not aware of all IECMH efforts across units and sections, and there is not always integration or collaboration around IECMH work. The DCFW Senior Medical Director (SMD) served as the leader of an IECMH planning group of about ten staff members from the WCHS which included the Title V CYSHCN Director and several CDSA directors in the Early Intervention Section in DCFW. The IECMH planning group reviewed a DCFW landscape survey and decided that reconvening the Early Childhood Matrix Team (ECMT) around IECMH was not the best way to approach this work. The IECMH planning group was able to work with UNC's Frank Porter Graham Child Development Institute (FPG) who helped guide this group through the strategic planning process from January 2024 through June 2024. The IECMH planning group invited two staff from the Division of Child Development and Early Education (DCDEE) and a WCHS Family Partner to participate in this more formal and newer phase of strategic planning with FPG. The Child Behavioral Health Unit manager and DCFW SMD met with FPG to determine the following scope of:

1. Determine an agreed upon shared definition of IECMH;
2. Determine priority area(s) internal and external to DCFW related to IECMH;
3. Create and use a survey, in-person conversations, and other processes to develop an inventory of internal and external practices, efforts, and partnerships that also include challenges and barriers;
4. Have DCFW programs and staff decide on a priority area *internal and external to DCFW (small piece)* and try to address several elements of that IECMH priority: policy, workforce, practice (i.e., screening, management, and treatment), interface with families, and funding to work on that area of IECMH;
5. Determine data to collect or use to measure how improvement on the internal and external priority for DCFW is achieved; and
6. Create an action plan to address the shared priority areas for DCFW in IECMH.

The DCFW Early Childhood Behavioral Health Programs Specialist (ECBHPS) joined the IECMH Planning Group in January 2024. The ECBHPS supported the group's identification of the three policy priorities which will be addressed through an action plan to be developed by the group and to guide the next phase of the work. The ECBHPS will lead efforts for the group's next phase through development and implementation of the action plan.

One of the key external IECMH efforts is the EarlyWell initiative to promote public policies that enhance the social-emotional health of children aged 0 to 8 and families in NC. EarlyWell continued to be led by NC Child, in collaboration with early childhood leaders including the NCECF, to promote and enact recommendations from the Pathways to Grade-Level Reading Action Framework, and to build a robust, evidence-based, and accessible early childhood social-emotional health system in NC. Title V staff members continued to participate on the EarlyWell Initiative advisory committee, joined by the DCFW ECBHPS. An important report from June 2022, *From Equity to*

Issue Campaigns: The Next Stop on the Road Map to Childhood Mental Health in North Carolina, was designed to organize and categorize the problems and solutions identified by families, Title V staff and others on the advisory committee, and other partners. This report continued to inform IECMH efforts during FY24. EarlyWell initiated work on three policy priorities which will carry into FY25: specific supports for families navigating a disability; a program for pediatricians to help foster language rich interactions between parents and children; and policy change to reduce barriers for families to get licensed as Kinship Care Providers.

In addition to these efforts, representatives from the WCHS participated in an external IECMH Consultation cross-sector workgroup of multiple partners focusing on expansion of IECMH consultation in the state. The group is facilitated by Dr. Marian Earls and staff from the NC Infant Mental Health Association. In FY24, the external IECMH Workgroup distributed a survey for advocates and for those professionals who provide IECMH consultation, in order to determine the extent of needs and activities in NC related to IECMH consultation. Survey results identified consultation activities and access points and can be used to inform future expansion efforts. The external Workgroup continued efforts to align IECMH efforts across the state, such as providing input into the NC Partnership for Children's Smart Solutions Catalogue, which details IECMH as "non-clinical TA-consultation and coaching service designed for Early Childhood Education professionals."

The State Child Care Nurse Consultant (SCCNC) and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Professional Development Coordinator participated in the Yay Babies! work group, which collaborates with DCDEE to engage partners and promote access to early childhood services for young children experiencing homelessness. In FY24, Yay Babies! and DCDEE published the comprehensive *Action Plan for an Early Childhood Homelessness Support System: Unleashing the Potential of our most Vulnerable Children to Raise North Carolina*. In FY24, Yay Babies! presented at a MIECHV Regional Meeting to train home visitors to support families experiencing homelessness. Resources on homelessness services by county were provided as well as links to access prerecorded trainings for home visitors and parents featuring a parent consultant sharing their lived experience with homelessness.

Developmental Screening NPM – Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed tool in the past year

The NC Title V Office chose to continue to use the Developmental Screening NPM and the corresponding ESM DS.1 (Percent of LHDs whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children during state fiscal year) to monitor its success at increasing appropriate, ongoing, and timely screenings in all of these areas for children. Working within this comprehensive system of care, the NC Title V Program is focused on collaborative strategies to increase the percent of children receiving a developmental screening, increasing discussions with parents and caregivers about their child's developmental progress, sharing anticipatory guidance (i.e., Bright Futures, Learn the Signs. Act Early [LTSAE] materials, the importance of books and reading using Reach Out and Read) and ensuring that families can access timely and appropriate care for further assessment. Per the 2022-23 NSCH, 47% of children in NC between 9-35 months had received appropriate developmental screening which is higher than the national average of 35.6%. This is an increase from the 2021-22 NSCH state percentage of 37.1%, as confidence intervals for the two time periods overlap, it's probably not a significant increase. (Developmental Screening NPM).

The WCHS helps support the provision of preventive health services to children from birth to 21 years of age primarily through LHD clinics and outreach to primary care providers through the NC Pediatric Society (state chapter of the AAP) which incorporate developmental surveillance and/or multiple types of screenings (i.e., behavioral health, psychosocial) including developmental screenings at each well visit. LHD providers include child health providers in the clinic providing direct clinical care as well as Care Management for At-Risk Children (CMARC) care managers providing service to members in their homes or other locations. Developmental screenings continued to be required at 6, 12, and 18 or 24 months and then at 3, 4 and 5 years of age by all Medicaid providers including those in LHDs during well child visits. Developmental screenings are also required at other visits when there are concerns that come up related to developmental surveillance. The NC Medicaid schedule of recommended visits and screenings are based on 2021 Bright Futures guidelines which are described in detail in the 2021 NC Medicaid Health Check Program Guide (HCPG). In FY24, 80% of the 66 LHDs providing clinical services for children had staff members

who had been trained in appropriate use of screening tools (ESM DS.1).

Efforts to Increase Screening for Developmental, Psychosocial, and Behavioral Health Concerns

The WCHS State Child Health Nurse Consultant (SCHNC), Regional Child Health Nurse Consultants (RCHNCs), and the DCFW SMD who also serves as the Pediatric Medical Consultant for Title V, conducted monthly 30-minute webinar trainings entitled *Strategies and Recommendations: Helping with Delivery of Child Health Services* for child health clinical staff and CMARC care managers working in LHDs. These webinars included information to connect staff with resources such as NC-PAL, Statewide Peer Warmline, CYSHCN Hotline, and NC Child Behavioral Health Dashboard. The Child Health webinars also provided child health program clinical staff and CMARC care managers with resource information for: breastfeeding, WIC updates, infant formula shortage, NCDHHS State Action Plan for Nutrition Security, nutrition programs, SUN Bucks (provides grocery-buying benefits to qualifying families with school-aged children during the summer months when schools are on summer break), safe sleep, respiratory viruses (COVID-19, flu, RSV), immunization updates, pertussis, monkeypox, measles, congenital syphilis, health literacy, human trafficking, national birth defects awareness, 4th Trimester Project, fetal alcohol spectrum disorder, autism awareness, general developmental screening – Parents Evaluation of Developmental Status – Revised (PEDS-R), Parents Evaluation of Developmental Status – Developmental Milestones (PEDS-DM), and Survey of Well-being of Young Children [SWYC]), tobacco use, Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) screening, dental health, NC Lead Poisoning and Prevention program, NC Sickle Cell program, asthma and asthma action plans, community health factors, foster care, school health assessments, preparticipation physical exams, adolescent health, suicide prevention, preparedness, Medicaid Expansion, and Tailored Plans. The DCFW SMD also provided one presentation to the NC Pediatric Society members, one to pediatric providers in the southeastern AHEC region, and two updates to pediatric providers in the western area of the state served by one of the hospital systems . Presentations by the DCFW SMD emphasized the need to continue to provide whole child health care which includes developmental, social-emotional, and mental health screenings. The presentations all included information about infant formula shortages, breastfeeding, respiratory virus updates (COVID-19, RSV and flu) and especially about changes in vaccine recommendations, referrals to EI services, and the processes available to physicians for exchanging information such as developmental screening results with EI service providers.

Monthly *Clinic Connections* for LHD Child Health Providers & Clinical staff started in May 2024 by the DCFW SMD and the SCHNC. The purpose of *Clinic Connections* is for child health clinical staff to bring issues, hot topics, and questions to the group and learn from other providers and clinical staff working in LHDs.

Child Health Program monitoring visits were held either virtually using Microsoft Teams (MS Teams) or onsite at the LHD during FY24. Due to the demands of COVID-19 on LHD staff, the Child Health Program Monitoring – Clinical Chart Review process was adjusted to provide additional TA to LHDs prior to being required to develop a corrective action plan (CAP) if findings were identified.

The SCHNC and RCHNCs continued to provide TA to LHD providers seeing clients seen in LHDs on the Medicaid requirement to provide, document, and discuss the results of developmental screenings with families (regardless of the score), promote anticipatory guidance, and review the charts for other items. Nurse consultants, along with the DCFW SMD, continued to update LHD staff members on minor changes to the current NC Medicaid requirements and reinforced the need for ongoing developmental screenings using validated tools. The NC Infant-Toddler Program continued with training to increase use of screening using the Ages and Stages Questionnaires®: Social-Emotional statewide.

A valuable webinar was created in 2020 by two developmental and behavioral pediatricians who were authors of the 2020 AAP policy statement titled *Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening*. Staff continued to promote this archived webinar with Child Health Training Program (CHTP) students during FY24 to increase knowledge, skills and abilities related to developmental surveillance and screening.

The following additional statewide webinars were provided to child health program clinical staff and CMARC staff:

- July 2023 – Clinical Asthma Education July 2023 – Environmental Asthma Triggers: A Training for Public Health Professionals

- October 2023 – Calling All Smile Crusaders

Consultation and TA were provided to several new LHD providers and current providers who presented questions regarding well child visit components. Guidance was provided related to developmental, behavioral, and maternal depression screening as well. The DCFW SMD continued to use a self-assessment tool which was shared with new providers as well as providers serving as preceptors for the CHTP so that they could rate their knowledge, skills and abilities related to all of the well child preventive visit components including developmental, behavioral, and maternal depression screening. This self-assessment tool has continued to assist the DCFW SMD with providing specific TA to meet the needs of the individual providers related to evidence-based strategies to support developmental screening, anticipatory guidance, management, and referral.

Healthy Families America (HFA) and Nurse-Family Partnership (NFP) home visiting models complete developmental screenings with enrolled families between ages 4 months to 30 months. The Health Resources and Services Administration (HRSA) funded MIECHV program measures the number of children aged 9 months to 30 months with at least one completed screening within the AAP-defined age groups conducted by their home visitor during each reporting year. All sites use the Ages and Stages Questionnaires® to complete this performance measure. In FY24, the developmental screening completion rate for all participants at MIECHV sites was 90.6%. Separate from MIECHV, the HFA and NFP home visiting models also complete the Ages and Stages Social-Emotional Questionnaires at 6, 12, 18, and 24 months of age. HFA programs conduct developmental screens during home visits at a frequency greater than required by HRSA.

During FY24, the PNC continued to integrate and enhance breastfeeding education, family engagement and Life Course Nutrition into the Child Health program through trainings conducted as part of the CHTP and through other Child Health opportunities, including work with programs that specifically target CYSHCN. The PNC also coordinated with the PMC/SMD and provided nutrition and weight inclusive TA for a presentation she delivered for CHTP students in January 2024 on the new AAP Clinical Guidelines for Childhood Obesity and Overweight. TA resulted in less emphasis on weight and more focus on growth and included additional information on weight stigma and use of clinical practices and environmental changes that support children living in bigger bodies.

Efforts to Improve Preventive, Screening, Assessment, Diagnostic, and Treatment Health and Well-Being Services

The 2023-2024 Child Health Training Program (CHTP) was provided in a combination of onsite and virtual training sessions using MS Teams technology. Six training opportunities were presented during the CHTP which included information on developmental, psychosocial, and behavioral screening. Ten Public Health Nurses successfully completed the CHTP and were rostered as Child Health Enhanced Role Registered Nurses (CH ERRNs). DPH and DCFW have a memorandum of understanding with DHB (Title V agency agreement) to train and roster CH ERRNs. Only rostered CH ERRNs may bill the Division of Health Benefits/NC Medicaid for services or use Title V funds to support preventative services. CH ERRNs practice within the North Carolina Nurse Practice Act. Training and rostering allow the CH ERRN to bill for Medicaid services, but does not extend the RN scope of practice. The NCDHHS Office of Chief Public Health Nurse (OCPHN) and the Child Health Program work collaboratively to support the CH ERRN. OCPHN consultants provide nursing scope of practice and billing and coding guidance. Child Health Nurse Consultants provide Health Check Program Guide and programmatic guidance and training as well as quality improvement resources.

During FY24, the CMARC program continued collaboration with other agencies and programs, such as CMHRP, NC Integrated Care for Kids (NC InCK) model, Healthy Opportunities Pilot (HOP) Division of Social Services, Children and Families Specialty Plan (supports Medicaid-enrolled children, youth and families served by the child welfare system), Local Management Entities/Managed Care Organizations (LMEs/MCOs), NCCARE 360, and Child First Initiative to ensure an effective system of care. The CMARC program required staff to collaborate with medical homes in their communities, both at the system level for effective identification of children in the CMARC target population and at the individual child level for children engaged in CMARC services, as collaboration with the medical home will ensure the healthiest outcomes for the child. CMARC staff also continued to support the work of NCDHHS' Plan of Safe Care (POSC) for substance affected infants. The CMARC program continued to encourage staff to navigate enhancements and reports in Virtual Health/Care Impact Platform documentation systems. The CMARC staff provided TA and training to ensure program expectations were met as described in the Program

Guide Management of High-Risk Pregnancies and At-Risk Children in Managed Care.

CMARC state staff continued to work closely with NC Medicaid, Prepaid Health Plans (PHPs), DPH (CMHRP), CCNCs, and LHDs as needed during FY24 to assure that care management services for the birth to five population were maintained and enhanced through NC Medicaid Managed Care, thereby promoting the use of the medical home, linking children and families to community resources, and providing education and family support. To ensure these services continue to be provided in a seamless fashion during the move to managed care, staff also assisted with updating the CMARC Program Guide and collaborated with DHB to update the process for LHDs to have first right of refusal to terminate or transfer CMARC coverage to another county or entity. The Companion Guide for Care Management Service Termination and Transfer of Services was reviewed by CMARC staff, CMHRP staff, and DHB to update the document in January 2024. Staff participated in PHP quarterly meetings with DHB to collaborate and discuss the needs of the high-risk population aged 4 years and 364 days. CMARC staff continued to ensure children who were eligible for Tailored Care Management (TCM) had a warm handoff to staff at the LMEs/MCOs. CMARC staff provided education through trainings and TA during the timeline for CMARC baseline and final assessments as well as contract changes as part of the Medicaid Managed Care process.

The DCFW SMD participated in two NC DHHS Medicaid Expansion work groups to help coordinate interdepartmental efforts. DCFW SMD developed a Medicaid Expansion training that was required for all DCFW staff to complete by December 1, 2023. About 760 staff members (>80%) completed the training by December 1. DCFW staff logged any presentation on Medicaid Expansion delivered to a variety of partners including families from November 2023 through March 2024. There were seventy presentations provided for more than 2,400 people across the state. The DCFW SMD provided Medicaid Expansion training to CMARC staff statewide in January 2024 as well as seven additional trainings to partners. The Minority Health Outreach Program Manager provided almost 40 presentations to partners across the state. The DCFW SMD and CMARC interim program manager have begun to develop a process for using a script for CMARC care managers to generate a conversation that points families, caregivers, and guardians to Medicaid as an option for health care coverage for parents, caregivers, guardians, or siblings who are 19-64 years of age. The goal is to have CMARC care managers routinely discuss Medicaid as an option with initial contact with the parent/caregiver and any time there are changes in life circumstances (loss of a job, decrease in income, death of spouse, divorce, change in family size due to birth or adoption) for the family or caregiver. It is also important to discuss Medicaid as an option when the child stops receiving CMARC services.

The following additional statewide webinars were provided for CMARC staff:

- November 2023- CMARC Assessment Training
- Jan 2024- CMARC Assessment Measures and Scoring Training
- March 2024- 4th Trimester: A Village for New Mothers
- May 9, 2024- Child Welfare & Foster Care Training
- June 2024- Sun Bucks overview

Another effort to improve treatment services was undertaken by the PNC who provides regular and timely monitoring, TA and consultation for AA 353 provided to the Durham County Department of Public Health (DCDPH) that supports provision of medical nutrition therapy (MNT) and nutrition consultation services (up to $20,000) for children referred to the LHD with no other funding source. These are often children with special nutritional needs. During FY24, DCDPH provided 468 MNT units and 84 patient consultations with medical providers, with 81 new clients and 86 follow-up clients served with AA353 funding. Durham County reported that positive changes in behavior, knowledge, weight and/or clinical measures occurred in 97% of subsequent nutrition visits in FY24 for all clinic nutrition services. A client case study provided by DCDPH nutrition staff showed improved clinical measures (HgA1C, etc.) and quality of life.

Positive Parenting Program (Triple P)

The Positive Parenting Program (Triple P) System in NC consists of the NC State Partnership for Strategy and Governance (PSG), the NC Triple P Support System (which consists of Triple P America, The Impact Center at UNC FPG, and Positive Childhood Alliance), the Triple P Design Team (The Impact Center and Triple P America), and the lead implementing agencies (LIAs). This system remained in place for 2024 and continues to practice model

flexibilities designed to maximize LIA and practitioner service delivery. The PSG (leadership level) continued to practice flexibility with regards to deliverables, especially relative to the “Scale-Up Plan.” LIAs are making efforts to work towards their developed goals and objectives based on community need and infrastructure to determine scaling counties (those with Triple P online and levels two to four) and supporting counties (non-scaling) to allow for flexibility. The current operating principle is that the Scale-Up Plan, which emanated from the Strategic Plan, is a “living” document, and allows for the flexibility of editing and revising at any time that it is a reasonable expectation to do so. The NC Triple P Support System worked with each LIA to assess the training and support needs of local practitioners to deliver Triple P as part of their work.

In FY24, the WCHS continued to support the Triple P System in NC through Title V and the NC Division of Social Services (DSS) funding by employing a State Triple P Coordinator, funding the LIAs for infrastructure and training support, and providing a part-time data specialist to work in coordination with the WCHS Data Manager to support statewide data collection and reporting and using data for local CQI projects.

In addition, the WCHS continued partnering with the NC DSS to support Incredible Years and Strengthening Families cohorts in local communities and integrate those evidence-based family strengthening programs with Triple P as those initiatives are very compatible and integrate well with Triple P. The WCHS continued to receive funds from DSS to provide additional funding for the LIAs and provide a co-chair for the PSG with the State Triple P Coordinator serving as the other co-chair. DSS continued to utilize the Triple P evidence-based program in their menu of approved family strengthening programs, that can be supported by local DSS funds.

During FY24, the Triple P State Learning Collaborative, consisting of all the coordinators at the LIAs, continued to provide a learning environment in which coordinators met to learn, share, and plan to implement best practices, offer collective problem solving and efficiencies, determine sustainability needs, and encourage model fidelity based on the Triple P Implementation Framework. The Collaborative members are an incredibly effective group of Triple P partners/coordinators who consistently provide perspectives for quality assurance and improvement for the operationalization of the Triple P Program.

With the addition of state appropriations transferred from DSS to the DCFW under an annual agreement, Triple P coverage has been expanded to all 100 counties in NC, which includes Triple P Online that is available statewide at no cost to families. In addition, hybrid support continued to be offered to families. Hybrid support refers to the active engagement of a practitioner in aiding a caregiver's comprehension of the Triple P Online modules' content and lessons. This involves the practitioner regularly checking in with the caregiver, providing answers and clarification for module concepts, assessing the caregiver's understanding of the learning goals, and encouraging the completion of all modules.

There was an ongoing focus for FY24 to reconnect with all the practitioners trained in the Triple P model to determine their status for continuing to provide Triple P services to families of children and teens. A combination of funding from Title V and DSS provided support to the LIAs to maintain three local coordinators, support training for practitioners, and purchase outreach and media materials to promote Triple P in their service area. The partnership between DCFW, DSS and The Duke Endowment has continued to support the implementation of Triple P. To ensure consistent delivery and availability of model implementation in all regions, a process referred to as the “Practitioner Round-Up” continued to be implemented that required all LIA Coordinators to seek out and follow up with all trained practitioners to assess their current status relative to delivery of the model at their agency. This process is in place to ensure that investments made in practitioner training at the local level are being sustained with full access to Triple P services as needed. The Practitioner Round-Up survey has been transformed into the Practitioner Impact and Needs Evaluation (PINE) report since the “Round-Up survey process proved to be a challenge in some cases with practitioners moving outside the service delivery region and/or having changed agencies or careers, thus no longer providing services. The hope for the PINE report is to streamline data collection processes for LIAs and practitioners informed by regular input from LIA data team leads during weekly data team meetings in addition to data requests from funders.

Four ICO4MCH project sites (covering eight counties) selected Triple P as one of their evidence-based strategies to improve health among children ages zero to five during FY24. Durham County implemented the Family Connects Home Visiting Program.

In FY24, in various disciplines, sectors and settings, the Triple P Program newly accredited 165 practitioners with the top settings being Children's Developmental Services Agencies, Mental Health Agencies and Community Resource Centers. Triple P had 782 practitioners in position to deliver services and reached 9,719 children in FY24.

NC Child Care Health Consultation Resources

The State Child Care Nurse Consultant (SCCNC) position, supported by Title V and Child Care and Development Block funding, collaborated in FY24 with programs within WCHS and other state partners to advance early childhood public health initiatives. The SCCNC worked closely with the NC Child Care Health and Safety Resource Center (CCHSRC) to support the health and safety of children aged 0 to 5 years attending early care and education programs through child care health consultation (CCHC). The CCHSRC is jointly funded through Title V and the Child Care and Development Block Grant (partnership with DCDEE). The SCCNC collaborated closely with the CCHSRC to deliver training, technical assistance, and coaching to 74 local and regional Child Care Health Consultants (CCHCs). These consultants provided support to 5,505 licensed child care programs statewide, including direct services to 3,377 centers for a total number of 4,379 encounters.

The SCCNC and CCHSRC continued to provide support to hiring and funding agencies in CCHC expansion counties and provided coaching for CCHCs and their supervisors. In FY24, the CCHC System Workgroup consisting of representatives from DCFW, DPH, CCHSRC, DCDEE, NC Partnership for Children (NCPC), the NC CCHC Association, and local NCPC Smart Start agencies met monthly to continue with implementation of a strategic plan. The SCCNC served as co-facilitator of the meetings. Five core agencies including CCHSRC, DCFW, DPH, DCDEE and NCPC provided a joint governance structure for the NC CCHC system.

The CCHSRC hosted two cohorts of the NC Child Care Health Consultation (CCHC) course for a total of nine new CCHCs. The SCCNC and CCHC coaches served as course instructors. Three participants completed the December 2023 course and six completed the May 2024 course. Medication Administration and Child Care Development Fund Overview Train-the-Trainer Courses were offered within both cohorts of the CCHC course. The SCCNC collaborated with local partners to offer the CCDF Health and Safety Overview Train-the-Trainer courses twice to CCHCs during FY24.

The Infant/Toddler Safe Sleep and Sudden Infant Death Syndrome (ITS-SIDS) Risk Reduction in Child Care (ITS-SIDS) course was offered in three cohorts resulting in 34 new trainers. Three ITS-SIDS trainers completed the ITS-SIDS Course for Trainers Refresher course in November 2023, and two trainers completed the course in June 2024. Ongoing training support has continued to be provided to ITS-SIDS trainers this fiscal year. At the time of this report, there were 323 active ITS-SIDS trainers. The Emergency Preparedness and Response (EPR) course was offered two times to CCHCs and other technical assistance providers across the state, resulting in 21 new active EPR trainers. Two EPR trainers successfully completed the EPR Course for Trainers Refresher in December 2023. Both ITS-SIDS and EPR courses are reviewed annually and offered to CCHCs and other technical assistance providers.

In FY24, the SCCNC, serving as a nurse planner, partnered with the CCHSRC to provide professional learning opportunities for CCHCs on various health and safety topics relevant to young children in early care and learning settings. Topics included: *Infant and Young Child Feeding in Emergencies (IYCF-E)*, *Communicable Disease*, *Infant Child Social and Emotional Wellbeing*, and *Policy Development and Implementation*. The CCHC Learning Collaboratives were designed to provide foundational knowledge of a given topic by a subject matter expert followed by an opportunity to experience peer-to-peer learning and explore practical application. The SCCNC and CCHSRC staff engaged with internal and external partners from CMARC, a local CDSA, DCDEE, DSS, PCANC, early educators, and the Asthma Alliance of NC in this collaboration. On average, 38 CCHCs serving child care facilities across the state participated in the learning collaboratives. Additionally, there were two cohorts with 22 CCHCs who attended the new *Fundamentals of Health and Safety in Child Care* course.

The SCCNC continued meetings with Carolina Global Breastfeeding Institute (CGBI) to promote and prepare to train CCHCs in IYCF-E practices developed by CGBI. Four cohorts were provided with this training for a total of 25 participants. The SCCNC worked in partnership with technical assistance partners to revise the Breastfeeding Friendly Child Care Training in preparation for the SCCNC and CCHSRC to provide and host the training and "Train

the Trainer" courses in FY25.

The CCHSRC developed and distributed four quarterly e-newsletters with health and safety themes that were made publicly available in English and Spanish. Topics included *It's the Little Things: Preventing Food Borne Illness in Child Care* and *Equipping Early Educators*. Additionally, the CCHSRC hosted a toll-free line/website inquiry form with a total of 665 contacts: 524 via the website, 120 phone calls, and 21 emails. These contacts were responded to through the CCHSRC in collaboration with the SCCNC's input, if needed.

Sixty CCHCs attended the annual NC CCHC Conference in September 2023. The SCCNC partnered with a group of three active CCHCs to participate in a panel discussion centered around educating the audience about how to build rapport with child care facilities and strategies for using the quality improvement cycle. The SCCNC highlighted the importance of the regional coaches, learning collaboratives, DCFW, local health departments, and local partnerships as front line supports for the CCHCs in the field.

SPM#3 – Percent of children with two or more Adverse Childhood Experiences (ACEs) as measured through the NSCH (which is now also a NOM)

One measure of the NC Title V Program's success at promoting safe, stable, and nurturing relationships is SPM#3, percent of children with two or more ACEs, which is now also a National Outcome Measure. This indicator was also selected as one of the Healthy NC 2030 indicators and is part of the ECAP. Results from the 2022-23 NSCH indicate that 17.3% of children in NC experienced ≥2 ACEs as reported by their parents. It is comparable to the 2022-23 national rate of 17.5% and an increase from the baseline 2018-19 NSCH for NC of 15.4%, although the confidence intervals overlap so it is probably not a significant increase.

The DCFW SMD served as a co-lead for three of the NC DPH/DHHS 16 community council work groups working on the 21 Healthy People 2030 indicators as part of the annual update to the NC State Health Improvement Plan (NC SHIP). These work groups included DCFW or DPH Title V staff members among those represented agencies and also included local community partners and partners across the state. The three work groups addressed the indicators related to third grade reading proficiency, short term suspensions, and ACEs. The ACEs work group decided on two priority areas in their discussions for potential action: improving data available on trauma and ACEs at the local level and increasing funding for and embedding community-rooted, culturally affirming family and community support programs into existing initiatives. Short term suspension (STS) is not formally considered one of the 10 ACEs but is often associated with ACEs. The priorities decided by the STS work group included: disrupting the school-to-prison pipeline, beginning with early childhood programs by reducing the use of short term suspensions and expulsions in pre-K through third grade, and increasing different racial, ethnic, gender, and disability status among school and childcare leadership and staff.

In FY24, several programs which provided direct services to clients regularly assessed families of infants, children, and youth for ACEs (i.e., interpersonal safety) as part of health screening. Programs and services supported by Title V and implemented at the local level included CMARC, the Child Health Program in LHDs, MIECHV, child care health consultation, Triple P, School Health Centers (SHCs), the EHDI program, and school health nurse services.

Efforts to Support the Learn the Signs. Act Early. and Reach Out and Read Campaign

The Survey of Well-Being for Young Children (SWYC), which was first required for use as a screening tool with all CMARC-engaged families in April 2018, continued to be a required screening tool in FY24. Additional TA has been provided to CMARC staff and health care providers in LHDs and private practice on the use of the SWYC tool and on linking with resources to address concerns in the community. CMARC care managers continued to conduct general developmental screenings using the Life Skills Progression Assessment, share the results with the appropriate medical home practitioners, and facilitate EI referrals. In addition to the previously documented activities regarding the use of LTSAE materials in FY24, the CMARC staff continued to provide LTSAE and the CMARC Education Standard with Matrix to promote child development and strong parent-child relationships. The NC ITP also promoted the LTSAE campaign both on its website and by sharing it with families seen at the CDSAs. In March 2024, the MIECHV Professional Development Coordinator received LTSAE materials to give to MIECHV sites. CMARC used Patient Education Standards to deliver a core set of educational interventions according to an

established timeline to all patients receiving CMARC care management as well as providing education on specific risk factors and complications for individual patients.

The SCHNC, RCHNCs, and DCFW SMD continued to promote the value of reading and Reach Out and Reach (ROR) during the CHTP for CH ERRNs. During FY24, six LHDs provided ROR using Title V funds through the Child Health AA.

Child Health Agreement Addenda

The WCHS continued to refine the Child Health AA with LHDs in FY24 to require that: 1) all services supported by Title V funding will be evidence-based; 2) services will support the MCHBG domains and reflect the needs of the community; and 3) priorities established by the local communities will be data driven. The Child Health Program has: 1) Created an online process for LHDs to self-report at mid-year and end of year on the measures for the services delivered by the LHD; 2) Improved standardized measures and reporting mechanisms to increase accountability; and 3) Increased TA to LHDs to support the use of additional evidence-based services and resources for children.

The FY24 Child Health AA with LHDs for child health services supported a variety of services for low-income families including, but not limited to: 1) Access to dental services and optometrists; 2) Access to asthma inhalers and spacers; 3) Direct preventive and sick visit services; 4) ROR support; 5) Interpreter services such as in-person interpreters and language line services; 6) Car seat and bicycle helmet purchases based on financial eligibility; 7) Reproductive health services for teens based on a sliding fee scale; 8) Funding for school nurses; 9) Funding for family strengthening initiatives such as Triple P and Innovative Approaches; 10) Accommodations to improve access to care for children with disabilities after site surveys for wheelchair scales and accessible examination tables; 11) Training related to skill development related to evidence-based services; 12) Family Friendly (Breastfeeding) Clinic Award for outpatient healthcare clinics; 13) Funding for CCHCs; 14) Community Coalitions Supporting Healthy Eating and/or Physical Activity; 15) Addressing Food Insecurity and/or Healthier Food Access; 16) Teen Friendly Clinics; and 17) Firearm Safe Storage.

NC Home Visiting Consortium

The Home Visiting and Parenting Education (HVPE) System Building Initiative work was put on hold in Summer 2023. There were leadership challenges, accountability issues, and a lack of project administration best practices at the host agency which resulted in unanticipated gaps in the implementation of HVPE. Many former HVPE partners are currently members of the NC Home Visiting Consortium (NCHVC) which has served as a mechanism to move home visiting programs forward in NC. The NCHVC is a network of perinatal/early childhood home visiting programs and MCH organizations that work to support initiatives across NC. Since 2015, NC MIECHV has facilitated the NCHVC, as there was little collaboration among home visiting models at that time. The NCHVC has solidified home visiting in NC by engaging model purveyors and partnering agencies through quarterly meetings. In 2024, PCANC and NCPC resumed providing HVPE updates during the NCHVC meetings. The NCHVC will continue to work with PCANC and NCPC and provide input as they resume the work of the HVPE initiative, integrating previous feedback and lessons learned from the past few years to ensure that the program is sustainable in the future.

Nurse-Family Partnership

In FY22, NFP was granted an additional $1.5 million dollars in recurring funds in the state budget to support the sustainability and expansion of the program. The funding was allocated in FY23 and enabled NFP to serve 150 additional families across the state. WCHS continued working with the NFP sites in FY24 to ensure that sites were meeting their funded caseload capacities. To do this, a specific focus has been on community marketing and outreach to ensure that qualified referrals are consistently available. Additionally, focus has been placed on recruiting and enrolling clients who meet at least 3 or more high-risk categories. There are 19 risk factors identified by the NFP National Service Office (NSO) with a new report available for staff to track the risks of enrolled clients. State Nurse Consultants have worked through monthly consultations to ensure that each site has an individualized plan for referral outreach and caseload maintenance. The NFP NSO has developed marketing and outreach “tool kits” available to all sites to assist sites in developing these individual outreach plans. In addition, the NFP NSO has a marketing and outreach team that is available to work individually with sites who are struggling in aspects of referral rates, referral-

to-enrollment conversion, and/or attaining funded caseload capacity. Efforts are now tracked through individual collaborative success plans unique to each site where goals are set and measured.

Client retention continues to be a focus of NFP and is reviewed quarterly for all program phases. Retention rates are also being discussed at annual site visits with each team's Nurse Home Visitors. In addition to a detailed report describing reasons for discharge, an additional focus is being placed on retention of populations. A newly added section to the fidelity report gives a breakdown of retention by race and ethnicity, as well as the percentage of addressable and non-addressable reasons for early discharge. This will allow sites to identify retention gaps and develop strategies based on specifically identified population.

In FY23, MIECHV home visiting data began integrating into the NC Early Childhood Integrated Data System (ECIDS). Previously, MOAs were signed and implemented in 2022 and NC MIECHV's Continuous Quality Improvement/Data Manager and data partners worked with the NC ECIDS staff to identify which data elements and indicators to integrate. Secure transfer file protocols were established, and all participant data from 2012 – 2024 from six LIAs have been integrated into ECIDS. NC MIECHV plans to start the data integration process for the final LIA in 2025.

MIECHV Regional Meetings were held quarterly for the professional development of home visiting staff. The meetings were structured to meet the needs of NC MIECHV's LIAs, also referred to as NC MIECHV's sites as suggested through post-meeting evaluations and monthly reports. Topics and presentations from this reporting period include: *Promoting Maternal Mental Health During Pregnancy through the Parent-Child Relationship Programs, University of Washington*; *Safe Sleep; Triple P in NC*; *What is the Exceptional Children's Assistance Center and How We Can Support Families Together*; *MIECHV LIA IPV Screening*; *Medicaid Expansion*; *Yay Babies!*; and *Perinatal Through Childhood Exposure to Violence*. Additionally, professional development opportunities including webinars, journal articles, and upcoming conferences/trainings are emailed monthly to MIECHV home visiting staff.

NC Child Fatality Prevention System

The NC Title V Program continued to play a key role in the implementation of the NC Child Fatality Prevention System (CFP System) that serves to prevent child deaths and child maltreatment. The original legislation creating the CFP System was passed in 1991. Three main components of the CFP System include: the NC Child Fatality Task Force (CFTF); the state Child Fatality Prevention Team; and local child death review teams in each county, called Child Fatality Prevention Teams (CFPTs) and Community Child Protection Teams (CCPTs). New legislation updated the Child Fatality System through legislation in 2023 and is governed by the North Carolina General 2023 Appropriations Act [Section 9H.15. of Session Law 2023-134]. This new legislation implements changes starting in 2025.

The CFTF is a legislative study commission that makes recommendations to the Governor and NC General Assembly focused on laws and policies to prevent child deaths as well as child maltreatment and to promote child safety and well-being. Although the Task Force is part of NCDHHS for budgetary purposes only, the position of the Executive Director of the CFTF is in the NCDHHS Office of the Secretary, and several NCDHHS employees serve on the Task Force, one of its three committees, or have participated in various CFTF efforts. In particular, the NC Title V Director serves as a statutory member of the Task Force, and the WICWS Chief co-chairs the Perinatal Committee of the Task Force as a subject matter expert. Two other committees of the CFTF are the Intentional Death Prevention Committee and the Unintentional Death Prevention Committee. The CFTF provides a unique forum that brings together agency officials, lawmakers, experts in child health and safety, and community volunteers to perform the important work of understanding what causes child fatalities and determining what can be done to prevent them. Aided by the work of three committees, the Task Force meets to study data, hear from experts, and prepare policy recommendations for consideration. The Executive Director of the Task Force and other NC Title V Program staff work closely with the staff of the Injury and Violence Prevention Branch (IVPB) and also work with additional partners including other state agencies and non-profit agencies such as NC Safe Kids, the UNC Injury Prevention Center, NC Child, and the Governor's Highway Safety Program. The CFTF reports annually to the Governor and NC General Assembly. These annual reports, as well as other reports, presentations, meeting schedules, and membership lists can be found at the following link: https://www.ncleg.gov/Files/NCCFTF/index.html.

The state CFPT Coordinator, who is a member of the WCHS, supports all 100 local CFPTs through Title V funds and ongoing TA. NC counties review all of the county's resident child fatalities. CCPTs review all cases in which a child died because of suspected or confirmed abuse or neglect and a report of abuse or neglect was made to DSS within the previous twelve months or the child or child's family was a recipient of child protective services within the previous twelve months. All additional child fatality cases are reviewed either by the CCPT or, if the CCPT does not review additional child fatality cases, a CFPT reviews them. Team members who serve on both CCPT and CFPT include: a member of the director's staff, local law enforcement office, attorney from the district attorney's office, local community action agency, superintendent of local school administration in the county, member of the county board of social services, mental health professional, guardian ad litem coordinator, LHD director, and a health care provider. CFPTs also include the following members: emergency medical services provider or firefighter, district court judge, county medical examiner, representative of a local child care facility or Head Start program, and a parent who has experienced a child's death before their eighteenth birthday. Additionally, the board of county commissioners may appoint a maximum of five additional members to represent county agencies or the community at large to serve on the local CFPT.

Each quarter, local CFPTs are provided documentation on the child deaths for their county which include a list of the child fatalities for review that quarter, death certificate transcripts, medical examiner reports (with a list of Pending cases), birth certificate information, and injury data. Data are provided through the SCHS and the Office of the Chief Medical Examiner (OCME). Local CFPTs meet to review all their resident child fatalities and identify system problems, make recommendations for prevention of future fatalities, and decide how to act on those recommendations. The local CFPTs provide education to their communities on ways to keep children alive and safe and connect applicable agencies in response to their created recommendations.

Beyond local recommendations and coordination, the state CFPT Coordinator links actions and noted recommendations from the local CFPTs with other state agencies and with the state CFPT, a noted component of the NC CFP System. The state CFPT Coordinator and DCFW SMD serve as members of the State CFPT Team. The State CFPT is a multi-disciplinary team with law enforcement, social services, mental health, health care providers, education, and public representation responsible for in-depth reviews of all deaths of children younger than eighteen years old reported to the NC Medical Examiner System, including deaths due to abuse and neglect. The DCFW SMD brings information to the team related to maternal and child health which includes specific case information from the NC Immunization Registry (about vaccines and location of visits for vaccines). The CMARC program provides data to the DCFW SMD to bring to the state CFPT Team about any involvement of infants and children under 5 years of age with the CMARC program and with POSC referrals. Annual recommendations are reviewed, bringing together local CFPT, CCPT, and state CFPT topics to share with the CFTF.

In coordination of the local CFPTs, the state CFPT Coordinator monitors the activities of the local CFPTs to ensure compliance with the NC CFP System's statutory requirements, makes virtual connection and site visits to local CFPTs, provides statewide webinars to increase the local teams' knowledge about current health, data, and child safety issues, and maintains the database for submitted child fatality review reports. This year, the state CFPT Coordinator focused on continued maintenance of the database of submitted review forms, prioritizing visits to local CFPTs, establishing unique avenues of communication to connect teams across the state, and preparation for the implementation of the new child fatality system legislation.

During FY24, the state CFPT Coordinator conducted 36 in-person visits and thirteen virtual visits with local CFPTs which enabled the Coordinator to gain insight into how these individual teams operate as well as how to best provide support and assistance. Visits also occurred for the purpose of monitoring local CFPTs in line with their LHD reaccreditation schedules. The Coordinator also initiated office hour "open forums" twice a month to help facilitate conversation among local CFPTs, provide an opportunity for teams to come ask questions and share with other CFPTs, and have general conversation about a variety of topics every month. The open forum events occur on a repeated schedule so local CFPT members can join as their schedules allow. I
During FY24, there were 1,149 fatality reviews completed by CFPTs and entered into the database. The state CFPT Coordinator continued collaboration between local CFPT work and state CFPT reviews to continue the process of bridging actions and noted recommendations throughout the CFP System structure.

Additional Strategies to Promote Child Health and Decrease ACEs

The WCHS and the EI Section continued their enduring partnerships with agencies and organizations such as NC Child, the NC Pediatric Society, the NC Academy of Family Physicians, Exceptional Children's Assistance Center (ECAC; Family-to-Family Health Information Center), NCPC, Family Support Network, Carolina Institute for Developmental Disabilities, and PCANC to prevent and mitigate ACEs and increase PCEs (positive childhood experiences).

The Title V Program continued to work with Duke and other partners to monitor and promote use of the many NC-PAL practice and community focused efforts. NC-PAL provided mental health consultation and education to many partners which include health care practices, CDSAs, schools and social service providers in NC, building mental health knowledge and capacity. NC-PAL also provided phone consultation, education, and practice supports to increase the capacity of primary care providers across the state to identify strengths and to provide timely identification, diagnosis, management, treatment, and referral as appropriate for children with mental or behavioral health concerns which includes assessing how social drivers of health, including ACEs, impact mental health. NC-PAL's community supports included working closely with DSS on statewide case reviews and policy development, consultation, and education pilots with selected DSS agencies. The SMD also continued to be involved with conversations to help guide and promote the variety of provider and community resources available through NC-PAL to primary care providers and with private and LHD child health providers in multiple presentations during FY24 related to child and perinatal mental health (NC MATTERS). More information about NC-PAL in addition to other Child Behavioral Health unit initiatives can be found in the NC's Systems of Services for CSHCN section.

In FY24, funding through Title V and state appropriations continued to support coverage of vision screening for both school-age and preschool age children with Title V funding the preschool services through a contract with Prevent Blindness NC. Educational materials were provided statewide on eye and vision health. Vouchers for services and eyeglasses for children who do not qualify for other assistance through public or private insurances were also provided. Vision disorders are the fourth most common disability among children. Prevent Blindness funds were also utilized to provide training and certification of vision screeners in 100 counties across NC who conduct mass and individual vision screenings for children of all ages in NC public and charter schools. Vision screening training ensures that school-aged vision screenings are conducted in a consistent and uniform manner implementing age-appropriate screening methods. In FY24, there were a total of 3,056 vision screeners certified to provide vision screenings throughout 100 counties in North Carolina. A total of 33,091 children were screened and a total of 3,493 were referred to eye care professionals for follow-up vision care.

The DCFW SMD continued to serve on a statewide multi-partner group to help advise the NC Childhood Lead Poisoning Prevention Program to LHDs and to pediatricians across the state in partnership with the NC Pediatric Society. The DCFW SMD worked with DPH CDIS Head and other partners and received feedback from providers that prescriptions are electronic and the idea of paper prescriptions for primary care providers was not the best way to give them directions to address elevated lead level follow up which includes testing and referrals. SCHNC and RCHNCs partnered to provide TA to LHDs on accessing NC Lead Training to better understand all these changes.

Priority Need 5. Improve Immunization Rates to Prevent Vaccine-Preventable Diseases

Vaccines for Children Program Strategies

The federal Vaccines for Children Program (VFC) was established after a measles epidemic in the United States and became operational in the fall of 1994 under section 1928 of the Social Security Act. VFC is an entitlement program for eligible children, age 18 and younger. Provider recruitment to maintain a strong public health infrastructure helps assure high immunization coverage levels and low incidence of vaccine-preventable diseases. The IB distributes vaccines at no charge to private and public VFC enrolled providers to vaccinate children whose parents or guardians may not be able to afford them. This helps ensure that children have a better chance of getting all the recommended vaccinations on schedule. Collaborative efforts include community engagement with existing and new partnerships are essential for increasing vaccination coverage and improving vaccine acceptance. The IB provides accurate and consistent focused training to its stakeholders about vaccination of infants, children, and adults.

The IB uses vaccine ordering data from VFC providers to determine which providers are high-volume and order both adolescent and childhood vaccines. At the state level, providers who have low coverage and high patient volume, and who see both children and adolescents, will be considered high priority to receive an Immunization Quality Improvement for Providers (IQIP) visit. Providers located in geographically underserved areas or in areas where outbreaks of vaccine preventable disease occur are also prioritized for IQIP. Immunization data from the NC Immunization Registry (NCIR), a web-based statewide-computerized immunization information system that maintains and consolidates immunization records, is used to assess provider-level vaccination coverage. Regional immunization consultants run an initial assessment report to evaluate coverage and work with providers to identify practice strengths and weaknesses and implement strategies to increase vaccine uptake to improve immunization coverage. Providers are trained to use the NCIR reports to track children who are overdue for immunizations, confirm data accuracy and completeness of records, and make any needed corrections in the NCIR. The regional immunization consultants will run assessment reports a second time after corrections are made to re-evaluate coverage. Providers are asked to monitor data quality on an ongoing basis. The IB completes a centralized statewide immunization assessment annually for all children 24 through 35 months of age from the NCIR. Immunization coverage assessment results are provided to each LHD. Quality improvement strategies are discussed to improve coverage and compliance with NC immunization laws.

Overall, the NC Immunization Program (NCIP) distributed a total of 2,575,218 doses of vaccine, including 299,780 doses of influenza vaccine and 236,770 doses of COVID vaccine in FY24.

National Immunization Survey

At the national level, CDC uses the National Immunization Survey (NIS) to monitor vaccination coverage among children 19-35 months and teens 13-17 years, and flu vaccinations for children 6 months to 17 years. The surveys are sponsored and conducted by the National Center for Immunization and Respiratory Diseases (NCIRD) of the CDC and authorized by the Public Health Service Act [Sections 306]. Data collection for the first survey began in April 1994 to check vaccination coverage after measles outbreaks in the early 1990s. The NIS provides current, population-based, state and local area estimates of vaccination coverage among children and teens using a standard survey methodology. Estimates of vaccination coverage are determined for child and teen vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP), and children and teens are classified as being up to date based on the ACIP-recommended numbers of doses for each vaccine.

Childhood and Adolescent Immunization Rates

While most of the funding for childhood immunizations does not come from Title V, the WCHS supports the work of the Immunization Branch (IB) to raise immunization rates across the lifespan. The 2021-2023 National Immunization Survey (NIS) results (for children born 2020-21) were released in September 2024. North Carolina's coverage estimate for the 4:3:1:3:3:1:4 series (which protects against Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus influenza type B, Hepatitis B, Varicella, and pneumococcal invasive disease) was 69.7%, which was higher than the national estimate of 66.9%, but lower than NC's previous year NIS results of 72.3%.

Results of the 2023 NIS-Teen, released in August 2024, showed that the rate of NC teens aged 13 through 15 years who have received one or more doses of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) since the age of ten years was 92.6%, which was higher than the national estimate of 88.8% and a 4% increase from the 2018 baseline of 88.9%. The 2023 meningococcal conjugate coverage estimate in NC was higher for teens age 13 to 15 than the national estimate (91.9% v. 86.9%) and was an increase of 5% from the baseline of 87.4% although a decrease from the 2021 rate of 95.6%. Regarding the percent of teens ages 13 to 15 who were up to date on the HPV series, the 2023 NC estimate was higher than the national estimate for all teens regardless of gender (61.2% v. 57.3%), and 64.3% of females were up to date while 58% of males were.

NCIP Partnerships

One IB staff member is designated as liaison to the North Carolina Immunization Coalition (NCIC). This individual serves as an ad hoc member on the steering committee and a committee member on NCIC's HPV subcommittee. Assistance is provided with crafting information and preparing for webinars and other activities. This liaison also

attends all regular meetings of the NCIC and provides updates on current activities of the IB.

IB leadership and communications staff have also partnered with the N.C. Pediatric Society on joint messaging and promotion of childhood immunizations during the annual observance of Adolescent Immunization Awareness Month in North Carolina.

Immunization Quality Improvement for Providers

On July 1, 2019, the CDC-developed quality improvement program formally known as AFIX (Assessment, Feedback, Incentive, and eXchange), underwent several methodological changes and was renamed IQIP (Immunization Quality Improvement for Providers). Like AFIX, IQIP is designed to promote and support implementation of provider-level strategies that were developed to help increase vaccination rates in children and adolescents. One of the key changes to this program is the incorporation of both childhood and adolescent assessments during each visit. Two-year-olds and thirteen-year-olds (as opposed to 13-17-year-olds in AFIX) are assessed to promote on-time vaccination. The follow-up process is also lengthier, extending to one year from the previous 3-6 months, to promote long-term, measurable changes within a provider's office. Strategies were also streamlined and broadened, to allow for wider interpretation. In July 2022, CDC authorized the use of tele-IQIP (virtual IQIP) as a permanent option for completing visits. Tele-IQIP was initially introduced as a temporary option during COVID. In FY24, IB initiated 517 IQIP visits, representing approximately 45% of VFC-enrolled providers.

Additional Title V Immunization Activities

The DCFW SMD continued to work with IB staff members to review a subset of medical exemption requests for immunizations that were non-standard from physicians licensed to practice in NC and continued to work with the attorney general's office on appeals for medical exemption requests. The DCFW SMD also provided eleven webinars to child health clinic staff in LHDs during FY24 that included highlighting the need for well visits, routine immunizations, and immunizations against COVID-19 and flu, RSV and routine vaccines and addressing vaccine hesitancy.

Priority Need 3 – Promote safe and nurturing relationships for children and adolescents

Priority Need 3 is very similar to a former priority need found in the NC 2021-2025 State Action Plan, with the major change being to specify both children and adolescents and have the need span two population domains. The NC Title V Program selected the Developmental Screening NPM for this priority need under the Child Health Domain and has created two ESMs (ESM DS.1 Percent of well-child visits among children ages birth to five in LHDs where developmental screening occurred and ESM DS.2 Percent of children continuously enrolled in Medicaid screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday).

CH PN3 Objective 1 By 2030, increase the percentage of children that are screened for developmental concerns using a parent completed tool by 5 percentage points from 47% (2022-23 Baseline NSCH) to 52%.

The DCFW Early Mental Health Action Team (EMHAT) will work with CMARC, MIECHV, Child Health, EI, CCHC and several other DCFW programs on an action plan of strategies that will promote safe stable and nurturing relationships through increased communication and collaboration of efforts around early relational health.

The Child Health and CMARC programs will provide at least one statewide training during FY26 about assessing relational health and promoting Safe Stable Nurturing Relationships (SSNRs) for infants, children, adolescents and their families as part of developmental surveillance and different developmental and behavioral screening to LHD clinical staff and care managers.

In FY26, up to 60% of MIECHV home visitors will be in the process of completing or will complete the Infant Early Childhood Mental Health-Endorsement® through the North Carolina Infant and Early Childhood Mental Health Association. Endorsement supports the provision of high-quality, culturally informed, reflective, and relationship-based services to pregnant women, infants, toddlers and their families across a variety of disciplines, systems, and early childhood workforce sectors.

Child Care Health Consultants (CCHCs) provide assessment, training, and TA to early educators to support CSHCN, including those with developmental concerns, in early care and education settings. If/when concerns are identified, CCHCs provide resources, make necessary referrals, and follow up to determine if services were utilized and if further guidance is needed to support CSHCN in the classroom. The State Child Care Nurse Consultant will collaborate with the NC Health and Safety Resource Center in FY26 to present a Learning Collaborate on the topic of children's social emotional development with attendance required for the active CCHCs. The CCHCs will use this training to inform their practice with child care facilities as they deliver the trainings to facility, staff, and administrators.

The MIECHV and non-MIECHV home visiting programs will continue to complete developmental screenings with all enrolled families who have children between ages 4 months to 30 months in FY26. The MIECHV program will measure the number of children aged 9 months to 30 months with at least one complete developmental screening within the AAP defined age groups conducted by their home visitor during each reporting year. All home visiting sites will use the Ages and Stages Questionnaires® to meet the MIECHV requirement to demonstrate improvement for the school readiness and achievement performance measure. Separate from MIECHV performance measure requirement, the HFA and NFP home visiting models will also complete the Ages and Stages Social-Emotional Questionnaires at 6, 12, 18, and 24 months of age, according to their home visiting model guidelines. NFP home visiting staff will provide assessments of the child and family needs by using the Strengths and Risks (STAR) framework to ensure wrap around services are offered if needed. NFP will begin discussion of identified needs by 18 months of age so the appropriate referrals can be made, and a seamless transition of services can occur by NFP program graduation at the child's age of 24 months. NFP will document referrals on the "Referrals to Community Services" data collection form.

The WCHS Child Health Program will increase awareness and promotion of evidence-based trauma informed therapeutic services by including information in one of the statewide child health webinars and in the CHERRN CHTP. Through their participation on DCFW's EMHAT via monthly meetings, a dedicated communication channel, and regular collaboration, Title V programs will receive and share information about evidence-based services and resources to address early relational health and IECMH. The EMHAT Action Plan focuses on programs alignment through communication and collaboration, as well as workforce development to support IECMH and early relational health.

CH PN3 Objective 2 By 2030, increase the percentage of children, ages 6 months-5 years, whose parents report

that they are flourishing by 5% from 80.5% (2022-23 Baseline) to 84.5%.

CH PN3 Objective 3 By 2030, increase the percentage of children, ages 6-11 years, whose parents report that they are flourishing by 5% from 61.1% (2022-23 Baseline) to 64.2%.

Early educators must understand the fundamentals of CDC's *Learn the Signs Act Early* program so they can share resources with families and know when to contact a CCHC for additional guidance. CCHCs can provide both consultation and training on this topic. In FY26, CCHCs will use the NC Health and Safety Assessment and Encounter Tool (NC HSAET) to direct the consultation and coaching they provide to early childhood educators. CCHCs provide the training *Early Childhood Development and Resources* which includes information related to developmental milestones including typical/atypical development for young children. The CCHC resources webpage also highlights community resources available to support children, families, and early childhood educators related to development and how to collaborate with those partners. In FY26, they will continue this work. The State Child Care Nurse Consultant will continue to provide updates and information to the CCHCs as part of the Early Literacy Workgroup.

CCHCs provide the following trainings to early educators on the topics of Caring for Children with Special Health Care Needs; Infant and Child Social Emotional Wellbeing for Early Educators; and Early Childhood Development and Resources. CCHCs also provide technical assistance and consultation for early educators on these topics and on topics related to child development and staff health and wellness. Using the NC HSAET, CCHCs gather data pertaining to the socioemotional wellness of both the staff and children, including whether they provide an environment that promotes children's proper development. After completing an initial assessment, CCHCs work with the facilities to develop policies and best practices as part of a quality improvement plan. In that quality improvement plan, specific strategies are developed, and technical assistance is provided. A follow-up assessment is performed and improvements noted as part of the outcome measures.

The LTSAE materials will continue to be included in at least one training that promotes use by child health program providers and CMARC care managers to help support families to engage with their infants and young children and monitor development which includes social emotional and relational health. The CMARC program will build a relationship and collaborate with the LTSAE NC ambassadors and continue to promote use of LTSAE materials as handouts while accessing the website as part of the CMARC Care Management Patient Education Standard. The CMARC program will continue to promote appropriate use of additional patient education materials that promote child development and strong parenting including resources from Triple P and Small Moments to Big Impact.

Evidence-based early literacy programs (i.e., Reach Out and Read) will continue to be evaluated and supported as options for LHDs to implement as part of the Child Health Agreement Addenda (contract) with LHDs. The WCHS Child Health Program will explore with early literacy partners ways to share a broader range of professional development and training resources for providers related to early literacy in LHDs.

DCFW will continue to participate in the NC Home Visiting Consortium to ensure all families have access to a range of parenting education supports in early childhood to strengthen parent-child relationships and improve family and child well-being. In FY26, Consortium leadership will continue the process of restructuring and revitalizing the group to build a stronger, unanimous voice through collaborating with existing and new partners in the perinatal and early childhood and MCH organizations to support home visiting programs across NC with a common purpose. A survey was launched in early 2025 to assess the work of the Consortium and capture feedback to plan for future meetings, and results and next steps were discussed based on survey feedback at the most recent Consortium meeting. A small workgroup is under development to finalize the NC Home Visiting and Parenting Education Core Competencies. The Core Competencies are an organizing framework to guide training and professional development for the home visiting and parenting education field in NC.

Staff will continue to focus on logistical support, expert engagement, stakeholder communication, and Medicaid collaboration to inform and align the CSHCN Commission's work. Staff will continue to partner with the Exceptional Children's Assistance Center to administer reimbursement to parents/caregivers of CYSHCN, youth (including youth with special health care needs), and self-advocates for active involvement with WCHS activities.

The Early Childhood Behavioral Health Programs Specialist will continue to engage with external partners (including families) to improve services and systems that support safe, stable and nurturing environments. This includes leadership groups, advisory committees and conferences that shape policy and messaging, address systems alignment and improvement of services, strengthen workforce development, and identify outcomes and data to support early childhood behavioral health. The Specialist will continue to engage a feedback loop of communication, strategies and policies between Title V programs, other NCDHHS initiatives, and external partners in support of

healthy early development and flourishing.

The Regional School Health Nurse Consultant (RSHNC) team facilitates the annual data collection regarding vision screening and referrals through the School Health Services report, Screening Form B. The submitted data is reviewed by the RSHNC team which facilitates the creation of the annual Prevent Blindness report. The State School Health Consultant will regularly attend meetings and collaborate with NC Healthy Schools as part of NC DPI as well as the Child Fatality Task Force on initiatives to promote the health and well-being of children. The 2024-25 School Health Services report will be provided to LHDs and statewide stakeholders via an annual report brochure in FY26 to include data reflecting common chronic health conditions, students at risk, and the current landscape of the opioid epidemic in the school setting.

The WCHS Child Health program and CMARC will use statewide webinar trainings and discussions to bring in community partners to share information and resources about how to support safe, stable and nurturing relationships for infants and children as part of well-child visits. The CHTP will continue to invite community partners (i.e., Prevent Blindness NC, NC MATTERS, Early Intervention, NC-PAL, Basic Insights) to share information and resources with students to help improve safe, stable and nurturing relationships for infants and children. CMARC will explore ongoing ways to partner with the State DSS program to improve collaboration to care for substance affected infants referred for Plans of Safe Care.

The DCFW SMD or EI MD will serve on the Advisory Committee of Basic Insights for pilot by Smart Start in several counties in NC. This evidence-based program will provide messages to parents, caregivers and families related to healthy child development and include customized message on early relational health and kindergarten readiness.

NFP nurse home visitors will continue to assess parent-child interactions using the Dyadic Assessment of Naturalistic Caregiver-Child Experiences (DANCE) tool at 4 intervals during the program in FY26. DANCE assessments will occur at the following time frames: Infancy 1-3 months; Infancy 8-10 months; Toddlerhood 15-18 months; and Toddlerhood 21-23 months. Percentages of completed assessments will be captured at each point listed above. Nurse home visitors use DANCE guidelines to plan education and make needed referrals based on individual findings.

HFA Family Support Specialists (FSS) will use one of the following during a home visit: 1) the Cues, Holding, Expression, Empathy, Rhythm, and Reciprocity (CHEERS) tool; 2) the Family Resilience and Opportunities for Growth Scale (FROG); 3) the CHEERS Check-In tool. At least one domain of CHEERS is documented in the second trimester of pregnancy beginning at 24 weeks gestation, and at least two domains of CHEERS are documented in the third trimester and for all families throughout the time they are enrolled. FSSs address parent-child interaction concerns and promote nurturing parent-child interaction, attachment, and bonding through parent-child activities, coaching, modeling, and educational and curriculum materials with all families based on CHEERS observations.

The Early Childhood Behavioral Health Programs Specialist will facilitate expansion of the mental health-focused home visiting model Child First into at least 20 additional NC counties, including strategies for strengthening outreach and referral relationships with Title V community service providers. The CMARC Program will include information about evidence-based infant and early childhood mental health-focused home visiting programs and other therapeutic services such as Child First as part of at least one statewide training to care managers.

Triple P LIAs will continue to support parents and caregivers of children from birth to 12 years old in their service areas through a variety of programs, including Triple P Online, seminars, one-on-one discussions, and discussion groups. Among these programs, Triple P LIAs will continue to offer Triple P Baby for new or expectant parents to learn proven strategies to understand their baby’s cues, nurture their development, handle challenges like crying and sleep, and build a strong bond as they change and grow.

Priority Need 4 – Improve access to quality whole child and adolescent health care

Priority Need 4 is similar to a former priority need found in the NC 2021-2025 State Action Plan, but this priority speaks to quality care for all children and adolescents both with and without special health care needs, thus the need spans several different domains. The NC Title V Program selected the Medical Home NPM (for non-CSHCN) for this priority need within the Child Health Domain.

CH PN4 Objective 1 By 2030, increase the percent of children without special health care needs having a medical home by 3% from 54.4% (NSCH 2022-23 baseline) to 56%.

The EI SMD and DCFW SMD will partner to provide a training that includes the importance of a medical home

approach to care during at least one NC Pediatric Society statewide event in FY26. In addition, the HFA and NFP programs will increase community outreach efforts about available home visiting services to new and existing primary care providers and the process for referring patients to the program.

In FY26, the WCHS Community Outreach Team will continue to incorporate messages about the importance of choosing a quality medical home (and making the most of health insurance benefits) in all outreach/enrollment activities.

Using the Whole School, Whole Community, Whole Child (WSCC) framework, the Regional School Health Nurse Consultants will review speaker proposal submissions for the 2025 Annual School Nurse Conference to ensure content promotes the integration of health (physical and behavioral) with the academic success of students. The selection of conference speakers will be based on a standard rubric which emphasizes school nurse best practice, competent nursing practice and the essential role of the school nurse related to whole child health. At the conclusion of the conference, participants will complete an evaluation which will be a tool to measure the success of presentations that feature whole child and adolescent health.

Home visitors will inform families enrolled in the NFP and HFA programs about the importance of choosing a medical home for their child during pregnancy and/or early in the enrollment process in FY26. The home visitors will also provide the names of practices in the community that serve as medical homes.

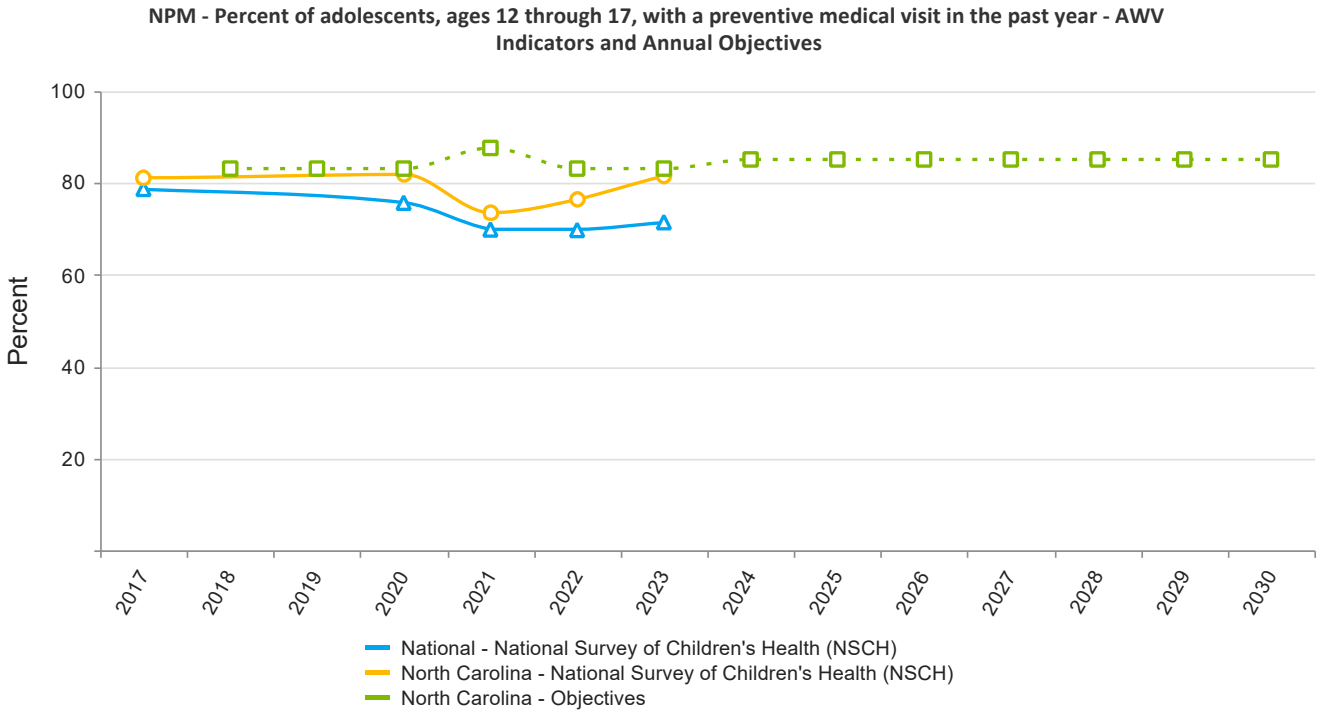
State supported SHCs will ensure a supportive medical home by continuing to seek and build a network of medical services and partnerships throughout the community and linking students and families with the services needed as direct referrals. When possible, SHCs are seeking and taking advantage of available funding opportunities to support the hiring of clinicians in-house to provide immediate clinical access for students. SHCs will also play a role in supporting student well-being by providing available access to health education and other resources related to mental health, anti-bullying, nutrition and other health related issues as a sustained approach to addressing student health. The state SHC consultant will support the enhancement of a medical home by providing professional development and educational training resources designed to address SHC healthcare provision. In addition, the consultant will collaborate with SHCs to collect, analyze and use health related data to identify opportunities to improve the quality and effectiveness of services provided. Data will be collected on a bi-annual basis.

The DCFW SMD and State Child Health Nurse consultant will continue to highlight the importance of serving as a medical home and communicating if not serving as the medical home as part of one of the NCPD provider webinars in FY26.

The State Child Health Nurse Consultant will change the NC CHERRN rostering collection form to collect number of well child visits under 11 years of age. The State Child Health Nurse Consultant, regional child health nurse consultants, and DCFW SMD will use statewide webinars and discussions with child health providers from LHDs to discuss strategies for how to increase child well visits provided at LHDs for children under 11 years of age.

Adolescent Health

National Performance Measures



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	83	83	83	83	85
Annual Indicator	87.3	72.4	72.4	76.3	81.5
Numerator	786,182	588,143	588,143	619,903	660,192
Denominator	900,582	812,116	812,116	812,165	810,229
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2020_2021	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	85.0	85.0	85.0	85.0	85.0

Evidence-Based or –Informed Strategy Measures

ESM AWV.1 - Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		24,225	8,000	17,000	20,000
Annual Indicator	16,676	7,656	16,169	18,265	18,379
Numerator					
Denominator					
Data Source	LHD/HSA and NC SHC Annual Report	LHD/HSA and NC SHC Annual Report	LHD/HSA and NC SHC Annual Report	LHD/HSA and NC SHC Annual Report	LHD/HSA and NC SHC Annual Report
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	20,000.0	20,000.0	20,000.0	20,000.0	20,000.0

ESM AWV.2 - Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		66.3	75	77	80
Annual Indicator		71.6	71.2	51.8	85.9
Numerator		4,334	5,073	5,207	7,476
Denominator		6,054	7,122	10,045	8,706
Data Source		LHD/HSA	LHD/HSA	LHD/HSA	LHD/HSA
Data Source Year		SFY20-21	SFY21-22	SFY22-23	SFY23-24
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	90.0	90.0	90.0	90.0	90.0

State Performance Measures

SPM 1 - Adult Mentor

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	86.6
Numerator	
Denominator	
Data Source	NSCH
Data Source Year	2022-23
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	87.0	88.0	89.0	90.0	90.9

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (North Carolina) - Adolescent Health - Entry 1
Priority Need
Improve access to quality whole child and adolescent health care
NPM
NPM - Adolescent Well-Visit
Five-Year Objectives
AH PN4 Objective 1 By 2030, increase the percent of adolescents with a preventive medical visit in the last year by 5% from 81.5% (Baseline 2022-23 NSCH) to 85.6%.
Strategies
AH PN4 1.1 Provide education and technical assistance to LHDs and to other statewide partners about the importance of recommended and required components of the annual well adolescent visit.
AH PN4 1.2 Subject matter experts in adolescent health, including behavioral health, will provide training on adolescent health needs and provision of services at the Annual School Nurse Conference.
AH PN4 1.3 School Health Centers (SHCs) will continue to be credentialed to assure they are providing primary and preventive adolescent health services in line with national SHC performance measures including behavioral health screening, and referral for management and/or treatment in collaboration with outside behavioral health providers or internal to the SHC when behavioral health services are offered locally.
AH PN4 1.4 Partner with youth statewide through the Youth Health Advisor (YHA) Team to promote youth voice within programs and positive public health messaging to adolescents across the state.
AH PN4 1.5 Increase the number of well child visits for adolescents 12 years of age and older provided by Child Health Enhanced Role Registered Nurses (CH ERRNs).
AH PN4 1.6 All child health clinical staff (i.e., CH ERRNs, physicians, advanced practice, providers, etc.) will continue to deliver quality adolescent health care to vulnerable populations at LHDs. Regional and state consultants will provide TA and monitoring to all child health clinical staff along with continuing education opportunities.
AH PN4 1.7 WCHS will provide technical assistance, consultation, training and/or monitoring on how to develop and implement health care transition strategies to local health department staff to help them meet the requirement from the Health Check Program Guide to address health care transition as part of well visits.
AH PN4 1.8 WCHS will explore technical assistance strategies for School Health Centers related to health care transition for adolescents and their families.

ESMs	Status
ESM AWV.1 - Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center	Active
ESM AWV.2 - Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department	Active

NOMs

Teen Births
Adolescent Mortality
Adolescent Motor Vehicle Death
Adolescent Suicide
Adolescent Firearm Death
Adolescent Injury Hospitalization
Children's Health Status
Child Obesity
Adolescent Depression/Anxiety
CSHCN Systems of Care
Flourishing - Child Adolescent - CSHCN
Flourishing - Child Adolescent - All

State Action Plan Table (North Carolina) - Adolescent Health - Entry 2

Priority Need

Promote safe and nurturing relationships for children and adolescents

SPM

SPM 1 - Adult Mentor

Five-Year Objectives

AH PN3 Objective 1 By 2030, increase the percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance by 5% from 86.6% (2022-23 Baseline) to 90.9%.

Strategies

AH PN3 1.1 WCHS staff members will provide statewide trainings and technical assistance on assessing and addressing mental and relational health and promoting safe, stable, nurturing relationships and positive childhood experiences with youth and their families to LHD child health clinical staff, and private health care providers caring for and/or supporting adolescents.

AH PN3 1.2 Positive Parenting Program (Triple P) Local Implementing Agencies will promote and connect parents and caregivers to the Triple P Teen parenting support intervention for parents and caregivers of teenagers up to 16 years of age.

AH PN3 1.3 School nurse conference and regional meetings will provide training and resources for school nurses about promoting need for adolescents to have positive childhood experiences and safe, stable and nurturing relationships.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

Priority Need 4 – Promote Safe, Stable, and Nurturing Relationships

An early childhood system of care ensures comprehensive, coordinated, individualized, family-driven services and supports for young children and families. The WCHS promotes the integration and coordination of discrete child and parent/caregiver services across all service sectors into a comprehensive system that "connects the dots" within the service community by participating in or facilitating many collaborative activities at the state, regional, and local levels. Through multiple collaborative opportunities, the WCHS convenes internal and external partners in planning and implementation of programs, including those supported by Title V funds. The Title V Office supports a system of care that uses a public health model to provide a continuum of care, promoting positive well-being, preventing problems in high-risk populations, and intervening/treating in a comprehensive manner when problems do arise. It is the collaborative relationships among the provider agencies, parents/caregivers, human services agencies, schools, child care, and other partners, along with a common set of values and goals that enables providers to see the broader needs of families, set aside turf issues, and utilize existing or build community services to benefit the health and well-being of infants, children, adolescents, and their families.

North Carolina is one of twelve states receiving funding from the Centers for Disease Control and Prevention (CDC) for Essentials for Childhood: Preventing Adverse Childhood Experiences through Data to Action. The current North Carolina Essentials for Childhood (NC EfC) Initiative is funded for five years (9/1/23 – 8/31/28). This is the third iteration of CDC's Essentials for Childhood and is currently emphasizing preventing adverse childhood experiences (ACEs) and promoting positive childhood experiences (PCEs) through upstream strategies; documenting and strengthening state surveillance of ACEs, PCEs, and social drivers of health; and proactively monitoring and using data to inform action such as modifying or developing prevention strategies, outreach to current and new partners, and disseminating data to communities and state-level stakeholders.

NC has been a recipient since the beginning of the CDC Essentials funding in 2013. In FY24, the administrative home for NC EfC in the Division of Public Health moved from the Title V Office to the Injury and Violence Prevention Branch (IVPB), part of the Chronic Disease and Injury Section. IVPB is the recipient of several CDC Cooperative Agreements focused on primary prevention, including Overdose Data to Action, the Comprehensive Suicide Prevention Program, the Rape Prevention and Education Program, and the Core State Injury Prevention Program, which also includes a focus on preventing ACEs. Moving the EfC program to IVPB increases effectiveness by consolidating similar programs together to enhance cross-topic collaboration and increases efficiency of administrative oversight and the support of the IVPS's epidemiology team.

For the current cooperative agreement, NC EfC is continuing to focus on policies that promote financial stability and economic mobility for families, including promoting the establishment of family friendly workplaces, increasing eligible tax filer uptake of the Federal Earned Income Tax Credit (EITC), and educating about the benefits to children and families of a refundable state EITC and a state Child Tax Credit. EfC accomplishments in FY24 included:

- Continued a partnership with the NC Institute of Medicine (NC IOM) to serve as the backbone organization for EfC and to administer subcontracts with four partners who have been supporting EfC strategies for many years: NC Child, Positive Childhood Alliance NC (PCANC, formerly named Prevent Child Abuse NC), MomsRising, and the NC Early Childhood Foundation (NCECF).
- Continued a partnership from previous EfC funding with the University of North Carolina Gillings School of Global Public Health and contracted the time of Dr. Meghan Shanahan to lead the work on establishing a surveillance system for ACEs, PCEs, community health factors, and identifying strategies for using the surveillance data to inform action. Dr. Shanahan also serves as the project evaluator.
- Provided supporting funds for the inaugural 2024 NC State of the Child Summit that was co-led by the NC IOM and NC Child and held on April 30, 2024. The Summit sold out tickets in one day and will be held annually moving forward with the next one scheduled for April 15, 2025.
- Continued to work with the four subcontracted partners to promote family friendly workplace policies, the development of a toolkit with educational information about the benefits of a refundable state EITC, and the refinement of a social norms campaign to prevent ACEs and promote PCEs.
- Partnered with the NCIOM to develop the Essentials State Action Plan to Prevent ACEs and Promote PCEs by revisiting and updating key priority recommendations from the 2015 North Carolina Institute of Medicine's

Task Force on Essential for Childhood and developing new recommendations to address current contexts, needs, and strengths. Work started during this reporting period but will conclude with the publication of the new state action plan in February 2025.

- Began planning alongside Dr. Shanahan and the NCIOM for a series of meetings with a data working group to define and identify the surveillance system for ACEs, PCEs, and community health factors as well as thresholds to guide data to action. The meetings will be held in the fall of 2024.

Infant Early Childhood Mental Health

DCFW is charged with working to meet the health, social and emotional needs of children, youth, and families in NC. Behavioral health is one of the Division's priority areas. DCFW programs and other efforts fall along a promotion, prevention, and treatment continuum to provide parents and caregivers and their young children with different levels of supports and resources to promote social and emotional development and prevent, mitigate, and improve timely access to evidence-based screening, assessment, management, and treatment for mental health concerns.

Infant early childhood mental health (IECMH) has been infused into NC Psychiatry Access Line (NC-PAL) efforts. NC-PAL completed a pilot with three CDSAs to implement IECMH educational and case-based curriculum about identification and support of social emotional development of children and families. The DCFW SMD assisted NC PAL's early childhood lead physician in the planning and debriefing of the CDSA pilot efforts which were used to plan for future CDSA pilots.

DCFW has many additional programs and efforts that are addressing IECMH. However, many programs and staff are not aware of all IECMH efforts across units and sections, and there is not always integration or collaboration around IECMH work. The DCFW Senior Medical Director (SMD) served as the leader of an IECMH planning group of about ten staff members from the WCHS which included the Title V CYSHCN Director and several CDSA directors in the Early Intervention Section in DCFW. The IECMH planning group reviewed a DCFW landscape survey and decided that reconvening the Early Childhood Matrix Team (ECMT) around IECMH was not the best way to approach this work. The IECMH planning group was able to work with UNC's Frank Porter Graham Child Development Institute (FPG) who helped guide this group through the strategic planning process from January 2024 through June 2024. The IECMH planning group invited two staff from the Division of Child Development and Early Education (DCDEE) and a WCHS Family Partner to participate in this more formal and newer phase of strategic planning with FPG. The Child Behavioral Health Unit manager and DCFW SMD met with FPG to determine the following scope of:

1. Determine an agreed upon shared definition of IECMH;
2. Determine priority area(s) internal and external to DCFW related to IECMH;
3. Create and use a survey, in-person conversations, and other processes to develop an inventory of internal and external practices, efforts, and partnerships that also include challenges and barriers;
4. Have DCFW programs and staff decide on a priority area *internal and external to DCFW (small piece)* and try to address several elements of that IECMH priority: policy, workforce, practice (i.e., screening, management, and treatment), interface with families, and funding to work on that area of IECMH;
5. Determine data to collect or use to measure how improvement on the internal and external priority for DCFW is achieved; and
6. Create an action plan to address the shared priority areas for DCFW in IECMH.

The DCFW Early Childhood Behavioral Health Programs Specialist (ECBHPS) joined the IECMH Planning Group in January 2024. The ECBHPS supported the group's identification of the three policy priorities which will be addressed through an action plan to be developed by the group and to guide the next phase of the work. The ECBHPS will lead efforts for the group's next phase through development and implementation of the action plan.

One of the key external IECMH efforts is the EarlyWell initiative to promote public policies that enhance the social-emotional health of children aged 0 to 8 and families in NC. EarlyWell continued to be led by NC Child, in collaboration with early childhood leaders including the NCECF, to promote and enact recommendations from the Pathways to Grade-Level Reading Action Framework, and to build a robust, evidence-based, and accessible early childhood social-emotional health system in NC. Title V staff members continued to participate on the EarlyWell Initiative advisory committee, joined by the DCFW ECBHPS. An important report from June 2022, *From Equity to*

Issue Campaigns: The Next Stop on the Road Map to Childhood Mental Health in North Carolina, was designed to organize and categorize the problems and solutions identified by families, Title V staff and others on the advisory committee, and other partners. This report continued to inform IECMH efforts during FY24. EarlyWell initiated work on three policy priorities which will carry into FY25: specific supports for families navigating a disability; a program for pediatricians to help foster language rich interactions between parents and children; and policy change to reduce barriers for families to get licensed as Kinship Care Providers.

In addition to these efforts, representatives from the WCHS participated in an external IECMH Consultation cross-sector workgroup of multiple partners focusing on expansion of IECMH consultation in the state. The group is facilitated by Dr. Marian Earls and staff from the NC Infant Mental Health Association. In FY24, the external IECMH Workgroup distributed a survey for advocates and for those professionals who provide IECMH consultation, in order to determine the extent of needs and activities in NC related to IECMH consultation. Survey results identified consultation activities and access points and can be used to inform future expansion efforts. The external Workgroup continued efforts to align IECMH efforts across the state, such as providing input into the NC Partnership for Children's Smart Solutions Catalogue, which details IECMH as "non-clinical TA-consultation and coaching service designed for Early Childhood Education professionals."

The State Child Care Nurse Consultant (SCCNC) and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Professional Development Coordinator participated in the Yay Babies! work group, which collaborates with DCDEE to engage partners and promote access to early childhood services for young children experiencing homelessness. In FY24, Yay Babies! and DCDEE published the comprehensive *Action Plan for an Early Childhood Homelessness Support System: Unleashing the Potential of our most Vulnerable Children to Raise North Carolina*. In FY24, Yay Babies! presented at a MIECHV Regional Meeting to train home visitors to support families experiencing homelessness. Resources on homelessness services by county were provided as well as links to access prerecorded trainings for home visitors and parents featuring a parent consultant sharing their lived experience with homelessness.

Developmental Screening NPM – Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed tool in the past year

The NC Title V Office chose to continue to use the Developmental Screening NPM and the corresponding ESM DS.1 (Percent of LHDs whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children during state fiscal year) to monitor its success at increasing appropriate, ongoing, and timely screenings in all of these areas for children. Working within this comprehensive system of care, the NC Title V Program is focused on collaborative strategies to increase the percent of children receiving a developmental screening, increasing discussions with parents and caregivers about their child's developmental progress, sharing anticipatory guidance (i.e., Bright Futures, Learn the Signs. Act Early [LTSAE] materials, the importance of books and reading using Reach Out and Read) and ensuring that families can access timely and appropriate care for further assessment. Per the 2022-23 NSCH, 47% of children in NC between 9-35 months had received appropriate developmental screening which is higher than the national average of 35.6%. This is an increase from the 2021-22 NSCH state percentage of 37.1%, as confidence intervals for the two time periods overlap, it's probably not a significant increase. (Developmental Screening NPM).

The WCHS helps support the provision of preventive health services to children from birth to 21 years of age primarily through LHD clinics and outreach to primary care providers through the NC Pediatric Society (state chapter of the AAP) which incorporate developmental surveillance and/or multiple types of screenings (i.e., behavioral health, psychosocial) including developmental screenings at each well visit. LHD providers include child health providers in the clinic providing direct clinical care as well as Care Management for At-Risk Children (CMARC) care managers providing service to members in their homes or other locations. Developmental screenings continued to be required at 6, 12, and 18 or 24 months and then at 3, 4 and 5 years of age by all Medicaid providers including those in LHDs during well child visits. Developmental screenings are also required at other visits when there are concerns that come up related to developmental surveillance. The NC Medicaid schedule of recommended visits and screenings are based on 2021 Bright Futures guidelines which are described in detail in the 2021 NC Medicaid Health Check Program Guide (HCPG). In FY24, 80% of the 66 LHDs providing clinical services for children had staff members

who had been trained in appropriate use of screening tools (ESM DS.1).

Efforts to Increase Screening for Developmental, Psychosocial, and Behavioral Health Concerns

The WCHS State Child Health Nurse Consultant (SCHNC), Regional Child Health Nurse Consultants (RCHNCs), and the DCFW SMD who also serves as the Pediatric Medical Consultant for Title V, conducted monthly 30-minute webinar trainings entitled *Strategies and Recommendations: Helping with Delivery of Child Health Services* for child health clinical staff and CMARC care managers working in LHDs. These webinars included information to connect staff with resources such as NC-PAL, Statewide Peer Warmline, CYSHCN Hotline, and NC Child Behavioral Health Dashboard. The Child Health webinars also provided child health program clinical staff and CMARC care managers with resource information for: breastfeeding, WIC updates, infant formula shortage, NCDHHS State Action Plan for Nutrition Security, nutrition programs, SUN Bucks (provides grocery-buying benefits to qualifying families with school-aged children during the summer months when schools are on summer break), safe sleep, respiratory viruses (COVID-19, flu, RSV), immunization updates, pertussis, monkeypox, measles, congenital syphilis, health literacy, human trafficking, national birth defects awareness, 4th Trimester Project, fetal alcohol spectrum disorder, autism awareness, general developmental screening – Parents Evaluation of Developmental Status – Revised (PEDS-R), Parents Evaluation of Developmental Status – Developmental Milestones (PEDS-DM), and Survey of Well-being of Young Children [SWYC]), tobacco use, Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) screening, dental health, NC Lead Poisoning and Prevention program, NC Sickle Cell program, asthma and asthma action plans, community health factors, foster care, school health assessments, preparticipation physical exams, adolescent health, suicide prevention, preparedness, Medicaid Expansion, and Tailored Plans. The DCFW SMD also provided one presentation to the NC Pediatric Society members, one to pediatric providers in the southeastern AHEC region, and two updates to pediatric providers in the western area of the state served by one of the hospital systems . Presentations by the DCFW SMD emphasized the need to continue to provide whole child health care which includes developmental, social-emotional, and mental health screenings. The presentations all included information about infant formula shortages, breastfeeding, respiratory virus updates (COVID-19, RSV and flu) and especially about changes in vaccine recommendations, referrals to EI services, and the processes available to physicians for exchanging information such as developmental screening results with EI service providers.

Monthly *Clinic Connections* for LHD Child Health Providers & Clinical staff started in May 2024 by the DCFW SMD and the SCHNC. The purpose of *Clinic Connections* is for child health clinical staff to bring issues, hot topics, and questions to the group and learn from other providers and clinical staff working in LHDs.

Child Health Program monitoring visits were held either virtually using Microsoft Teams (MS Teams) or onsite at the LHD during FY24. Due to the demands of COVID-19 on LHD staff, the Child Health Program Monitoring – Clinical Chart Review process was adjusted to provide additional TA to LHDs prior to being required to develop a corrective action plan (CAP) if findings were identified.

The SCHNC and RCHNCs continued to provide TA to LHD providers seeing clients seen in LHDs on the Medicaid requirement to provide, document, and discuss the results of developmental screenings with families (regardless of the score), promote anticipatory guidance, and review the charts for other items. Nurse consultants, along with the DCFW SMD, continued to update LHD staff members on minor changes to the current NC Medicaid requirements and reinforced the need for ongoing developmental screenings using validated tools. The NC Infant-Toddler Program continued with training to increase use of screening using the Ages and Stages Questionnaires®: Social-Emotional statewide.

A valuable webinar was created in 2020 by two developmental and behavioral pediatricians who were authors of the 2020 AAP policy statement titled *Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening*. Staff continued to promote this archived webinar with Child Health Training Program (CHTP) students during FY24 to increase knowledge, skills and abilities related to developmental surveillance and screening.

The following additional statewide webinars were provided to child health program clinical staff and CMARC staff:

- July 2023 – Clinical Asthma Education July 2023 – Environmental Asthma Triggers: A Training for Public Health Professionals

- October 2023 – Calling All Smile Crusaders

Consultation and TA were provided to several new LHD providers and current providers who presented questions regarding well child visit components. Guidance was provided related to developmental, behavioral, and maternal depression screening as well. The DCFW SMD continued to use a self-assessment tool which was shared with new providers as well as providers serving as preceptors for the CHTP so that they could rate their knowledge, skills and abilities related to all of the well child preventive visit components including developmental, behavioral, and maternal depression screening. This self-assessment tool has continued to assist the DCFW SMD with providing specific TA to meet the needs of the individual providers related to evidence-based strategies to support developmental screening, anticipatory guidance, management, and referral.

Healthy Families America (HFA) and Nurse-Family Partnership (NFP) home visiting models complete developmental screenings with enrolled families between ages 4 months to 30 months. The Health Resources and Services Administration (HRSA) funded MIECHV program measures the number of children aged 9 months to 30 months with at least one completed screening within the AAP-defined age groups conducted by their home visitor during each reporting year. All sites use the Ages and Stages Questionnaires® to complete this performance measure. In FY24, the developmental screening completion rate for all participants at MIECHV sites was 90.6%. Separate from MIECHV, the HFA and NFP home visiting models also complete the Ages and Stages Social-Emotional Questionnaires at 6, 12, 18, and 24 months of age. HFA programs conduct developmental screens during home visits at a frequency greater than required by HRSA.

During FY24, the PNC continued to integrate and enhance breastfeeding education, family engagement and Life Course Nutrition into the Child Health program through trainings conducted as part of the CHTP and through other Child Health opportunities, including work with programs that specifically target CYSHCN. The PNC also coordinated with the PMC/SMD and provided nutrition and weight inclusive TA for a presentation she delivered for CHTP students in January 2024 on the new AAP Clinical Guidelines for Childhood Obesity and Overweight. TA resulted in less emphasis on weight and more focus on growth and included additional information on weight stigma and use of clinical practices and environmental changes that support children living in bigger bodies.

Efforts to Improve Preventive, Screening, Assessment, Diagnostic, and Treatment Health and Well-Being Services

The 2023-2024 Child Health Training Program (CHTP) was provided in a combination of onsite and virtual training sessions using MS Teams technology. Six training opportunities were presented during the CHTP which included information on developmental, psychosocial, and behavioral screening. Ten Public Health Nurses successfully completed the CHTP and were rostered as Child Health Enhanced Role Registered Nurses (CH ERRNs). DPH and DCFW have a memorandum of understanding with DHB (Title V agency agreement) to train and roster CH ERRNs. Only rostered CH ERRNs may bill the Division of Health Benefits/NC Medicaid for services or use Title V funds to support preventative services. CH ERRNs practice within the North Carolina Nurse Practice Act. Training and rostering allow the CH ERRN to bill for Medicaid services, but does not extend the RN scope of practice. The NCDHHS Office of Chief Public Health Nurse (OCPHN) and the Child Health Program work collaboratively to support the CH ERRN. OCPHN consultants provide nursing scope of practice and billing and coding guidance. Child Health Nurse Consultants provide Health Check Program Guide and programmatic guidance and training as well as quality improvement resources.

During FY24, the CMARC program continued collaboration with other agencies and programs, such as CMHRP, NC Integrated Care for Kids (NC InCK) model, Healthy Opportunities Pilot (HOP) Division of Social Services, Children and Families Specialty Plan (supports Medicaid-enrolled children, youth and families served by the child welfare system), Local Management Entities/Managed Care Organizations (LMEs/MCOs), NCCARE 360, and Child First Initiative to ensure an effective system of care. The CMARC program required staff to collaborate with medical homes in their communities, both at the system level for effective identification of children in the CMARC target population and at the individual child level for children engaged in CMARC services, as collaboration with the medical home will ensure the healthiest outcomes for the child. CMARC staff also continued to support the work of NCDHHS' Plan of Safe Care (POSC) for substance affected infants. The CMARC program continued to encourage staff to navigate enhancements and reports in Virtual Health/Care Impact Platform documentation systems. The CMARC staff provided TA and training to ensure program expectations were met as described in the Program

Guide Management of High-Risk Pregnancies and At-Risk Children in Managed Care.

CMARC state staff continued to work closely with NC Medicaid, Prepaid Health Plans (PHPs), DPH (CMHRP), CCNCs, and LHDs as needed during FY24 to assure that care management services for the birth to five population were maintained and enhanced through NC Medicaid Managed Care, thereby promoting the use of the medical home, linking children and families to community resources, and providing education and family support. To ensure these services continue to be provided in a seamless fashion during the move to managed care, staff also assisted with updating the CMARC Program Guide and collaborated with DHB to update the process for LHDs to have first right of refusal to terminate or transfer CMARC coverage to another county or entity. The Companion Guide for Care Management Service Termination and Transfer of Services was reviewed by CMARC staff, CMHRP staff, and DHB to update the document in January 2024. Staff participated in PHP quarterly meetings with DHB to collaborate and discuss the needs of the high-risk population aged 4 years and 364 days. CMARC staff continued to ensure children who were eligible for Tailored Care Management (TCM) had a warm handoff to staff at the LMEs/MCOs. CMARC staff provided education through trainings and TA during the timeline for CMARC baseline and final assessments as well as contract changes as part of the Medicaid Managed Care process.

The DCFW SMD participated in two NC DHHS Medicaid Expansion work groups to help coordinate interdepartmental efforts. DCFW SMD developed a Medicaid Expansion training that was required for all DCFW staff to complete by December 1, 2023. About 760 staff members (>80%) completed the training by December 1. DCFW staff logged any presentation on Medicaid Expansion delivered to a variety of partners including families from November 2023 through March 2024. There were seventy presentations provided for more than 2,400 people across the state. The DCFW SMD provided Medicaid Expansion training to CMARC staff statewide in January 2024 as well as seven additional trainings to partners. The Minority Health Outreach Program Manager provided almost 40 presentations to partners across the state. The DCFW SMD and CMARC interim program manager have begun to develop a process for using a script for CMARC care managers to generate a conversation that points families, caregivers, and guardians to Medicaid as an option for health care coverage for parents, caregivers, guardians, or siblings who are 19-64 years of age. The goal is to have CMARC care managers routinely discuss Medicaid as an option with initial contact with the parent/caregiver and any time there are changes in life circumstances (loss of a job, decrease in income, death of spouse, divorce, change in family size due to birth or adoption) for the family or caregiver. It is also important to discuss Medicaid as an option when the child stops receiving CMARC services.

The following additional statewide webinars were provided for CMARC staff:

- November 2023- CMARC Assessment Training
- Jan 2024- CMARC Assessment Measures and Scoring Training
- March 2024- 4th Trimester: A Village for New Mothers
- May 9, 2024- Child Welfare & Foster Care Training
- June 2024- Sun Bucks overview

Another effort to improve treatment services was undertaken by the PNC who provides regular and timely monitoring, TA and consultation for AA 353 provided to the Durham County Department of Public Health (DCDPH) that supports provision of medical nutrition therapy (MNT) and nutrition consultation services (up to $20,000) for children referred to the LHD with no other funding source. These are often children with special nutritional needs. During FY24, DCDPH provided 468 MNT units and 84 patient consultations with medical providers, with 81 new clients and 86 follow-up clients served with AA353 funding. Durham County reported that positive changes in behavior, knowledge, weight and/or clinical measures occurred in 97% of subsequent nutrition visits in FY24 for all clinic nutrition services. A client case study provided by DCDPH nutrition staff showed improved clinical measures (HgA1C, etc.) and quality of life.

Positive Parenting Program (Triple P)

The Positive Parenting Program (Triple P) System in NC consists of the NC State Partnership for Strategy and Governance (PSG), the NC Triple P Support System (which consists of Triple P America, The Impact Center at UNC FPG, and Positive Childhood Alliance), the Triple P Design Team (The Impact Center and Triple P America), and the lead implementing agencies (LIAs). This system remained in place for 2024 and continues to practice model

flexibilities designed to maximize LIA and practitioner service delivery. The PSG (leadership level) continued to practice flexibility with regards to deliverables, especially relative to the “Scale-Up Plan.” LIAs are making efforts to work towards their developed goals and objectives based on community need and infrastructure to determine scaling counties (those with Triple P online and levels two to four) and supporting counties (non-scaling) to allow for flexibility. The current operating principle is that the Scale-Up Plan, which emanated from the Strategic Plan, is a “living” document, and allows for the flexibility of editing and revising at any time that it is a reasonable expectation to do so. The NC Triple P Support System worked with each LIA to assess the training and support needs of local practitioners to deliver Triple P as part of their work.

In FY24, the WCHS continued to support the Triple P System in NC through Title V and the NC Division of Social Services (DSS) funding by employing a State Triple P Coordinator, funding the LIAs for infrastructure and training support, and providing a part-time data specialist to work in coordination with the WCHS Data Manager to support statewide data collection and reporting and using data for local CQI projects.

In addition, the WCHS continued partnering with the NC DSS to support Incredible Years and Strengthening Families cohorts in local communities and integrate those evidence-based family strengthening programs with Triple P as those initiatives are very compatible and integrate well with Triple P. The WCHS continued to receive funds from DSS to provide additional funding for the LIAs and provide a co-chair for the PSG with the State Triple P Coordinator serving as the other co-chair. DSS continued to utilize the Triple P evidence-based program in their menu of approved family strengthening programs, that can be supported by local DSS funds.

During FY24, the Triple P State Learning Collaborative, consisting of all the coordinators at the LIAs, continued to provide a learning environment in which coordinators met to learn, share, and plan to implement best practices, offer collective problem solving and efficiencies, determine sustainability needs, and encourage model fidelity based on the Triple P Implementation Framework. The Collaborative members are an incredibly effective group of Triple P partners/coordinators who consistently provide perspectives for quality assurance and improvement for the operationalization of the Triple P Program.

With the addition of state appropriations transferred from DSS to the DCFW under an annual agreement, Triple P coverage has been expanded to all 100 counties in NC, which includes Triple P Online that is available statewide at no cost to families. In addition, hybrid support continued to be offered to families. Hybrid support refers to the active engagement of a practitioner in aiding a caregiver's comprehension of the Triple P Online modules' content and lessons. This involves the practitioner regularly checking in with the caregiver, providing answers and clarification for module concepts, assessing the caregiver's understanding of the learning goals, and encouraging the completion of all modules.

There was an ongoing focus for FY24 to reconnect with all the practitioners trained in the Triple P model to determine their status for continuing to provide Triple P services to families of children and teens. A combination of funding from Title V and DSS provided support to the LIAs to maintain three local coordinators, support training for practitioners, and purchase outreach and media materials to promote Triple P in their service area. The partnership between DCFW, DSS and The Duke Endowment has continued to support the implementation of Triple P. To ensure consistent delivery and availability of model implementation in all regions, a process referred to as the “Practitioner Round-Up” continued to be implemented that required all LIA Coordinators to seek out and follow up with all trained practitioners to assess their current status relative to delivery of the model at their agency. This process is in place to ensure that investments made in practitioner training at the local level are being sustained with full access to Triple P services as needed. The Practitioner Round-Up survey has been transformed into the Practitioner Impact and Needs Evaluation (PINE) report since the “Round-Up survey process proved to be a challenge in some cases with practitioners moving outside the service delivery region and/or having changed agencies or careers, thus no longer providing services. The hope for the PINE report is to streamline data collection processes for LIAs and practitioners informed by regular input from LIA data team leads during weekly data team meetings in addition to data requests from funders.

Four ICO4MCH project sites (covering eight counties) selected Triple P as one of their evidence-based strategies to improve health among children ages zero to five during FY24. Durham County implemented the Family Connects Home Visiting Program.

In FY24, in various disciplines, sectors and settings, the Triple P Program newly accredited 165 practitioners with the top settings being Children's Developmental Services Agencies, Mental Health Agencies and Community Resource Centers. Triple P had 782 practitioners in position to deliver services and reached 9,719 children in FY24.

NC Child Care Health Consultation Resources

The State Child Care Nurse Consultant (SCCNC) position, supported by Title V and Child Care and Development Block funding, collaborated in FY24 with programs within WCHS and other state partners to advance early childhood public health initiatives. The SCCNC worked closely with the NC Child Care Health and Safety Resource Center (CCHSRC) to support the health and safety of children aged 0 to 5 years attending early care and education programs through child care health consultation (CCHC). The CCHSRC is jointly funded through Title V and the Child Care and Development Block Grant (partnership with DCDEE). The SCCNC collaborated closely with the CCHSRC to deliver training, technical assistance, and coaching to 74 local and regional Child Care Health Consultants (CCHCs). These consultants provided support to 5,505 licensed child care programs statewide, including direct services to 3,377 centers for a total number of 4,379 encounters.

The SCCNC and CCHSRC continued to provide support to hiring and funding agencies in CCHC expansion counties and provided coaching for CCHCs and their supervisors. In FY24, the CCHC System Workgroup consisting of representatives from DCFW, DPH, CCHSRC, DCDEE, NC Partnership for Children (NCPC), the NC CCHC Association, and local NCPC Smart Start agencies met monthly to continue with implementation of a strategic plan. The SCCNC served as co-facilitator of the meetings. Five core agencies including CCHSRC, DCFW, DPH, DCDEE and NCPC provided a joint governance structure for the NC CCHC system.

The CCHSRC hosted two cohorts of the NC Child Care Health Consultation (CCHC) course for a total of nine new CCHCs. The SCCNC and CCHC coaches served as course instructors. Three participants completed the December 2023 course and six completed the May 2024 course. Medication Administration and Child Care Development Fund Overview Train-the-Trainer Courses were offered within both cohorts of the CCHC course. The SCCNC collaborated with local partners to offer the CCDF Health and Safety Overview Train-the-Trainer courses twice to CCHCs during FY24.

The Infant/Toddler Safe Sleep and Sudden Infant Death Syndrome (ITS-SIDS) Risk Reduction in Child Care (ITS-SIDS) course was offered in three cohorts resulting in 34 new trainers. Three ITS-SIDS trainers completed the ITS-SIDS Course for Trainers Refresher course in November 2023, and two trainers completed the course in June 2024. Ongoing training support has continued to be provided to ITS-SIDS trainers this fiscal year. At the time of this report, there were 323 active ITS-SIDS trainers. The Emergency Preparedness and Response (EPR) course was offered two times to CCHCs and other technical assistance providers across the state, resulting in 21 new active EPR trainers. Two EPR trainers successfully completed the EPR Course for Trainers Refresher in December 2023. Both ITS-SIDS and EPR courses are reviewed annually and offered to CCHCs and other technical assistance providers.

In FY24, the SCCNC, serving as a nurse planner, partnered with the CCHSRC to provide professional learning opportunities for CCHCs on various health and safety topics relevant to young children in early care and learning settings. Topics included: *Infant and Young Child Feeding in Emergencies (IYCF-E)*, *Communicable Disease*, *Infant Child Social and Emotional Wellbeing*, and *Policy Development and Implementation*. The CCHC Learning Collaboratives were designed to provide foundational knowledge of a given topic by a subject matter expert followed by an opportunity to experience peer-to-peer learning and explore practical application. The SCCNC and CCHSRC staff engaged with internal and external partners from CMARC, a local CDSA, DCDEE, DSS, PCANC, early educators, and the Asthma Alliance of NC in this collaboration. On average, 38 CCHCs serving child care facilities across the state participated in the learning collaboratives. Additionally, there were two cohorts with 22 CCHCs who attended the new *Fundamentals of Health and Safety in Child Care* course.

The SCCNC continued meetings with Carolina Global Breastfeeding Institute (CGBI) to promote and prepare to train CCHCs in IYCF-E practices developed by CGBI. Four cohorts were provided with this training for a total of 25 participants. The SCCNC worked in partnership with technical assistance partners to revise the Breastfeeding Friendly Child Care Training in preparation for the SCCNC and CCHSRC to provide and host the training and "Train

the Trainer" courses in FY25.

The CCHSRC developed and distributed four quarterly e-newsletters with health and safety themes that were made publicly available in English and Spanish. Topics included *It's the Little Things: Preventing Food Borne Illness in Child Care* and *Equipping Early Educators*. Additionally, the CCHSRC hosted a toll-free line/website inquiry form with a total of 665 contacts: 524 via the website, 120 phone calls, and 21 emails. These contacts were responded to through the CCHSRC in collaboration with the SCCNC's input, if needed.

Sixty CCHCs attended the annual NC CCHC Conference in September 2023. The SCCNC partnered with a group of three active CCHCs to participate in a panel discussion centered around educating the audience about how to build rapport with child care facilities and strategies for using the quality improvement cycle. The SCCNC highlighted the importance of the regional coaches, learning collaboratives, DCFW, local health departments, and local partnerships as front line supports for the CCHCs in the field.

SPM#3 – Percent of children with two or more Adverse Childhood Experiences (ACEs) as measured through the NSCH (which is now also a NOM)

One measure of the NC Title V Program's success at promoting safe, stable, and nurturing relationships is SPM#3, percent of children with two or more ACEs, which is now also a National Outcome Measure. This indicator was also selected as one of the Healthy NC 2030 indicators and is part of the ECAP. Results from the 2022-23 NSCH indicate that 17.3% of children in NC experienced ≥2 ACEs as reported by their parents. It is comparable to the 2022-23 national rate of 17.5% and an increase from the baseline 2018-19 NSCH for NC of 15.4%, although the confidence intervals overlap so it is probably not a significant increase.

The DCFW SMD served as a co-lead for three of the NC DPH/DHHS 16 community council work groups working on the 21 Healthy People 2030 indicators as part of the annual update to the NC State Health Improvement Plan (NC SHIP). These work groups included DCFW or DPH Title V staff members among those represented agencies and also included local community partners and partners across the state. The three work groups addressed the indicators related to third grade reading proficiency, short term suspensions, and ACEs. The ACEs work group decided on two priority areas in their discussions for potential action: improving data available on trauma and ACEs at the local level and increasing funding for and embedding community-rooted, culturally affirming family and community support programs into existing initiatives. Short term suspension (STS) is not formally considered one of the 10 ACEs but is often associated with ACEs. The priorities decided by the STS work group included: disrupting the school-to-prison pipeline, beginning with early childhood programs by reducing the use of short term suspensions and expulsions in pre-K through third grade, and increasing different racial, ethnic, gender, and disability status among school and childcare leadership and staff.

In FY24, several programs which provided direct services to clients regularly assessed families of infants, children, and youth for ACEs (i.e., interpersonal safety) as part of health screening. Programs and services supported by Title V and implemented at the local level included CMARC, the Child Health Program in LHDs, MIECHV, child care health consultation, Triple P, School Health Centers (SHCs), the EHDI program, and school health nurse services.

Efforts to Support the Learn the Signs. Act Early. and Reach Out and Read Campaign

The Survey of Well-Being for Young Children (SWYC), which was first required for use as a screening tool with all CMARC-engaged families in April 2018, continued to be a required screening tool in FY24. Additional TA has been provided to CMARC staff and health care providers in LHDs and private practice on the use of the SWYC tool and on linking with resources to address concerns in the community. CMARC care managers continued to conduct general developmental screenings using the Life Skills Progression Assessment, share the results with the appropriate medical home practitioners, and facilitate EI referrals. In addition to the previously documented activities regarding the use of LTSAE materials in FY24, the CMARC staff continued to provide LTSAE and the CMARC Education Standard with Matrix to promote child development and strong parent-child relationships. The NC ITP also promoted the LTSAE campaign both on its website and by sharing it with families seen at the CDSAs. In March 2024, the MIECHV Professional Development Coordinator received LTSAE materials to give to MIECHV sites. CMARC used Patient Education Standards to deliver a core set of educational interventions according to an

established timeline to all patients receiving CMARC care management as well as providing education on specific risk factors and complications for individual patients.

The SCHNC, RCHNCs, and DCFW SMD continued to promote the value of reading and Reach Out and Reach (ROR) during the CHTP for CH ERRNs. During FY24, six LHDs provided ROR using Title V funds through the Child Health AA.

Child Health Agreement Addenda

The WCHS continued to refine the Child Health AA with LHDs in FY24 to require that: 1) all services supported by Title V funding will be evidence-based; 2) services will support the MCHBG domains and reflect the needs of the community; and 3) priorities established by the local communities will be data driven. The Child Health Program has: 1) Created an online process for LHDs to self-report at mid-year and end of year on the measures for the services delivered by the LHD; 2) Improved standardized measures and reporting mechanisms to increase accountability; and 3) Increased TA to LHDs to support the use of additional evidence-based services and resources for children.

The FY24 Child Health AA with LHDs for child health services supported a variety of services for low-income families including, but not limited to: 1) Access to dental services and optometrists; 2) Access to asthma inhalers and spacers; 3) Direct preventive and sick visit services; 4) ROR support; 5) Interpreter services such as in-person interpreters and language line services; 6) Car seat and bicycle helmet purchases based on financial eligibility; 7) Reproductive health services for teens based on a sliding fee scale; 8) Funding for school nurses; 9) Funding for family strengthening initiatives such as Triple P and Innovative Approaches; 10) Accommodations to improve access to care for children with disabilities after site surveys for wheelchair scales and accessible examination tables; 11) Training related to skill development related to evidence-based services; 12) Family Friendly (Breastfeeding) Clinic Award for outpatient healthcare clinics; 13) Funding for CCHCs; 14) Community Coalitions Supporting Healthy Eating and/or Physical Activity; 15) Addressing Food Insecurity and/or Healthier Food Access; 16) Teen Friendly Clinics; and 17) Firearm Safe Storage.

NC Home Visiting Consortium

The Home Visiting and Parenting Education (HVPE) System Building Initiative work was put on hold in Summer 2023. There were leadership challenges, accountability issues, and a lack of project administration best practices at the host agency which resulted in unanticipated gaps in the implementation of HVPE. Many former HVPE partners are currently members of the NC Home Visiting Consortium (NCHVC) which has served as a mechanism to move home visiting programs forward in NC. The NCHVC is a network of perinatal/early childhood home visiting programs and MCH organizations that work to support initiatives across NC. Since 2015, NC MIECHV has facilitated the NCHVC, as there was little collaboration among home visiting models at that time. The NCHVC has solidified home visiting in NC by engaging model purveyors and partnering agencies through quarterly meetings. In 2024, PCANC and NCPC resumed providing HVPE updates during the NCHVC meetings. The NCHVC will continue to work with PCANC and NCPC and provide input as they resume the work of the HVPE initiative, integrating previous feedback and lessons learned from the past few years to ensure that the program is sustainable in the future.

Nurse-Family Partnership

In FY22, NFP was granted an additional $1.5 million dollars in recurring funds in the state budget to support the sustainability and expansion of the program. The funding was allocated in FY23 and enabled NFP to serve 150 additional families across the state. WCHS continued working with the NFP sites in FY24 to ensure that sites were meeting their funded caseload capacities. To do this, a specific focus has been on community marketing and outreach to ensure that qualified referrals are consistently available. Additionally, focus has been placed on recruiting and enrolling clients who meet at least 3 or more high-risk categories. There are 19 risk factors identified by the NFP National Service Office (NSO) with a new report available for staff to track the risks of enrolled clients. State Nurse Consultants have worked through monthly consultations to ensure that each site has an individualized plan for referral outreach and caseload maintenance. The NFP NSO has developed marketing and outreach “tool kits” available to all sites to assist sites in developing these individual outreach plans. In addition, the NFP NSO has a marketing and outreach team that is available to work individually with sites who are struggling in aspects of referral rates, referral-

to-enrollment conversion, and/or attaining funded caseload capacity. Efforts are now tracked through individual collaborative success plans unique to each site where goals are set and measured.

Client retention continues to be a focus of NFP and is reviewed quarterly for all program phases. Retention rates are also being discussed at annual site visits with each team's Nurse Home Visitors. In addition to a detailed report describing reasons for discharge, an additional focus is being placed on retention of populations. A newly added section to the fidelity report gives a breakdown of retention by race and ethnicity, as well as the percentage of addressable and non-addressable reasons for early discharge. This will allow sites to identify retention gaps and develop strategies based on specifically identified population.

In FY23, MIECHV home visiting data began integrating into the NC Early Childhood Integrated Data System (ECIDS). Previously, MOAs were signed and implemented in 2022 and NC MIECHV's Continuous Quality Improvement/Data Manager and data partners worked with the NC ECIDS staff to identify which data elements and indicators to integrate. Secure transfer file protocols were established, and all participant data from 2012 – 2024 from six LIAs have been integrated into ECIDS. NC MIECHV plans to start the data integration process for the final LIA in 2025.

MIECHV Regional Meetings were held quarterly for the professional development of home visiting staff. The meetings were structured to meet the needs of NC MIECHV's LIAs, also referred to as NC MIECHV's sites as suggested through post-meeting evaluations and monthly reports. Topics and presentations from this reporting period include: *Promoting Maternal Mental Health During Pregnancy through the Parent-Child Relationship Programs, University of Washington*; *Safe Sleep; Triple P in NC*; *What is the Exceptional Children's Assistance Center and How We Can Support Families Together*; *MIECHV LIA IPV Screening*; *Medicaid Expansion*; *Yay Babies!*; and *Perinatal Through Childhood Exposure to Violence*. Additionally, professional development opportunities including webinars, journal articles, and upcoming conferences/trainings are emailed monthly to MIECHV home visiting staff.

NC Child Fatality Prevention System

The NC Title V Program continued to play a key role in the implementation of the NC Child Fatality Prevention System (CFP System) that serves to prevent child deaths and child maltreatment. The original legislation creating the CFP System was passed in 1991. Three main components of the CFP System include: the NC Child Fatality Task Force (CFTF); the state Child Fatality Prevention Team; and local child death review teams in each county, called Child Fatality Prevention Teams (CFPTs) and Community Child Protection Teams (CCPTs). New legislation updated the Child Fatality System through legislation in 2023 and is governed by the North Carolina General 2023 Appropriations Act [Section 9H.15. of Session Law 2023-134]. This new legislation implements changes starting in 2025.

The CFTF is a legislative study commission that makes recommendations to the Governor and NC General Assembly focused on laws and policies to prevent child deaths as well as child maltreatment and to promote child safety and well-being. Although the Task Force is part of NCDHHS for budgetary purposes only, the position of the Executive Director of the CFTF is in the NCDHHS Office of the Secretary, and several NCDHHS employees serve on the Task Force, one of its three committees, or have participated in various CFTF efforts. In particular, the NC Title V Director serves as a statutory member of the Task Force, and the WICWS Chief co-chairs the Perinatal Committee of the Task Force as a subject matter expert. Two other committees of the CFTF are the Intentional Death Prevention Committee and the Unintentional Death Prevention Committee. The CFTF provides a unique forum that brings together agency officials, lawmakers, experts in child health and safety, and community volunteers to perform the important work of understanding what causes child fatalities and determining what can be done to prevent them. Aided by the work of three committees, the Task Force meets to study data, hear from experts, and prepare policy recommendations for consideration. The Executive Director of the Task Force and other NC Title V Program staff work closely with the staff of the Injury and Violence Prevention Branch (IVPB) and also work with additional partners including other state agencies and non-profit agencies such as NC Safe Kids, the UNC Injury Prevention Center, NC Child, and the Governor's Highway Safety Program. The CFTF reports annually to the Governor and NC General Assembly. These annual reports, as well as other reports, presentations, meeting schedules, and membership lists can be found at the following link: https://www.ncleg.gov/Files/NCCFTF/index.html.

The state CFPT Coordinator, who is a member of the WCHS, supports all 100 local CFPTs through Title V funds and ongoing TA. NC counties review all of the county's resident child fatalities. CCPTs review all cases in which a child died because of suspected or confirmed abuse or neglect and a report of abuse or neglect was made to DSS within the previous twelve months or the child or child's family was a recipient of child protective services within the previous twelve months. All additional child fatality cases are reviewed either by the CCPT or, if the CCPT does not review additional child fatality cases, a CFPT reviews them. Team members who serve on both CCPT and CFPT include: a member of the director's staff, local law enforcement office, attorney from the district attorney's office, local community action agency, superintendent of local school administration in the county, member of the county board of social services, mental health professional, guardian ad litem coordinator, LHD director, and a health care provider. CFPTs also include the following members: emergency medical services provider or firefighter, district court judge, county medical examiner, representative of a local child care facility or Head Start program, and a parent who has experienced a child's death before their eighteenth birthday. Additionally, the board of county commissioners may appoint a maximum of five additional members to represent county agencies or the community at large to serve on the local CFPT.

Each quarter, local CFPTs are provided documentation on the child deaths for their county which include a list of the child fatalities for review that quarter, death certificate transcripts, medical examiner reports (with a list of Pending cases), birth certificate information, and injury data. Data are provided through the SCHS and the Office of the Chief Medical Examiner (OCME). Local CFPTs meet to review all their resident child fatalities and identify system problems, make recommendations for prevention of future fatalities, and decide how to act on those recommendations. The local CFPTs provide education to their communities on ways to keep children alive and safe and connect applicable agencies in response to their created recommendations.

Beyond local recommendations and coordination, the state CFPT Coordinator links actions and noted recommendations from the local CFPTs with other state agencies and with the state CFPT, a noted component of the NC CFP System. The state CFPT Coordinator and DCFW SMD serve as members of the State CFPT Team. The State CFPT is a multi-disciplinary team with law enforcement, social services, mental health, health care providers, education, and public representation responsible for in-depth reviews of all deaths of children younger than eighteen years old reported to the NC Medical Examiner System, including deaths due to abuse and neglect. The DCFW SMD brings information to the team related to maternal and child health which includes specific case information from the NC Immunization Registry (about vaccines and location of visits for vaccines). The CMARC program provides data to the DCFW SMD to bring to the state CFPT Team about any involvement of infants and children under 5 years of age with the CMARC program and with POSC referrals. Annual recommendations are reviewed, bringing together local CFPT, CCPT, and state CFPT topics to share with the CFTF.

In coordination of the local CFPTs, the state CFPT Coordinator monitors the activities of the local CFPTs to ensure compliance with the NC CFP System's statutory requirements, makes virtual connection and site visits to local CFPTs, provides statewide webinars to increase the local teams' knowledge about current health, data, and child safety issues, and maintains the database for submitted child fatality review reports. This year, the state CFPT Coordinator focused on continued maintenance of the database of submitted review forms, prioritizing visits to local CFPTs, establishing unique avenues of communication to connect teams across the state, and preparation for the implementation of the new child fatality system legislation.

During FY24, the state CFPT Coordinator conducted 36 in-person visits and thirteen virtual visits with local CFPTs which enabled the Coordinator to gain insight into how these individual teams operate as well as how to best provide support and assistance. Visits also occurred for the purpose of monitoring local CFPTs in line with their LHD reaccreditation schedules. The Coordinator also initiated office hour "open forums" twice a month to help facilitate conversation among local CFPTs, provide an opportunity for teams to come ask questions and share with other CFPTs, and have general conversation about a variety of topics every month. The open forum events occur on a repeated schedule so local CFPT members can join as their schedules allow. I
During FY24, there were 1,149 fatality reviews completed by CFPTs and entered into the database. The state CFPT Coordinator continued collaboration between local CFPT work and state CFPT reviews to continue the process of bridging actions and noted recommendations throughout the CFP System structure.

Additional Strategies to Promote Child Health and Decrease ACEs

The WCHS and the EI Section continued their enduring partnerships with agencies and organizations such as NC Child, the NC Pediatric Society, the NC Academy of Family Physicians, Exceptional Children's Assistance Center (ECAC; Family-to-Family Health Information Center), NCPC, Family Support Network, Carolina Institute for Developmental Disabilities, and PCANC to prevent and mitigate ACEs and increase PCEs (positive childhood experiences).

The Title V Program continued to work with Duke and other partners to monitor and promote use of the many NC-PAL practice and community focused efforts. NC-PAL provided mental health consultation and education to many partners which include health care practices, CDSAs, schools and social service providers in NC, building mental health knowledge and capacity. NC-PAL also provided phone consultation, education, and practice supports to increase the capacity of primary care providers across the state to identify strengths and to provide timely identification, diagnosis, management, treatment, and referral as appropriate for children with mental or behavioral health concerns which includes assessing how social drivers of health, including ACEs, impact mental health. NC-PAL's community supports included working closely with DSS on statewide case reviews and policy development, consultation, and education pilots with selected DSS agencies. The SMD also continued to be involved with conversations to help guide and promote the variety of provider and community resources available through NC-PAL to primary care providers and with private and LHD child health providers in multiple presentations during FY24 related to child and perinatal mental health (NC MATTERS). More information about NC-PAL in addition to other Child Behavioral Health unit initiatives can be found in the NC's Systems of Services for CSHCN section.

In FY24, funding through Title V and state appropriations continued to support coverage of vision screening for both school-age and preschool age children with Title V funding the preschool services through a contract with Prevent Blindness NC. Educational materials were provided statewide on eye and vision health. Vouchers for services and eyeglasses for children who do not qualify for other assistance through public or private insurances were also provided. Vision disorders are the fourth most common disability among children. Prevent Blindness funds were also utilized to provide training and certification of vision screeners in 100 counties across NC who conduct mass and individual vision screenings for children of all ages in NC public and charter schools. Vision screening training ensures that school-aged vision screenings are conducted in a consistent and uniform manner implementing age-appropriate screening methods. In FY24, there were a total of 3,056 vision screeners certified to provide vision screenings throughout 100 counties in North Carolina. A total of 33,091 children were screened and a total of 3,493 were referred to eye care professionals for follow-up vision care.

The DCFW SMD continued to serve on a statewide multi-partner group to help advise the NC Childhood Lead Poisoning Prevention Program to LHDs and to pediatricians across the state in partnership with the NC Pediatric Society. The DCFW SMD worked with DPH CDIS Head and other partners and received feedback from providers that prescriptions are electronic and the idea of paper prescriptions for primary care providers was not the best way to give them directions to address elevated lead level follow up which includes testing and referrals. SCHNC and RCHNCs partnered to provide TA to LHDs on accessing NC Lead Training to better understand all these changes.

Priority Need 5. Improve Immunization Rates to Prevent Vaccine-Preventable Diseases

Vaccines for Children Program Strategies

The federal Vaccines for Children Program (VFC) was established after a measles epidemic in the United States and became operational in the fall of 1994 under section 1928 of the Social Security Act. VFC is an entitlement program for eligible children, age 18 and younger. Provider recruitment to maintain a strong public health infrastructure helps assure high immunization coverage levels and low incidence of vaccine-preventable diseases. The IB distributes vaccines at no charge to private and public VFC enrolled providers to vaccinate children whose parents or guardians may not be able to afford them. This helps ensure that children have a better chance of getting all the recommended vaccinations on schedule. Collaborative efforts include community engagement with existing and new partnerships are essential for increasing vaccination coverage and improving vaccine acceptance. The IB provides accurate and consistent focused training to its stakeholders about vaccination of infants, children, and adults.

The IB uses vaccine ordering data from VFC providers to determine which providers are high-volume and order both adolescent and childhood vaccines. At the state level, providers who have low coverage and high patient volume, and who see both children and adolescents, will be considered high priority to receive an Immunization Quality Improvement for Providers (IQIP) visit. Providers located in geographically underserved areas or in areas where outbreaks of vaccine preventable disease occur are also prioritized for IQIP. Immunization data from the NC Immunization Registry (NCIR), a web-based statewide-computerized immunization information system that maintains and consolidates immunization records, is used to assess provider-level vaccination coverage. Regional immunization consultants run an initial assessment report to evaluate coverage and work with providers to identify practice strengths and weaknesses and implement strategies to increase vaccine uptake to improve immunization coverage. Providers are trained to use the NCIR reports to track children who are overdue for immunizations, confirm data accuracy and completeness of records, and make any needed corrections in the NCIR. The regional immunization consultants will run assessment reports a second time after corrections are made to re-evaluate coverage. Providers are asked to monitor data quality on an ongoing basis. The IB completes a centralized statewide immunization assessment annually for all children 24 through 35 months of age from the NCIR. Immunization coverage assessment results are provided to each LHD. Quality improvement strategies are discussed to improve coverage and compliance with NC immunization laws.

Overall, the NC Immunization Program (NCIP) distributed a total of 2,575,218 doses of vaccine, including 299,780 doses of influenza vaccine and 236,770 doses of COVID vaccine in FY24.

National Immunization Survey

At the national level, CDC uses the National Immunization Survey (NIS) to monitor vaccination coverage among children 19-35 months and teens 13-17 years, and flu vaccinations for children 6 months to 17 years. The surveys are sponsored and conducted by the National Center for Immunization and Respiratory Diseases (NCIRD) of the CDC and authorized by the Public Health Service Act [Sections 306]. Data collection for the first survey began in April 1994 to check vaccination coverage after measles outbreaks in the early 1990s. The NIS provides current, population-based, state and local area estimates of vaccination coverage among children and teens using a standard survey methodology. Estimates of vaccination coverage are determined for child and teen vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP), and children and teens are classified as being up to date based on the ACIP-recommended numbers of doses for each vaccine.

Childhood and Adolescent Immunization Rates

While most of the funding for childhood immunizations does not come from Title V, the WCHS supports the work of the Immunization Branch (IB) to raise immunization rates across the lifespan. The 2021-2023 National Immunization Survey (NIS) results (for children born 2020-21) were released in September 2024. North Carolina’s coverage estimate for the 4:3:1:3:3:1:4 series (which protects against Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus influenza type B, Hepatitis B, Varicella, and pneumococcal invasive disease) was 69.7%, which was higher than the national estimate of 66.9%, but lower than NC’s previous year NIS results of 72.3%.

Results of the 2023 NIS-Teen, released in August 2024, showed that the rate of NC teens aged 13 through 15 years who have received one or more doses of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) since the age of ten years was 92.6%, which was higher than the national estimate of 88.8% and a 4% increase from the 2018 baseline of 88.9%. The 2023 meningococcal conjugate coverage estimate in NC was higher for teens age 13 to 15 than the national estimate (91.9% v. 86.9%) and was an increase of 5% from the baseline of 87.4% although a decrease from the 2021 rate of 95.6%. Regarding the percent of teens ages 13 to 15 who were up to date on the HPV series, the 2023 NC estimate was higher than the national estimate for all teens regardless of gender (61.2% v. 57.3%), and 64.3% of females were up to date while 58% of males were.

NCIP Partnerships

One IB staff member is designated as liaison to the North Carolina Immunization Coalition (NCIC). This individual serves as an ad hoc member on the steering committee and a committee member on NCIC’s HPV subcommittee. Assistance is provided with crafting information and preparing for webinars and other activities. This liaison also

attends all regular meetings of the NCIC and provides updates on current activities of the IB.

IB leadership and communications staff have also partnered with the N.C. Pediatric Society on joint messaging and promotion of childhood immunizations during the annual observance of Adolescent Immunization Awareness Month in North Carolina.

Immunization Quality Improvement for Providers

On July 1, 2019, the CDC-developed quality improvement program formally known as AFIX (Assessment, Feedback, Incentive, and eXchange), underwent several methodological changes and was renamed IQIP (Immunization Quality Improvement for Providers). Like AFIX, IQIP is designed to promote and support implementation of provider-level strategies that were developed to help increase vaccination rates in children and adolescents. One of the key changes to this program is the incorporation of both childhood and adolescent assessments during each visit. Two-year-olds and thirteen-year-olds (as opposed to 13-17-year-olds in AFIX) are assessed to promote on-time vaccination. The follow-up process is also lengthier, extending to one year from the previous 3-6 months, to promote long-term, measurable changes within a provider's office. Strategies were also streamlined and broadened, to allow for wider interpretation. In July 2022, CDC authorized the use of tele-IQIP (virtual IQIP) as a permanent option for completing visits. Tele-IQIP was initially introduced as a temporary option during COVID. In FY24, IB initiated 517 IQIP visits, representing approximately 45% of VFC-enrolled providers.

Additional Title V Immunization Activities

The DCFW SMD continued to work with IB staff members to review a subset of medical exemption requests for immunizations that were non-standard from physicians licensed to practice in NC and continued to work with the attorney general's office on appeals for medical exemption requests. The DCFW SMD also provided eleven webinars to child health clinic staff in LHDs during FY24 that included highlighting the need for well visits, routine immunizations, and immunizations against COVID-19 and flu, RSV and routine vaccines and addressing vaccine hesitancy.

Priority Need 3 – Promote safe and nurturing relationships for children and adolescents

As noted earlier, Priority Need 3 is very similar to a former priority need found in the NC 2021-2025 State Action Plan, with the major change being to specify both children and adolescents and have the need span two population domains. The NC Title V Program selected to use the Adult Mentor NPM as SPM 1 in the Adolescent Health Domain for this priority.

AH PN3 Objective 1 By 2030, increase the percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance by 5% from 86.6% (2022-23 Baseline) to 90.9%.

The CHTP will continue to share information and resources to address relational health and promote safe, stable and nurturing relationships for adolescents. Additionally, the Child Health Program will use statewide webinar trainings and discussions to share information and resources about how to promote safe, stable and nurturing relationships for adolescents as part of well visits provided at LHDs.

Triple P Local Implementing Agencies will continue to provide local support for families in their service areas and promote and connect parents and caregivers of teenagers to Triple P Teen as part of the variety of Triple P online modules. Parents and caregivers will set their own goals, learn ways to encourage positive behavior for teens, teach their teens new skill such as problem solving, conflict resolution, and self-regulation.

The RSHNC team will include speaker presentation(s) regarding topics that promote adolescents' physical and mental health and well-being that support safe and nurturing relationships at the Annual School Health Conference. The topic(s) and presentation(s) will emphasize the role of the school nurse and best practices to address common health/relationship issues and trends. The topics will be based on data from the 2024-25 School Health Services report including student issues known to the school nurses as well as desired topics from the 2024 School Nurse Conference evaluations. During FY26, the RSHCN team will share evidence-based resources during regional school nurse trainings focused on identifying barriers or influences that negatively impact safe, nurturing relationships. The RSHNC team will also collaborate with DPI NC Healthy Schools to promote the Youth Risk Behavior Survey results with school nurses across the state. When sharing the survey results, the emphasis will include things such as trends that impact adolescent health, the role of the school nurse to promote healthy behaviors and habits.

The State Adolescent Health Coordinator will collaborate on the Statewide Mental Health Initiatives and Social Emotional Learning Collaboratives to actively participate in and disseminate relevant information to school districts, DPI, and community partners. Whole School, Child, and Community (WSCC) Emotional Well-Being Learning Collaborative is supported by Collaborative for Academic, Social, and Emotional Learning (CASEL) and North Carolina School Mental Health (NCSMH) to identify school districts with a commitment to engage all and a holistic approach to supporting adults and students in school communities that have been historically underserved, face socio-economic disparities, and are disproportionately impacted by chronic health conditions and the social determinants that contribute to these challenges.

In FY26, the SHC Consultant will work with partners such as NC DPI and School Health Center Alliance to integrate and improve services provided by SHCs. The SHC Consultant will attend regularly scheduled meetings as a collaborative effort with NC Healthy Schools to address efforts promoting the health and well-being of adolescents. Data will be collected bi-annually from state funded grantees and LHDs to assess effectiveness of effort to improve child and family well-being.

AH Priority Need 4 – Improve access to quality whole child and adolescent health care

As stated previously, Priority Need 4 crosses three domains. Within the Adolescent Health Domain, the NC Title V Program selected the Adolescent Well-Visit NPM and created two ESMs (AWV.1 – Number of adolescents receiving a preventive medical visit in the past year at a LHD or school health center and AWV.2 – Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department).

AH PN4 Objective 1 By 2030, increase the percent of adolescents with a preventive medical visit in the last year by 5% from 81.5% (Baseline 2022-23 NSCH) to 85.6%.

Education and technical assistance about the importance of the annual well visit to LHDs and other partners will continue in FY26 in a number of ways. A webinar created by state WCHS staff members will be used to promote the most current recommended and required components of a Health Check well visit for all ages including adolescents

seen in LHDs. This webinar will include the importance of health care transition from pediatric to adult health care as part of the well visit to offer strategies to use with adolescents and their families.

For the 2025 Annual School Nurse Conference, the RSCHNC team will seek to include subject matter experts regarding the physical and behavioral health needs of adolescents. The topics will be prioritized to include those most commonly noted in the North Carolina Youth Risk Behavioral Survey results and the 2024-25 School Health Services report data. School nurse participants from the annual conference will be provided with an evaluation survey to provide feedback regarding the learning objectives, increased knowledge on featured topics and ability to apply to their practice.

In FY26, the SACH Unit will continue to maintain the credentialing/re-credentialing processes with SHCs based on best practice guidelines as described in the AH Domain Annual Report (i.e., Health Check Program Guide, Bright Futures). The SHC Consultant will collaborate with the DCFW SMD or designee and one or more representatives from the NC School-Based Health Alliance to begin work on the process of reviewing, updating, utilizing the NC Performance Measures for SHCs and NC Quality Assurance Standards for SHCs. These standards and performance measures will continue to support the delivery of quality comprehensive, adolescent-centered preventive and primary care services, with consideration for the integration of behavioral health.
In addition, the SHC Consultant will explore having an agency provide focused training to support SHCs in effectively integrating behavioral health services into their care models. Future trainings will promote improved care coordination for adolescents, ensuring timely access to appropriate services and enhancing overall health outcomes.

The YHA team will continue to meet bimonthly to provide support to programs in the WCHS that serve adolescents in FY26, building upon partnership work established during FY25. The team will prioritize partnerships with other youth-led organizations that are comprised of CYSHCN. The team will continue to prioritize planning activities and outreach for Adolescent Health Month during FY26. In addition, the team will continue to focus on improving and redeveloping website content for youth and parents/caregivers to promote the adolescent well visit. Social media and other networking platforms will continue to be utilized to feature the YHA team sharing pertinent and timely messages for teens. The Adolescent Health Coordinator will also continue to coordinate health related presentations of interest for the YHA team designed to inform and address relevant issues based on YHA interested areas. In FY26, the DCFW SMD will continue to attend periodic YHA team meetings as an engaging guest willing to share information and resources requested by the youth for their own self-care and sharing among peers. Health information that would be useful in developing outreach materials will be shared in-person or via social media network platforms.

The year end youth summit will provide a platform for the YHA Team and other youth led groups to engage in meaningful discussions surrounding pressing social issues. The aims of the summit will be to foster leadership development, empower participants with valuable skills, and inform the development of programs within NC. This event will unite youth from different backgrounds within NC to explore significant topics such as physical and mental health, as well as strategies for strengthening communities. By involving youth groups, the summit will not only allow participants to actively contribute their perspectives but also enable them to showcase their research findings and initiatives undertaken throughout the year. Ultimately, the summit will serve as an opportunity for young people to lead conversations that directly impact their futures, while improving the skills necessary to be effective advocates for adolescent health.

The SCHNC will revise the CH ERRN Re-rostering Compliance Survey to collect the number of well-child visits provided by CH ERRNs to adolescents 12 years of age and older. The revisions will require CH ERRNs to report the number of preventative visits completed using new and established client preventative visit CPT Codes. The SCHNC, regional child health nurse consultants, and the DCFW SMD will use statewide webinars and discussions with child health providers from LHDs to discuss strategies for how to increase the number of adolescent well visits provided.

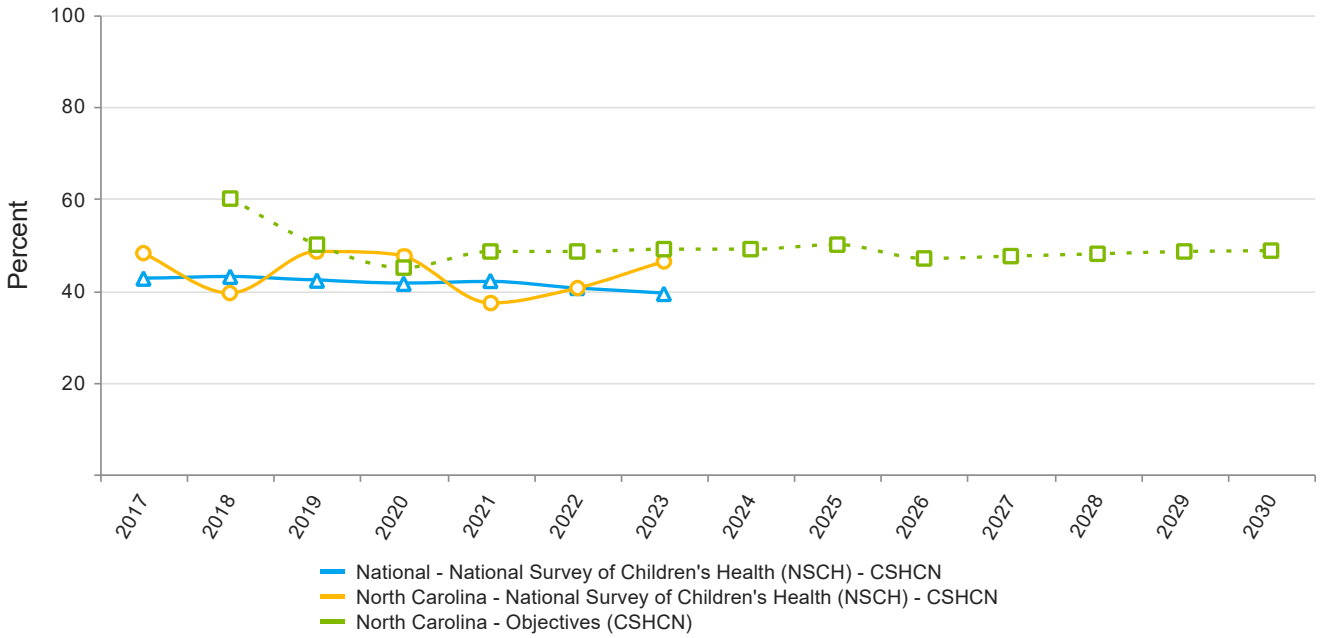
Regional and state child health nurse consultants will continue to provide TA and monitoring to all child health clinical staff at LHDs related to the required and recommended components of well visits from birth to 21 years of age in FY26. In addition, the CHTP will continue to highlight the importance of a comprehensive physical assessment and health care self-management strategies (transition from pediatric to adult health care) and other components of a quality adolescent well visit.

The SHC Consultant will partner with other DCFW staff to arrange for a training and discussion about health care transition from pediatric to health care for SHC staff in FY26. The SHC Consultant will use this to begin to identify challenges and successes related to health care transition from pediatric to adult health care for SHCs.

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH Indicators and Annual Objectives



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	45	48.5	48.5	49	49
Annual Indicator	48.4	36.3	36.3	41.2	46.4
Numerator	241,421	184,239	184,239	211,221	308,004
Denominator	498,468	507,316	507,316	512,437	663,667
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2020_2021	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	47.0	47.5	48.0	48.5	48.7

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Parents who Report That They Understand the Available Tools and Resources Necessary to Access and Maintain Having a Health Care Provider/Team That Uses a Medical Home Approach to Care

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	75.0	75.0	75.0	75.0

ESM MH.2 - Percent of children with special health care needs who received family-centered care

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		88.7	85	87	90
Annual Indicator		80.8	80.3	84.3	83.4
Numerator					
Denominator					
Data Source		2019-20 NSCH	2020-21 NSCH	2021-22 NSCH	2022-23 NSCH
Data Source Year		2019-20	2020-21	2021-22	2022-23
Provisional or Final ?		Final	Final	Final	Final

ESM MH.3 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	12	18	15
Annual Indicator	8	9	17	13	14
Numerator					
Denominator					
Data Source	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

State Performance Measures

SPM 2 - CYSHCN Receiving Care in Well-Functioning System

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	15.6
Numerator	
Denominator	
Data Source	NSCH
Data Source Year	2022-23
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	15.8	15.9	16.0	16.2	16.4

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (North Carolina) - Children with Special Health Care Needs - Entry 1
Priority Need
Improve access to quality whole child and adolescent health care
NPM
NPM - Medical Home
Five-Year Objectives
CYSHCN PN4 Objective 1 By 2030, increase the percent of CYSHCN having a medical home by 5% from 48.6% (NSCH 2022-23 baseline) to 51%.
Strategies
CYSHCN PN4 1.1 Provide education, training, and support to providers on delivering a medical home approach to care by collaborating with the NC Chapter of American Academy of Pediatrics to promote patient-centered medical home and educate and train providers and by CMARC care managers and home visitors providing outreach to primary care providers.
CYSHCN PN4 1.2 Provide education, training, and/or support to families on medical home approach to care including: 1) Varied communication strategies (presentations, exhibits, website updates, CYSHCN Help Line , and targeted email campaigns to parents/caregivers and partner agencies); and 2) Training to equip parents/caregivers with the knowledge and skills to navigate the medical home system effectively.
CYSHCN PN4 1.3 Incorporate messages about the importance of choosing a quality medical home, increasing awareness about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and making the most of health insurance benefits in all outreach/enrollment activities.
CYSHCN PN4 1.4 Continue to train parents, caregivers, and dental providers serving CYSHCN in best oral health practices and the importance of a dental home.
CYSHCN PN4 1.5 The NC Office of Disability and Health (NCODH) will continue to provide technical assistance and education to partners to support increased access and engagement of CYSHCN in public health activities and health care settings.
CYSHCN PN4 1.6 Regional School Health Nurse Consultants will provide professional development opportunities to school nurses related to their role in supporting CYSHCN in the school setting through courses provided and the annual School Nurse Conference opportunities.
CYSHCN PN4 1.7 Regional School Health Nurse Consultant team will maintain the School Health Program Manual related to CYSHCN as a resource for school nurses emphasizing best practice and promoting advocacy for children/youth and their families.

ESMs	Status
ESM MH.1 - Parents who Report That They Understand the Available Tools and Resources Necessary to Access and Maintain Having a Health Care Provider/Team That Uses a Medical Home Approach to Care	Active
ESM MH.2 - Percent of children with special health care needs who received family-centered care	Inactive
ESM MH.3 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion	Inactive

NOMs

- Children's Health Status
- CSHCN Systems of Care
- Flourishing - Young Child
- Flourishing - Child Adolescent - CSHCN
- Flourishing - Child Adolescent - All

State Action Plan Table (North Carolina) - Children with Special Health Care Needs - Entry 2

Priority Need

Ensure all CYSHCN and families receive care in a well-functioning system

SPM

SPM 2 - CYSHCN Receiving Care in Well-Functioning System

Five-Year Objectives

CYSHCN PN5 Objective 1 By 2030, increase percent of CSHCN who receive care in a well-functioning system by 5% from 15.6% (2022-23 Baseline) to 16.4%.

CYSHCN PN5 Objective 2 By 2030, increase the percentage of children ages 4 months to 5 years with sickle cell disease who are placed on prophylactic antibiotics by 3 percentage points from 86% (2023 baseline) to 89%.

Strategies
CYSHCN PN5 1.1 CMARC program will continue to promote outreach and engagement using communication strategies and processes with NICUs, hospitals, primary care providers, DSS, WIC, Early Intervention, and other local, regional and state programs that serve CSHCN.
CYSHCN PN5 1.2 CMARC state program will provide TA and consultation to CMARC staff in LHDs about strategies for how to motivate families of CSHCN to choose to receive services and decrease families choosing to leave the CMARC program before family driven social and health goals and needs are met in the care plan.
CYSHCN PN5 1.3 The North Carolina System of Care infrastructure support team will assess and determine strategies to be used across Title V CYSHCN programs to improve the function of systems of care for CYSHCN.
CYSHCN PN5 1.4 Innovative Approaches 2.0 grantees will provide increased access to care for CYSHCN and families through system changes in areas of emergency preparedness, health care transition, and community accessibility.
CYSHCN PN5 1.5 Engage parents/caregivers of CYSHCN in WCHS program planning, implementation, and evaluation, and in training opportunities to be collaborative leaders at the community, state, and national level.
CYSHCN PN5 1.6 Continue to partner with internal and external partners to assure a supportive system of care for CSHCN in child care facilities, receiving genetic testing, counseling and other services, and for children and youth with hearing loss, including parent choice in communication modes for their child.
CYSHCN PN5 1.7 Provide staff support to the Commission for Children with Special Health Care Needs, and its related committees by preparing reports, gathering data, and explaining the implications of proposed policies that keep these entities informed and focused on the interests of priority populations.
CYSHCN PN5 1.8 Explore how to best update the WCHS Strategic Plan for CYSHCN with meaningful engagement with system partners to include the six core outcomes that serve as indicators of a well-functioning system of services for CYSHCN.
CYSHCN PN5 1.9 Continue to implement and improve parent to parent training using curriculum included in the Parent Training Cadre (Parent Leadership, Sexual Health, Dental Home, and Medical Home) by outreach to prospective host organizations, recruiting trainers based on identified needs (geography, language, etc.), coaching/training current and prospective trainers, and utilizing post-training survey results to make improvements to curriculum.
CYSHCN PN5 1.10 The WCHS Community Outreach Coordinator will continue to co-chair the NC Coalition to Promote Health Insurance for Children which provides a forum for statewide collaboration on outreach.
CYSHCN PN5 1.11 Increase health care transition efforts for CYSHCN from pediatric to adult health care into at least two WCHS efforts and/or programs for CYSHCN.
CYSHCN PN5 1.12 CYSHCN Help Line will continue to provide information and resources to families, caregivers and providers that improve access to health care and related services for CYSHCN.
CYSHCN PN5 2.1 Provide education, including a flyer about the provider webinar, to parents on the importance of prophylactic antibiotics during Educator Counselors initial contact.
CYSHCN PN5 2.2 Add web link and a flyer in the newborn screening follow-up provider resource packet that provides webinar information for providers on the importance of prophylactic antibiotics.
CYSHCN PN5 2.3 Post link to prophylactic antibiotics educational webinar for providers on the NC Sickle Cell Syndrome Program web page.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

Priority 7 – Improve Access to Coordinated, Comprehensive, Ongoing Medical Care for CYSHCN

As detailed in the Child Health Domain, the NC Title V Office supports a comprehensive, coordinated, family-centered system of care for all children regardless of whether they are CYSHCN or not. Many years ago, prior to the transition to DCFW, the personnel were intentionally restructured so that services and supports for CYSHCN are better integrated into all aspects of WCHS programs and initiatives. The following specific services and programs, while described separately, represent the components of a system of care for CYSHCN supported by Title V funding in FY24 to improve the health of all children and decrease child deaths and morbidity.

Medical Home NPM – Number of children with and without special health care needs, ages 0 through 17, who meet the criteria for having a medical home

Promoting the medical home approach using team-based care is a core message within all WCHS programs. Much work is being done to improve the Medical Home NPM. Data for NC from the 2022-23 NSCH indicate that 48.6% of CYSHCN had a medical home as compared to 54.4% of children and youth without special health care needs (non-CYSHCN). NC's rates for this measure appear to be significantly higher than national rates (confidence intervals don't overlap) in the 2022-23 NSCH, with national rates of 39.7% for CYSHCN and 46.8% for non-CYSHCN.

In addition to the Medical Home NPM, two ESMs have been selected to help monitor progress in this area: ESM MH.1 – the percent of CYSHCN who received family-centered care as reported in the NSCH and ESM MH.2 – the number of Medicaid, Managed Care Organization, or other meetings with partners attended by WCHS staff members with an agenda item related to medical home promotion.

2022-23 NSCH data for ESM MH.1 showed that 83.4% of respondents said their CYSHCN received family-centered care which was slightly higher than the national rate of 81.6%, but this is not a significant difference as the confidence intervals overlapped. It is comparable to the NSCH 2018-19 baseline of 84.9% for NC. Baseline data for ESM MH.2 was obtained in FY21 based on what occurred in FY20 when there were eight relevant partner meetings with an agenda item related to medical home promotion. A goal of increasing this to sixteen meetings by 2025 was set. In FY24 there were at least fourteen relevant meetings where medical home promotion was discussed.

Several WCHS staff members and Family Partners (FPs) continued to participate in the Children's Complex Care Coalition of NC (4CNC) advisory committee that started as funding from a grant from the National Center for Complex Health and Social Needs. This effort has continued without grant support with leadership from pediatricians and medical students at UNC and Duke, and has continued to include several other academic centers, Legal Aid of NC, ECAC (who served as the NC Family to Family Health Information Center and Parent Training and Information Center), additional state and local agencies, health professionals, community-based organizations, and families of CYSHCN. The 4CNC Advisory Committee continued to rally around its vision to have family-centered, integrated systems of care that enable all children with complex health needs to thrive. During FY24, the Advisory Committee met two times to continue to discuss the key priorities and actionable recommendations to address scope and scale of care for children with complex needs in NC. These priorities were generated from the virtual conference series called *Path for Better Health for Children with Complex Needs* (PATH4CNC) for health professionals, families of CYSHCN, community and state agencies which was held in January-March 2021. More information can be found in the resulting white paper *Improving Systems of Care for Children with Complex Health Needs in North Carolina*.

Education, Training, and Support for Providers Regarding Medical Home

In FY24, information to support the medical home approach and the importance in partnering with medical homes was included in Child Health Program live and archived webinars scheduled throughout the year for LHD clinical staff and as part of the 2023-24 CHTP. The DCFW SMD and SCHNC worked with NC DHHS Office of the Chief Public Health Nurse to include information in trainings for LHDs that included guidance related to required child health services for LHD providers to deliver a number of services (i.e., newborn home visiting, CMARC, and well child services) that increased access to care in a medical home or supported access to other providers who serve as medical homes. Additional Child Health Provider webinar trainings included: *Clinical Asthma Education*; *Environmental Asthma Triggers – A Training for Public Health Professionals*; and *Calling All Smile Crusaders*.

Bright Futures forms continued to be promoted for use in all LHDs to support comprehensive care of CYSHCN using the medical home approach and the identification of children as CYSHCN. Audits of services in LHDs continued to encourage the need for linkage to a medical home or communication with the medical home as part of Medicaid requirements for well visits at all ages.

The DCFW SMD continued to use opportunities with the NCPS (weekly Solution Share and practice managers listserv) to promote the delivery of care for well and sick care using a family-centered medical home approach, especially with CYSHCN. The weekly Solution Share event with NCPS typically had an audience of 20-30 medical home practice managers and primary care pediatricians from medical homes across the state. The NCPS practice managers listserv continued to have almost 100 practices represented with practice managers and pediatricians to address a variety of issues which included care of CYSHCN. The DCFW SMD specifically tried to include information about the CYSHCN Help Line via presentations. The DCFW SMD continued to stay current on clinical policy changes related to Medicaid to provide technical assistance and consultation to providers in LHDs, and pediatric practices to increase access to whole child health care in the medical home for children. The DCFW SMD continued to actively participate in monthly meetings of a statewide multidisciplinary group called the NC Physician Advisory Group that advises Medicaid for beneficiaries of all ages.

The DCFW SMD provided presentations for pediatric providers in LHDs (eleven monthly lunch time sessions) and multiple presentations in other settings (regional meetings of pediatric providers and meetings of NCPS) serving as medical homes or working with medical homes caring for children. The presentations in LHDs included updates relevant to medical home and other providers on a variety of timely topics for care of CYSHCN such as: child mental and behavioral health and including specific information about launch of Tailored Plans for children with serious mental health and substance use issues; intellectual or developmental disabilities (I/DD) or a traumatic brain injury; tobacco use; COVID-19, RSV and flu surveillance and immunizations; measles and pertussis disease and vaccines; coordination with school nurses related to individualized health care plans for CYSHCN; Medicaid expansion for parents of CYSHCN; prevention, detection and treatment of congenital syphilis; asthma disparities; and sickle cell disease. Two presentations to LHDs included guest speakers from DPH about sickle cell disease and childhood lead poisoning prevention updates.

WCHS staff members collaborate with ACA outreach efforts to ensure that continued enrollment in public and private health insurance is available to all families and that transition services are coordinated. The WCHS Minority Outreach Coordinator leads this effort.

Lastly, regarding accessibility of medical homes, the NC Office on Disability and Health (NCODH) Director continued to offer accessibility reviews for LHDs at their request to enhance the care of CYSHCN and to assist in achieving accreditation requirements.

Education, Training, and Support for Providers Regarding Family-Centered Care

To increase the percentage of families of CYSHCN who report that their children receive family-centered care, the WCHS continued several programs and activities during FY24. The CMARC program, which serves Medicaid and non-Medicaid children birth to five years of age, continued its work to improve health outcomes for newborns, infants, and young children. The WCHS continued its partnership with the DSS, DMH/DD/SAS, PHPs, and other partners to provide care management for infants exposed prenatally to substances. CMARC developed a resource list to help with care of substance affected infants that was shared with all five PHPs. In addition, the CMARC program continued to support families of children who were in the NICU, exposed to toxic stress, and have or are at risk for special health care. CMARC identified children and families whose health could be impacted by community health factors and connected them to community resources. There were twelve CMARC programs among LHDs that participated in implementing NCDHHS HOP pilot efforts that address non-medical drivers of health as part a multi-year NC Medicaid 1115 demonstration waiver which continued to use NCCARE360, a statewide coordinated care platform, to link individuals to resources. In addition, numerous webinars and care pathways were developed and made available for CMARC care managers to help them partner with Advanced Medical Homes, Clinically Integrated Networks, HOP partners, Community Care of NC, and Health Plans to care for children with a variety of conditions such as asthma, sickle cell, foster care, and neonatal abstinence syndrome.

Title V funding continued to be used to support CMARC services although the CMARC Program Nurse Consultant remained vacant during FY24. Recruiting efforts for the position continued. The CMARC care managers used data reports to identify children who are receiving CMARC services that are not enrolled in Medicaid so that those children can be assessed for Medicaid eligibility.

WCHS staff members continued to provide support to the NC Commission on CSHCN and its established workgroups (Oral Health, Behavioral Health, Community Alternatives Program for Children [CAP/C], and Pediatric Home Nursing). The Commission's nine members were appointed by the Governor and met bimonthly to review and make recommendations related to issues affecting CYSHCN. Support included the preparation of reports, gathering data, scheduling meetings, securing subject matter experts as presenters, liaising with the Governor's office to keep membership current, and explaining the implications of proposed policies that keep these entities informed and focused on the interests of children and families. The WCHS also fostered Title V Parent Representatives to participate on the Commission and its four workgroups. Bimonthly throughout FY24, the Commission hosted workgroup leads, reliable contributors, and invited guests with expertise on priority issues faced by CSHCN to raise awareness of issues, spark dialogue, and explore partnership opportunities to improve outcomes.

NC Medicaid continued to be a primary focus area, and the Commission sought out experts to discuss the current landscape who graciously agreed to share their expertise and make themselves vulnerable to tough questions. A behavioral health policy manager from NC Medicaid addressed challenges and opportunities regarding access to behavioral health service providers. Access and execution of Tailored Care Management was addressed by NC Medicaid's Chief of Population Health. To monitor trends that impact CYSHCN served by NC Medicaid, Commission participants learned about how inquiries are tracked and resolved from NC Medicaid's beneficiary and provider ombudsman representatives. The Deputy Director, and Behavioral Health I/DD Tailored Plans presented about the implementation of Tailored Plans and readiness for launch. At the end of FY24, the Commission hosted senior representatives from the four LME/MCOs just prior to the Tailored Plan launch to answer questions about network adequacy, telehealth, communication with Primary Care Providers, and care management services. Additionally, co-directors from the NC Navigator Consortium raised awareness about providing guidance to families on affordable health coverage. Concerns about ensuring funding to support children remaining in their communities not going towards psychiatric residential treatment facilities were addressed in an Olmstead update presentation from DHHS' Assistant Director for Olmstead Implementation and Mental Health, Substance Use and Juvenile Justice Director.

The Commission's longstanding Behavioral Health Workgroup convened monthly, as needed, to address issues pertinent to CYSHCN specifically, behavioral health care needs across the state. The workgroup collaborated closely with NC Medicaid, staying informed on the 1915i State Plan Amendment and providing feedback on clinical coverage policies, including 8A (Enhanced Mental Health and Substance Abuse Services), 8C (Outpatient Behavioral Health Services), and NCs Children and Families Specialty Plan (support Medicaid-enrolled children, youth and families served by the child welfare system). The workgroup also monitored ongoing developments in behavioral health care, engaging with representatives from The Arc of NC to explore ways to improve access to Tailored Care Management and with NC START to discuss services for individuals with dual diagnoses and their multimodal evaluation clinic in partnership with Duke. Updates from the multi-divisional workgroup on Child Behavioral Health were regularly presented, including plans for the $80 million investment in behavioral health initiatives, fostering alignment and support for progress.
The Commission's CAP/C Workgroup was proposed and sanctioned by the Commission in 2021 to highlight current barriers for families and explore possible pathways for systems' change. The workgroup convened quarterly and collaborated closely with the CAP/C Waiver Operations Manager (CAP/C Manager). The CAP/C Manager provided updates on the transition to the new NC Medicaid Linking Individuals & Families for Long Term Services and Supports (LIFTSS) vendor. The workgroup strived to align the waiver program's intentions with the lived experiences of families and providers offering bidirectional feedback to improve outcomes. Furthermore, the CAP/C Manager responded to workgroup inquiries regarding coordinated caregiving, consumer direction, and the development of the CAP/C dashboard. Given the reduced need for a standalone CAP/C Workgroup, the Commission determined that its functions could be more effectively integrated into the Pediatric Home Nursing Workgroup, optimizing resources and streamlining efforts.

The Pediatric Home Nursing Workgroup of the Commission was established in FY23 in response to the pediatric

nursing shortage crisis in NC. The workgroup convened monthly to prioritize objectives and refine its messaging. To enhance understanding and broaden perspectives on home health agency oversight, the group hosted several experts, including representatives from home health nursing agencies, accrediting organizations, and the NCDHHS' Division of Health Service Regulation. In response to a formal data request, the workgroup received NC Medicaid data highlighting the number of children receiving Private Duty Nursing, the approved hours, and the hours utilized. This data revealed gaps in care continuity, prompting the creation of an infographic as an educational tool to raise awareness. The workgroup also drafted a follow-up data request for the subsequent year to identify trends. Additionally, discussions with accrediting bodies revealed a lack of clear guidelines for home health agency expectations. The workgroup began considering the development of these guidelines to address this oversight.

Education for Families Regarding Medical Home

Many families access the NCDHHS CYSHCN web page for Medical Home materials. The web page maintains current information and reliable resources that address several key topics including: Diagnosis and Healthcare; Insurance and Financial Support; Family Support; Education Resources; Transition to Adulthood; and Advocacy/Legal. Web page links and content were updated by WCHS staff members who received ongoing feedback from families and partner agencies. Additionally, FPs contributed family stories about their personal journey and engagement in WCHS activities.

The WCHS continued to maintain a state toll-free Help Line (available Monday through Friday) and email account to assist families and providers with services for CYSHCN. Backup Help Line coverage was provided by WCHS staff until the vacant Help Line/Outreach Coordinator position was filled in February 2024. A The CYSHCN Help Line contact volume for FY24 was 535 inquiries. Families and caregivers of CYSHCN reflect 78% of the call/email volume. Most Help Line users (80%) utilized direct phone contact, which allows callers to talk directly with staff. Seventy-three percent of Help Line users communicated in English, 26% in Spanish, and one caller spoke Swahili. For their child's primary insurance, 48% of Help Line users reported Medicaid, 23% private insurance, and 22% reported their child was uninsured. Fifty percent of the Help Line users indicated their child's disability was a mental, behavioral, or neurodevelopmental disorder (including Autism, IDD, ADHD, or a behavioral health need). The age group of the child the Help Line user was inquiring about was: 30% from birth to 5 years old, 33% from 5 to 11, 23% from 12 to 18, and 14% over 18 years old. The top three topics discussed with Help Line users were health insurance (31%), Innovations Waiver (24%), and Mental/Behavioral Health (23%). Help Line users indicated they learned about the Help Line using various methods: 40% via the website, 21% as a referral from a state/local agency, and 7% had previous experience with the Help Line.

Help Line users were invited to complete a services satisfaction survey and sent a weblink. The Help Line services continually receive ratings between 90-100% on service indicators including: timeliness of response from the Help Line staff, how well questions/concerns were addressed, and respect shown for the user's opinions/feelings. Help Line callers reported:

- "(The Help Line staff person) was very helpful. She also sent a follow up email with more info within the hour."
- "So glad to have found this resource!"
- "Cuando llame la persona no sabia español y quedaron en llamarme más tarde. La llamada en español fue casi instantánea. El trato de excelencia! Gracias." (Translation: When I called, the person didn't know Spanish, and they agreed to call me back later. The call in Spanish was almost instantaneous. Excellent service! Thank you.)

Outreach efforts to promote the awareness and access of Help Line services utilized several strategies. Supplemental Security Income (SSI) applicants, ages birth to 18 years, received direct notification about the Help Line as a resource. WCHS staff shared Help Line information at partner meetings, presentations directed at families of CYSHCN and providers who work with them, or via exhibits at professional conferences or local community events. Help Line informational materials (available in English and Spanish) were promoted electronically (through email distribution and the CYSHCN website) and in hard copy. Over 15,000 Help Line info cards were distributed via mail (690) and at outreach events (14,524) in FY24. The DCFW SMD regularly included information for outreach about the Help Line in presentations to help expand use and encourage new partnerships for providers working with CYSHCN.

Through the Commission's Oral Health Initiative, families of CYSHCN were offered training that focused on effective ways to partner with their dental provider for a more positive, lifelong dental experience for their child. This presentation was co-presented with a dental hygienist consultant and a WCHS FP. In FY24, three presentations addressing families of CYSHCN were completed, reaching 35 families. In partnership with Poder y Esperanza, a training was offered in person with simultaneous Spanish interpretation. The dental home training was also offered to families at the NC Down Syndrome Alliance Conference. WCHS staff and FPs recognized the need to revise the training for families to better meet their informational needs and worked together on the revision in FY24. The *Finding the Right Dental Home for Your Child or Youth with Special Health Care Needs* checklist was revised in FY23 and continued to be shared with family members to assist them in finding the dental home that best suits their child's needs. The English and Spanish versions of the checklist were distributed to families at outreach and training events throughout FY24.

In FY24, NC was one of five states to participate in a Learning Collaborative organized by the National Center for a System of Services for CYSHCN with a goal to advance and strengthen the system of services for CYSHCN, their families and caregivers at the community, state, and national levels by supporting implementation of the *Blueprint for Change*. This state team is co-led by the Title V CYSHCN Director and the Family Liaison Specialist and includes the DCFW SMD and WCHS Unit Managers. The team partnered with Boston University/Catalyst Center for technical support who serve as coaches for the state team. This state team met monthly and after considering multiple sources of data such as the "Parent Training Choices" survey and CYSHCN Help Line data, the team moved forward with a focus on the development of a Medical Home Training for parents/caregivers. A Family Partner Medical Home Workgroup including six Family Partners works alongside the state team and meets monthly to inform the training development. Additional items the state team worked on included:

- Revising the Innovative Approaches RFA (system changes for CYSHCN).
- Providing feedback at the request of the National Center for a System of Services for CYSHCN to inform the National Survey of Children's Health Factsheet: North Carolina.

Increasing Family Engagement

Cultivating family and youth engagement between state Title V programs is a continuous journey. The WCHS is committed to authentic involvement and engagement amid its Title V work. Fostering family and youth partner engagement involves developing genuine relationships with family partners, recognizing the contributions of their knowledge and skills, along with nurturing their natural desire and drive to give back and make a difference for other families or youth. The WCHS maintains a multi-faceted engagement framework that offers family and youth partners a variety of opportunities to intersect with and contribute to program planning, activity development, implementation, and evaluation. Alongside those who prefer to contribute as volunteers, 45 FPs were reimbursed for 303 documented hours in FY24 towards WCHS program efforts. In addition, the WCHS employed one part-time Parent Consultant who served the Early Hearing Detection and Intervention (EHDI) Program. A second EHDI program Parent Consultant position was vacant, and recruitment efforts were ongoing. The CYSHCN Access to Care Specialist role provided TA to the FPs in addition to managing the FP and Youth Health Advisors (YHA) reimbursement. Activities conducted by the YHA are described in the Adolescent Health Domain Annual Report.

The WCHS FP Engagement and Leadership Committee (formerly known as the FP Steering Committee), which represents nine FPs with extensive experience in NC's System of Care and WCHS activities, continued to inform and add value to program development within supported activities for both FPs and WCHS staff members. The Committee met four times in FY24 and participated in bidirectional communication regarding topics including the CYSHCN *Blueprint for Change*, parent training cadre updates, the AMCHP scholarship and recipient presentations, NC Medicaid expansion, community events, and WCHS staff roles and transitions.

The WCHS parent leadership training reflects a peer-to-peer empowerment training model implementing evidenced informed/based curricula. The nationally recognized *Parents as Collaborative Leaders* (PACL) curriculum continues as a cornerstone leadership training. In December 2023, AMCHP recognized NC's training model and implementation of PACL as an Emerging Practice within the AMCHP Innovation Hub. PACL trainings are provided virtually or in person in English and Spanish at no cost to parents, either as a series or as individual modules according to the parents' needs. FP trainers presented 12 trainings (11 in English and one in Spanish) to 198 parents/caregivers of CYSHCN across the state during FY24. There was also a significant increase in requests for

in-person PACL training for events hosted by community partners which resulted in higher attendance for the in-person training. PACL training participants reported:

- I feel like this will help me be better understanding in areas of conflict.
- I have a better understanding of what it is to be a leader in different situations and areas and how I can communicate and understand different roles.
- I am excited to help other parents grow and share. This has empowered me to be able to not only give me my voice but help others learn to use theirs.

In addition to the dental home and parent leadership training offerings, the WCHS launched a sexual health training in January 2024, *Teaching Parents of Children and Youth with Special Healthcare Needs about Sexual Health*, to add to the parent training cadre. Sexual Health trainings are offered virtually or in person in English and Spanish and at no cost to parents. Host organizations are encouraged to offer all three modules in the training. FP trainers presented 19 trainings (12 in English and seven in Spanish) to 197 parents/caregivers of CYSHCN across the state during FY24. The WCHS began work on parent/caregiver informed development of the previously mentioned Medical Home training in August 2023 to add to the parent training cadre.

The WCHS continued to invest in Title V family leadership development by sponsoring FPs to attend national conferences, specifically AMCHP (three attendees) and the Hands and Voices Annual Leadership Conference (one attendee) in FY24. These conferences allowed families to expand their existing family partnerships internal and external to NC and to broaden their comprehension of Title V programmatic opportunities. All the attending FPs reported back to either the FP Engagement and Leadership Committee or the WCHS EHDI Advisory Committee on what they learned and how they planned to use the information to improve the lives of CYSHCN on a local or state level. The attendees enhanced their participation in WCHS committees, workgroups, and activities by promoting and applying information gained through attending the conferences. Additionally, the Family Liaison Specialist successfully completed AMCHP's Family Leader Cohort (FLC) 2023-2024 Leadership Lab. The Leadership Lab is a unique opportunity for those working with Title V programs to accelerate their professional development in a way that is framed by the MCH Leadership Competencies and guided by adult learning principles.

Other FP engagement opportunities during FY24 included:

- Co-presenting with Senior Medical Director to NC Pediatric Emergency Care Coordinators (PECCs)
- Reviewing and providing feedback for the revision of the Dental Home training
- Reviewing newly developed Medicaid dental messaging
- Reviewing and providing feedback for newly developed Newborn Screening education materials
- Co-chairing the NC EHDI Advisory Committee Meetings
- Attending National Center for a System of Services CYSHCN Learning Collaborative calls
- Contributing to the MCH Block Grant review process
- Co-chairing the NC Genetics and Genomics Advisory Council
- Serving as Parent Mentors on the NC EHDI Parent Leadership Team

Outreach Efforts

The WCHS outreach team (comprised of the Minority Outreach Coordinator, Help Line/Outreach Coordinator, and the CYSHCN Access to Care Specialist) directed outreach efforts in low resource geographic areas in addition to marginalized, disenfranchised populations that would benefit from accessing NC's public health insurance options. The outreach team met monthly with the Best Practices Unit manager to discuss optimal outreach strategies, using state Medicaid enrollment data to focus on county populations for partner engagement and outreach, and to develop updated outreach materials.

Focused efforts by the outreach team resulted in 556 outreach activities incorporating 123 exhibits (tabling at community events), 95 presentations (in both virtual and in-person formats), and 338 collaborations (meetings with community partners) to reach priority populations. Specific outreach activities addressed Smart Start (NC Partnership for Children [NCPC]), local Interagency Coordinating Councils (LICCs), public schools, churches, Community Medicaid Health Plan Expos, and community health centers in counties with a high rate of uninsured children. A total of 14,418 (English/Spanish) NC Medicaid informational flyers were distributed in FY24; outreach

staff circulated 13,901 flyers at community events and mailed 517 flyers to site contacts for inclusion in their distribution efforts. Educational materials for other children and youth programs such as EHDI, Dental Home information, Triple P, 988: Mental Health and Suicide Hotline for Teens, and the WIC program were shared as appropriate. Members of the Outreach Team participated in an array of trainings for professionals who serve minority populations to inform their outreach efforts by networking with potential partners, including webinars that addressed Medicaid changes, learning about cultural events and festivals, language accessibility, and gaining insights into barriers faced by families trying to access health care. A highlight during this reporting period was the Minority Outreach Coordinator being recognized with the “Champion of WIC” award.

To specifically reach families of CYSHCN populations, the outreach team’s partnerships included CYSHCN parent support groups (HITCH-UP for families of children who are deaf or hard of hearing and Poder y Esperanza), Autism Society, Exceptional Children’s Assistance Center, Marbles Museum (sensory friendly playtime events), and the Tailored Plans.

Outreach staff, in cooperation with the NCPS, continued to facilitate the quarterly NC Coalition to Promote Children’s Health Insurance. The Coalition is a forum for statewide partners to address topics that can directly impact marginalized or vulnerable populations who would most benefit from enrollment and services available via NC Medicaid. Regular attendees represent: Child Health Nurse Consultants and other WCHS staff, Fostering Health NC, Office of Rural Health, Office on Refugee Health, NC Association of Community Health Centers, NC Child, Community Care of North Carolina, CMARC, and the NCPC. In FY24, the Coalition hosted subject matter experts who led discussions about the NC Navigator Consortium, Tailored Care Management, NC Medicaid Provider and Beneficiary Ombudsman, and NC Medicaid Dental Services. The meetings also offered an opportunity for participants to provide updates from their communities.

Innovative Approaches Initiative

FY24 marked the second year of the three-year (2022-2025) funding cycle for Innovative Approaches (IA). The WCHS funded two LHDs (serving three counties) to assess and improve the local systems of care for CYSHCN through their IA initiatives. During FY24, one site was not able to maintain staffing and chose to withdraw from the initiative. Extensive training continued into FY24 to ensure readiness in serving CYSHCN through a systems change approach.

IA sites worked directly with families and IA Steering Committees to develop action plans addressing community systems of care for CYSHCN. Through county-specific needs assessments, which included focus groups and surveys of families of CYSHCN, priorities were established, and strategies were refined in FY24. In Polk County, because of the small size and existing community connections, IA staff determined that it would be more effective and sustainable to have IA imbedded in several existing workgroups rather than establish a Steering Committee. This approach has proven to be the best fit for this community, while Henderson IA has maintained an IA Steering Committee.

At both sites, the Parent Advisory Committees (PAC) advise the local IA Steering Committees, prioritizing critical issues and guiding the work of IA for their respective counties. In Polk County, the bilingual and bicultural Parent Outreach Coordinator has greatly expanded the reach of IA to Spanish speaking families and established the English and Spanish speaking PAC in FY24. Also, the Parent Outreach Coordinators at both sites continued a mix of virtual meetings and in-person meetings and provided communications through multiple platforms (Facebook pages, websites, communication portals, etc.) to increase awareness about educational opportunities, meetings, and IA projects.

In FY24, Polk County IA made significant efforts for outreach to the Latinx population to build trust and provide information and resources in Spanish. The Parent Outreach Coordinator also focused on equipping the Spanish PAC members to advocate and “tell their story.” Polk County held two very successful transition fairs in partnership with Polk County Schools, with the second one focusing on health care transition. Polk IA was able to work with the Exceptional Children’s Director to strengthen school transition policies to better meet the needs of CYSHCN. Additional areas of focus, based on input from PACs, were ACEs and resilience trainings and mental health screenings. Also, in FY24, Polk County used sensory tents in partnership with Special Olympics that had been

purchased in FY23, demonstrating sustainability.

In FY24, the Henderson County IA completed the AMCHP Innovations Database Cutting-Edge Practice https://amchp.org/database_entry/track-trails/designation for Track Trails which focuses on accessibility reviews of area trails to promote inclusive outdoor activity among CYSHCN. Henderson IA also focused on promoting LTSAE screening through partnerships with the LICC and promotional efforts through social media. They organized a Transitions to Adulthood Fair to connect families to resources which was reported to be very successful with plans to continue to expand the effort in future years. The position held by the IA Coordinator at the Henderson County Health Department will become a permanent position after the end of the grant cycle, focusing on the needs of CYSHCN, which represents a significant systems change.

Both IA sites utilized Care Notebooks which provide resources for parents in a centralized location to encourage coordinated care and promote a Medical Home and health care transition. This resource is available online as a fillable PDF, as hard copy notebooks, and in Spanish. In Henderson County they will be maintained and updated by the LHD. Parents in both counties have expressed very positive responses to these resources and continue to prioritize their distribution.

Due to the IA current funding cycle ending in FY25, WCHS began preparing for the new funding cycle in FY24. Working with the CYSHCN Learning Collaborative, including staff from across the Section and national partners, the IA Initiative was revised, now referred to as Innovative Approaches 2.0. The foundational focus on systems change for CYSHCN remains, but the RFA reflects expansion to at least three counties, opportunities for non-profit organizations and Federally Qualified Health Centers to apply, alignment with the *Blueprint for Change,* and four specific areas of focus (health care transition from pediatric to adult care, emergency preparedness, community accessibility, and palliative care integration).

Additional Strategies to Support CYSHCN

The SCCNC, working collaboratively with the NC CCHSRC, continued to provide training, TA, and support for 74 local and regional CCHCs to develop strategies for the inclusion of CYSHCN in the state's 5,505 licensed child care facilities. In the CCHC Service Model, which aligns with the Caring for Our Children best practice standards from the National Resource Center for Health and Safety in Child Care and Early Education, priority of services is given in order of the vulnerability of the children in early care settings, beginning with those serving infants and CYSHCN. During FY24, the SCCNC, serving as a nurse planner, collaborated with the NC CCHSRC to provide quarterly professional development opportunities on various health and safety topics, including the inclusion of CYSHCN in early learning settings for children ages zero to five.

The CCHC Learning Collaboratives were designed to provide foundational knowledge of a given topic by a subject matter expert followed by an opportunity to experience peer-to-peer learning and explore practical application. The SCCNC and DCFW SMD engaged with local and state partners who served as subject matter experts. Additional partners were CMARC, a local CDSA, DCDEE, DSS, PCANC, early educators, and the Asthma Alliance of NC. These CCHC Learning Collaboratives covered topics including Infant and Young Child Feeding in Emergencies (IYCF-E), Infant and Child Social, and Emotional Wellbeing, and Policy Development and Implementation. On average, 38 CCHCs serving child care facilities across the state participated in the sessions. The SCCNC and CCHSRC began planning for the quarterly Learning Collaborative on the topics of sickle cell disease and Autism in the Early Childhood Setting for FY25.

The SCCNC, SMD, and other DCFW staff continued to engage as partners with the EarlyWell Initiative, aligned with the NC Early Childhood Foundation Pathways to Grade-level Reading, addressing the social and emotional health of children birth to third grade. From the EarlyWell work, a cross-sector workgroup led by Dr. Marian Earls focused on Infant and Early Childhood Mental Health Consultation (IECHMC) efforts in NC. The SCCNC, SMD, Title V CYSHCN Director, and other WCHS staff participated in the large group monthly meetings.

As part of the work with IECMH, the SCCNC led a sub-workgroup looking at existing data sources and determining ideal data metrics for the state. The SCCNC also participated with a second sub-workgroup that successfully defined IECMHC for NC. As part of a broad landscape assessment, the SCCNC participated with the group in

successfully completing an annual survey of an array of professionals providing any type of mental health or behavioral health services to children, including those with special health care needs, throughout the state. The survey data was used by the group to guide their efforts at integrating and promoting mental health care for these children. The SCCNC held a position on the Board of Director's for the North Carolina Infant and Early Childhood Mental Health Association (NCIMHA). In this role, the SCCNC participated in the monthly meetings and provided general support to the work of the NCIMHA.

The SCCNC participated as a panelist with the DCFW Division Director, School Health Unit Manager, Child Mental Health Program Consultant in a breakout session at the Behavioral Health Springboard's sponsored NC Child Behavioral Health Conference in October 2023. The SCCNC discussed early childhood development within the contact of child care services and CYSHCN.

With respect to families of children who are deaf and hard of hearing (DHH), the EHDI Advisory Committee continued meeting quarterly and assisted with outreach efforts and program evaluation. EHDI Program staff increased collaborative efforts with other state and national programs and agencies such as CMARC, Family Connects, EI, MIECHV, LHDs, WIC, Hands & Voices Family Leadership in Language & Learning Center (FL3), National Center for Hearing Assessment and Management (NCHAM), American Academy of Pediatrics (AAP), HRSA, CDC, and EHDI programs in other states and territories to influence systems change.

The EHDI program worked with The CARE Project to provide opportunities for parents and professionals to support each other and gain greater understanding of the emotional journey of children who are D/HH and their families. NC-EHDI sponsored one family retreat and three in-person CARE Family Fun Day events. One of the Family Fun Days was for Spanish-speaking families and was coordinated by the NC-EHDI bilingual Parent Consultant. The in-person events offered families time to enjoy being together, making connections and participating in fun activities.

NC-EHDI also sponsored activities offered by other parent-to-parent support groups including a spring picnic, teen jump party, fall picnic and holiday party offered by the Charlotte Hitch-up, a summer splash pad event and a fall picnic offered by the Triangle Hitch-Up, three holiday parties for Spanish-speaking families offered by Triunfa Caracol Latino and a Spring egg hunt offered by Real COHL.

NC-EHDI sponsored an in-person Care Project Parent-Professional Collaborative in February 2024. This event brought 33 parents and 85 professionals together for a two-day learning experience covering a range of topics focused on belonging as a way to improve the culture of communication between professionals and parents of children with a diagnosis of hearing loss.

NC-EHDI continued the DHH Heroes program to provide opportunities for DHH adult-to-family interaction. The team has identified twelve DHH Heroes (adults living with hearing loss), created unique trading cards for each Hero to share with DHH children, and made superhero t-shirts for each Hero to wear when attending family events. The DHH Heroes attended seven EHDI sponsored family events.

The NC-EHDI part-time Spanish speaking parent consultant increased outreach and engagement with the Hispanic community by organizing an additional three support groups across the state (total of six) and offering social and educational events for the Hispanic families of DHH children. NC-EHDI team members continued collaborating with partners on a learning community in the Mecklenburg/Union County area that is focused on the needs of the Hispanic population in the area.

The EHDI Parent Consultants continued coordination of the EHDI Parent Support Team to offer parent-to-parent support for families of children who are DHH. The team includes members who utilize different communication modes, language (American Sign Language [ASL], Spanish), geographical location, and type of hearing technology used (hearing aids, cochlear implants, no technology). The EHDI program continues to partner with the Early Learning Sensory Support Program for Children with Hearing Impairment and the EHDI Advisory Committee member agencies to enroll families in this support program.

Current information about the receipt of intervention services and the outcomes of DHH children that are identified through EHDI programs is limited. With the shift in focus toward evaluating long-term outcomes for children who are

DHH, the EHDI Program enhanced collaborations with educational programs serving these children with a focus on language, educational, and literacy outcomes. Collaboration meetings were held monthly between the NC EHDI Coordinator and the NC Part C Coordinator (NC Infant-Toddler Program).

The ECIDS Governance Council recommended integration of EHDI data into ECIDS to facilitate earlier assignment of a unique identifier which can be used to match data from a variety of early childhood programs and better measure outcomes for children. The MOA between the NC Department of Information Technology and NCDHHS for support services provided by the Government Data Analytics Center was amended in May 2022 to add NC-EHDI data into ECIDS. During FY23, sample data files were created by the EHDI program and testing of data transfer was initiated with the goal of a “soft launch” of EHDI data in the ECIDS system in early 2024. During FY24, quarterly data transfers from WCSWeb to ECIDS began.

The AAP NC-EHDI Chapter Champion, who is Deaf, carried out these and other activities in FY24: 1) participated on the EHDI Advisory Committee; 2) participated in the development of a residency training module about EHDI; and 3) participated in the development of a training for primary care providers about risk factors for late onset or progressive hearing loss

The NC-EHDI Program’s Parent Consultants continued to engage parent partners in EHDI activities. Additional parent members were sought for: 1) participation on the EHDI Advisory Committee; 2) participation on EHDI Program committees; 3) review and development of program materials; 4) attendance at PACL Trainings; 5) attendance at the National EHDI conference and the Hands and Voices Leadership Conference; and, 6) co-presenting with EHDI regional consultants at partner meetings and conferences.

In addition, the NC Title V Program continued to leverage resources to support a variety of contracts including genetic/metabolic services, screening to identify at-risk infants with neural tube and other birth defects, multidisciplinary craniofacial services for children, and treatment for communicative disorders related to hearing loss.

In relation to nutrition, in FY24, the PNC with input from the CDSA nutritionists transitioned from biannual meetings to email networking only. This was due to the increased workloads of these registered dietitian nutritionists and their increased comfort level in using each other as support systems for sharing nutrition information. The PNC continued to share CYSHCN nutrition with the CDSA nutritionists and to advocate for the value of these highly specialized clinical nutritionists.

As noted in other Block Grant sections, the PNC continued to focus and develop nutrition training and resources and compile data sources to promote weight inclusivity and weight neutrality to address weight bias, stigma and bullying among children and adolescents living in larger bodies, especially since research suggests that CYSHCN also experience higher rates of obesity and evidence suggests “that having a chronic health condition, including physical and intellectual disabilities, is another important risk factor in the development of eating disorders and disordered eating.” (Kumar MM. Eating Disorders in Youth with Chronic Health Conditions: Clinical Strategies for Early Recognition and Prevention. Nutrients. 2023 Sep;15(17):3672).

NC Office on Disability and Health (NCODH)

NCODH continued to integrate the health concerns of persons with disabilities, including CYSHCN, into state and local public health programs in FY24. This integration helped to promote access to care and inclusion within program practices and policies in collaboration with state and community partners.

NCODH works with LHDs to increase accessibility and inclusion for CYSHCN by providing information, TA and resources and conducting on-site accessibility reviews. During FY24, NCODH provided accessibility reviews for 10 individual LHDs across the state. As part of the accessibility reviews, NCODH provides a report to LHDs with recommendations and resources needed to make changes to improve access. The accessibility reviews fulfill new requirements by the NC LHD Accreditation Program to conduct an accessibility assessment within two years of accreditation.

NCODH revised the Active Routes to Schools Accessibility Checklist at the request of the Director of the National

Center for Safe Routes to School for inclusion on the Walk to School Website. Additionally, NCODH along with other WCHS attend Olmstead Plan Stakeholder Advisory (champions the right of all people with disabilities to choose to live life fully included in the community) meetings informing the NC Olmstead Plan strategies and quarterly reports for children and families.

Involvement in emergency preparedness efforts continued in FY24 as the NCODH strengthened the partnership with NC Emergency Management (NCEM). NCODH participated in efforts to improve preparedness efforts for children and adults with disabilities through involvement in statewide workgroups including C-MIST (Communication, Maintaining Health, Independence, Support and Safety, and Transportation) Advisory Committee, Registries Workgroup, and FAST (Functional Assessment Support Team) Workgroup. In FY24, NCODH continued to serve as a FAST Coordinator and trained additional FAST members. NCODH worked to ensure families of CYSHCN received timely information and updates through regular partner updates with NCEM.

NCODH continued collaboration with the NC Sexual Violence Prevention Team to promote the inclusion of individuals with disabilities in sexual health and sexual violence prevention in NC. As part of this committee, NCODH is a member of the K-12 workgroup to further address sexual health education needs of CYSHCN. As a result of these workgroups, additional partnerships were established with NC DPI, Carolina Institute for Developmental Disabilities and NC Coalition Against Sexual Assault.

NCODH provided multiple trainings in FY24 to NCDHHS staff, community-based organizations, and providers to encourage inclusion of people with disabilities and CYSHCN in all efforts, recognizing health disparities, and promoting access and inclusion in prevention efforts. The Title V CYSHCN Director contributed to additional efforts to improve health outcomes for all CYSHCN by serving on the CYSHCN National Advisory Board to 1) provide national leadership and guidance to the CYSHCN field; 2) identify priorities that will improve outcomes for CYSHCN and their families; and 3) provide national guidance on specific actions that are likely to coordinate and improve systems serving CYSHCN and their families. In addition, the CYSHCN Director served on the National Network for Advancing Systems of Services for CYSHCN workgroup to inform sample strategies to implement the four domains of the *Blueprint for Change*. Lastly, the CYSHCN Director delivered a presentation centered on advancing anti-ableism in relation to I/DD and social justice to the Leadership in Neurodevelopmental and Other Related Disabilities (LEND) Program students/trainees for the Leadership in Action series. Due to the positive response, this presentation will now be included annually.

Ensuring Health Care Transition Services

One component of improving access to coordinated, comprehensive, ongoing medical care for CYSHCN is to ensure that YSHCN receive the services necessary to make transitions to adult health care. The WCHS has set an objective to improve this indicator as measured through the NSCH by 30% from the 2018-19 NCHS baseline by 2025. The 2022-23 NSCH results showed 21.6% of YSHCN receiving transition services as compared to 22.3% nationwide. While the NC rate slightly exceeds the goal of a 30% increase, the confidence intervals for the two time periods overlap, so it is not clear that the increase is significant. More work needs to be done to ensure that YSHCN in NC are able to transition to adult health care more easily. Even with combining two years of survey results, rates for subgroups by race/ethnicity are not reliable.

Transition Work Group and CYSHCN Strategic Plan Health Care Transition Recommendations

During FY24, the IA Director position was vacant, so the work on Health Care Transition (HCT) was transitioned to a medical home work group that would also address HCT. The medical home work group did not meet due to staffing issues and other priorities and was repurposed to be the CYSHCN Learning Collaborative state team. The DCFW SMD continued to participate in a national group with several states (i.e., Texas, Florida, Minnesota, Wisconsin, New Mexico) and Got Transition® staff to explore how to address HCT in the school setting and especially with Individualized Education Programs (IEPs). This HCT in education work group engaged the National Technical Assistance Center on Transition and continued to share state efforts and examples of policy language to help increase and support special education settings in each state. The DCFW SMD continued to try to promote communication among academic and community providers working on HCT efforts for YSHCN (i.e., Duke, East Carolina University, Wake Forest Baptist) and with WCHS programs to share best practices on a group listserv.

The NCDHHS CYSHCN web page remained a source of information on HCT and was updated to include additional resources on a regular basis. The Help Line for CYSHCN linked families to ECAC, GotTransition.org, and the AAP for HCT information and resources. The SHC program continued to emphasize the importance of “on-site” clinical services to support the needs of YSHCN, programs, incentives, and educational opportunities that help adolescents transition into all aspects of adult life. SHCs ensure that all students enrolled or served have a medical home and dental home. Results of all visits to the SHCs and recommendations for follow-up shall be shared with students’ medical homes within 24 to 48 hours of visiting and documented in their medical records (pursuant to the release of information permissions as required by FERPA/HIPAA). For chronic physical and mental health conditions, shared plans of care between the SHC and medical home should be used whenever possible. Addressing HCT as a requirement of the annual well visit for all adolescents is strongly recommended in DHB’s HCPG (NC Medicaid for Children).

MIECHV and CMARC programs increased efforts to work on HCT skills with adolescent mothers served by their programs or whose children are served by these programs. Additional efforts related to HCT in the 4CNC and Path4CNC efforts are included in the earlier medical home section of this domain.

Health Care Transition for Youth in Foster Care

The Transition Age Youth (TAY) Work Group shifted its structure to become a subcommittee of the DSS Well Being Design Team that the DCFW SMD has participated in for four or more years. DSS began staffing the TAY Work Group and membership changed, but the DCFW SMD continued to participate in the periodic meeting although not as co-chair. The DCFW SMD also continued to participate in and raise issues related to HCT in the larger DSS cross disciplinary Well Being Design Team. The Well Being Design Team continued to look at data to assess and think about strategies to address physical, mental and oral health of children in foster care and involved with DSS.

Modifications to Agreement Addenda and Contracts

HCT and self-management of care were able to be formally included into the FY24 AA language as a focus area for child health clinics in LHDs. During FY24, the Child Health Program continued to offer TA related to incorporating HCT into LHD agency policies and included HCT information in several training opportunities with LHD staff and CHTP students.

Prophylactic Antibiotics for Children with Sickle Cell Disease

The NC Sickle Cell Syndrome Program (NCSCSP) provided services to 1,821 clients with sickle cell disease, ages 0 to 21, during FY24. This included providing care coordination services along with client, family, and community education and newborn screening follow-up efforts to infants that have an abnormal hemoglobin result when tested at birth. Sickle Cell Educator Counselors worked collaboratively with health care providers to support clients in living healthier lives. During FY24, eighty-six newborns were identified with an abnormal hemoglobin through newborn screening. Approximately 86% (390 of 455) of children ages 4 months to 5 years served by the NCSCSP were placed on prophylaxis antibiotics (i.e., penicillin) per data entered into the WCS-Web database. Newborns that were not placed on penicillin did not receive this antibiotic due to the following reasons: having a genotype in which penicillin is not recommended; parent declined treatment; physician decision; infant lost to follow-up; or infant had out of state residency.

Parents with children ages three months to five years with sickle cell disease were educated on the importance of prophylactic antibiotics from Sickle Cell Educator Counselors utilizing the educational materials *North Carolina Sickle Cell Syndrome Protocol and Outline for Discussing Prophylaxis Penicillin*. This information was provided during the initial intake process and annually until the child reaches five years of age or as recommended by the hematologist. Additionally, parents were provided a penicillin toolkit including a *Parents Handbook on Sickle Cell Disease- Part I: Birth – 5 years,* a thermometer, pill crusher, pill box, syringe and teacher workbook entitled *Sickle Cell Disease: The Teacher Can Make a Difference*. Specific patient education was given to parents regarding preventative health care measures including keeping regular doctor appointments, staying on task with immunizations, taking penicillin to prevent bacterial infections, recognition of early signs of complications, and when

to seek immediate medical attention. Sickle Cell Educator Counselors also provide education to increase knowledge about sickle cell disease to community groups that serve clients and families living with sickle cell disease. Education is provided to daycare centers, Head Start programs, schools, colleges, LHDs, local housing authorities, local DSS agencies, and other agencies including faith-based organizations.

The SC Education Consultant formed the *NC Sickle Cell Transitioning Committee* comprised of DPH sickle cell staff and regional sickle cell educator counselors, representatives from the sickle cell community-based agency (Piedmont Health Services and Sickle Cell Agency), and representatives from the comprehensive sickle cell medical centers. In April 2024, the committee updated its framework document with a focus on acquiring data on transition efforts employed by sickle cell patients in North Carolina. The committee submitted a data request to the NC Sickle Cell Data Collection Program in May 2024. Data on the number and percentage of sickle cell patients in NC who successfully transferred from pediatric to adult care based on the National Alliance of Sickle Cell Centers' (NASCC) guidelines was requested. The NASCC recommends that the last pediatric clinic visit and first adult sickle cell care visit to establish care should be done in less than three months. Additionally, NASCC defines a successful transfer of care as two visits with a comprehensive adult sickle cell program in the first year. Visits can be done in person or via telemedicine. Data had not been received as of June 30, 2024. Finally, a survey was disseminated to approximately 40 subject matter experts across the state to obtain feedback on how to improve transitioning of SC patient care. Feedback is being reviewed.

The community-based organization partner, Piedmont Health Services and Sickle Cell Agency, planned and hosted several transition and life skills education sessions and related events to educate and empower clients about the importance of preparing for and engaging in HCT efforts. They included:

- Camp Carefree in which multiple HCT sessions were held for campers with sickle cell disease. The sessions centered around navigating healthcare systems and life skills simulations.
- Back to School Event that focused on building self-esteem and the importance of education.
- Game Night for Teens which involved transitioning aged clients and focused on the importance of medication compliance.
- Teen Education/Support Groups
- Roadmap to Transition-Life Skills Simulations

Priority Need 4 – Improve access to quality whole child and adolescent health care

As noted previously in the Child Health Domain Annual Plan, Priority Need 4 speaks to quality care for all children and adolescents both with and without special health care needs, thus the need spans several different domains. The NC Title V Program selected the Medical Home NPM (for CSHCN) for this priority need in the CYSHCN Domain and created ESM MH.1 (Percent of parents who report that they understand the available tools and resources necessary to access and maintain having a health care provider/team that uses a medical home approach to care).

CYSHCN PN4 Objective By 2030, increase the percent of CYSHCN having a medical home by 5% from 48.6% (NSCH 2022-23 baseline) to 51%.

The EI MD and/or DCFW SMD will continue to partner with DCFW staff to provide content for WCHS and EI trainings that include the importance of a medical home approach to care for all children and especially CYSHCN. In FY26, the DCFW SMD or EI MD will provide a training during at least one statewide meeting of the NC Chapter of American Academy of Pediatrics.

The CMARC state program will continue to work with families, primary care providers, and specialists to reinforce the importance of the use of a patient-centered medical home approach for CYSHCN under five years of age. Also, in FY26, the HFA and NFP programs will increase community outreach efforts about available home visiting services to new and existing primary care providers and the process for referring patients to the program.

The WCHS Community Outreach Team will continue to incorporate messages about the importance of choosing a quality medical home (and making the most of health insurance benefits) in all outreach/enrollment activities and by staffing a statewide toll-free Help Line to assist families with services for CYSHCN. In FY26, WCHS will launch an additional peer-to-peer empowerment training curriculum titled *Teaching Parents of Children and Youth with Disabilities About the Medical Home Approach*. WCHS developed this three-module training in collaboration with a core workgroup that included parents of children with disabilities, youth partners, WCHS staff, community partners, and healthcare providers. Module topics include defining the medical home approach, partnering with providers/communicating your child's special health care needs, and health care transition from pediatric to adult health care. The training modules will be presented by trained parents/caregivers of CYSHCN and will be available in English and Spanish both in person and virtually. The training will feature an online Medical Home toolkit. Training participants will understand the benefits of a medical home approach to healthcare for CYSHCN, gain confidence in engaging in the medical home approach with their child's providers, and be introduced to tools to help prepare for health care transition from pediatric to adult care. Baseline data for ESM MH.1 will be collected in FY26 from the *Teaching Parents of Children and Youth with Disabilities About the Medical Home Approach Training Post Evaluation Survey* which will be asked of every participant in each module of the training.

The Best Practices Outreach/Help Line Team will review the 2024 CMS guidance shared around Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and explore strategies with the EI MD and/or DCFW SMD to share this information (i.e., website, social media and fact sheets).

The Commission's Oral Health Workgroup will continue to focus on education and outreach to families and providers through their Dental Home Initiative. Dental Home training for both families and providers will continue to promote strategies to improve access to oral health care for CYSHCN. In FY26, WCHS will expand outreach for the newly revised Dental Home training for families/caregivers and the new Dental Home Initiative webpage. Efforts to develop partnerships with oral health providers and organizations and promotion of the Dental Home training for providers will continue. The Oral Health Workgroup's monitoring of Medicaid Transformation issues will be maintained as oral health remains carved out which can be confusing for parents and caregivers, as well as providers.

In FY26, NCODH will continue to provide TA to LHDs to increase accessibility and promote full participation of CYSHCN by providing resources, training and on-site accessibility reviews as requested. NCODH will continue to partner with NC Emergency Management to ensure the needs of CYSHCN and families are supported in state and local disaster planning, response, and recovery through involvement in workgroups and training. In response to Hurricane Helene, NCODH will focus efforts on individual emergency preparedness and expand partnerships to address continued needs to improve emergency preparedness and response. Partnerships will continue in areas related to sexual violence prevention, oral health care, and access to care with focus on expanding collaborative opportunities to promote CYSHCN priorities. NCODH will continue to build on its partnership within NCDHHS to ensure full participation of CYSHCN and people with disabilities, specifically as it relates to physical and communication access. In FY26, NCODH will continue to support disability data collection across NCDHHS, especially increased use of disability status in the collection of demographic data.

During FY26, the annual School Nurse Conference slate of speakers will include topic(s) and speaker(s) related to the subject of CYSHCN. Additionally, the Roles and Responsibilities course taught by RSHNC bi-annually will include care coordination and advocacy content which supports CYSHCN in the school setting. This course is promoted to school nurses across NC with a year of experience and, upon completion, 4.0 Contact Hours are awarded.

The School Health Program Manual is accessible to all school nurses in NC and is an evidence-based resource which promotes best practice for optimal student outcomes. During FY26, as part of its bi-annual review, the RSHNC team will examine the School Health Program Manual located on the School Nurse Support webpage to ensure information regarding CYSHCN utilizes current, evidence-based references.

Priority Need 5 – Ensure all CYSHCN and families receive care in a well-functioning system

Priority Need 5 is similar to a priority need cited in the NC 2021-2025 State Action Plan (Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN), but the wording has been revised. Components of a well-functioning system of care are the following: families partner in decision-making if needed; medical home; preventive medical and dental care; continuous and adequate insurance; easy access to services; and preparation for transition to adult health care among adolescents. As noted in the CYSHCN Domain Annual Report, NC was one of five states to participate in a Learning Collaborative supporting CYSHCN and their families and many of the objectives and strategies for this part of the NC 2026-2030 State Action Plan stem from the work of that collaborative. SPM 2 (Percent of children with special health care needs who receive care in a well-functioning system as measured by the NSCH, which is also CSHCN Systems of Care NOM) was selected by the NC Title V Program for this Priority Need.

CYSHCN PN5 Objective 1 By 2030, increase percent of CSHCN who receive care in a well-functioning system by 5% from 15.6% (2022-23 Baseline) to 16.4%.

CMARC will continue to provide outreach by establishing and maintaining strong linkages with NICUs, hospitals, primary care providers, DSS, WIC, EI, and other local, regional and state programs that serve CSHCN in FY26. CMARC will continue to reach out to other possible referral sources through community events and by contacting social services agencies including DSS using the CMARC brochure and outreach materials. As CMARC referrals are received, member outreach will be initiated within three business days using Motivational Interviewing Skills. CMARC engagement will involve the parent/caregiver (legal guardian when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care. Face-to-face family interactions (home visit, medical home office visit, hospital visit, community visit, video conferencing, etc.) will be encouraged over telephone interactions.

In FY26, the RCHNCs will continue to provide TA to develop patient-centered care plans per program guidelines, including: development of appropriate goals, the use of condition specific pathways and interventions that are most effective in engagement members' families, meeting their needs and achieving care plan goals; identifying and coordinating care with community agencies/resources needed to meet the specific needs of the child (including statewide resource platform) thereby ensuring children/families are well-linked to needed resources, including the child's medical home or other practice; and ensuring the level of care management services are based upon the members' level of need as determined through evaluation of the care plan and ongoing assessment. These efforts will be directed in a manner to decrease the number of families choosing to leave the CMARC program before family driven social and health goals and needs are met in the care plan.

The System of Care (SOC) Team will leverage the Learning Collaborative Team, including DCFW unit managers, to brainstorm and develop and integrate strategies to inform the local SOC Community Collaboratives, which include youth and family members with lived experience, and connect them to resources and training opportunities.

A new three-year funding cycle for Innovative Approaches (IA) reflects the revised IA framework now titled Innovative Approaches 2.0 (IA 2.0). In this revised framework, the purpose remains to enhance community systems of care for CYSHCN and their families using a family-driven system change approach. IA 2.0 will focus system change efforts within key areas of focus which include (1) health care transition from pediatric to adult care, (2) emergency preparedness, and (3) community accessibility. Three grantees were chosen through the RFA process to implement IA 2.0 beginning in July 2025. Grantees include a university which will focus on emergency preparedness and health care transition from pediatric to adult care in seven counties in rural western NC. A non-profit parent-led disability organization will also address emergency preparedness and health care transition from pediatric to adult care in four additional rural counties. Finally, a Federally Qualified Health Center, serving one urban county, will focus on healthcare transition from pediatric to adult health care and community accessibility in a large metropolitan area.

In FY26, WCHS staff will continue to maintain a multi-faceted engagement framework that engages parents/caregivers of CYSHCN in a variety of opportunities to intersect with and contribute to program planning, activity development, implementation, and evaluation. WCHS will continue to employ a full-time Family Liaison Specialist. Additionally, in relation to child behavioral health, a Family Peer Support Partner will continue to be employed to increase family engagement efforts. The Family Peer Support Partner will meet with section unit managers and staff to determine how the family voice can be integrated into units/section activities.

The WCHS Family Partner Engagement and Leadership Committee, which represents nine family partners with extensive experience in NC's system of care and WCHS activities, will continue to inform and add value to program development within supported activities for both family partners and WCHS staff members. The Committee will meet four times in FY26 and participate in communication regarding topics such as parent training cadre updates, the AMCHP scholarship application process, scaling up Medicaid, and WCHS staff roles and transitions. In FY26, this committee will now be co-led by the Family Liaison Specialist and a Family Partner rather than being led by just the Family Liaison Specialist.

The WCHS Parent Training Cadre reflects a peer-to-peer empowerment training model implementing evidenced-informed/based curricula. In FY26, these trainings will continue to be provided virtually or in person in English and Spanish at no cost to parents/caregivers, either as a series or as individual modules according to parent/caregiver needs. The Parent Training Cadre includes the following curricula:

1. *Parents as Collaborative Leaders (PACL)*
2. *Teaching Parents of Children and Youth with Special Healthcare Needs about Sexual Health*
3. *Dental Home Strategies for Success*
4. *Teaching Parents of Children and Youth with Disabilities About the Medical Home Approach*.

WCHS will invest in Title V family leadership development by sponsoring family partners to attend national conferences in FY26. These conferences allow families to expand their existing family partnerships internal and external to NC and to broaden their comprehension of Title V programmatic opportunities. The attending family partners will report back to either the Family Partner Engagement and Leadership Committee or WCHS EHDI Advisory Committee about what they learned and how they plan to use the information to improve the lives of CYSHCN on a local or state level. By attending these conferences, Family Partners will enhance their participation in WCHS committees, workgroups, and activities by promoting and applying information gained through attending the conferences.

During FY26, the annual Child Care Health Consultant (CCHC) Conference will feature a comprehensive agenda focused on CYSHCN. The event will include guest experts specializing in food and medication allergies and anaphylaxis in children enrolled in child care settings. In addition, the bi-annual CCHC Certification Course, presented collaboratively by the SCCNC and the NC CCHSRC, will place particular emphasis on supporting CYSHCN in child care facilities. The course will address key topics such as care coordination, referral systems, and resource navigation for staff and early childhood educators. This professional development opportunity is widely promoted to CCHCs across NC, and participants who complete the course will earn 8.0 Nursing contact hours. Following successful completion, certified CCHCs will be equipped to deliver in-person training sessions to early care and education professionals on a variety of CYSHCN-related topics including asthma, diabetes, allergies and anaphylaxis, autism spectrum disorder, enteral feeding, seizure management, sickle cell disease, and mobility-related challenges. These courses provide vital support information for the child care facilities to implement best practices for children enrolled in their respective programs.

The Child Care Health Consultation Manual, a comprehensive, evidence-based resource, remains available to all active CCHCs serving every county in NC. This manual promotes best practices aimed at achieving optimal outcomes for CYSHCN in child care settings. As part of its annual review process during FY26, the NC CCHSRC, in partnership with the CCHC Committee and the SCCNC, will evaluate the manual to ensure that training content related to CYSHCN reflects current, evidence-based guidance and resources. The manual is accessible via the NC CCHSRC website.

Family Partners will continue to be engaged in WCHS program planning and implementation by contributing to the MCH Block Grant review process in addition to co-chairing the NC Genetics and Genomics Advisory Committee, NC EHDI Advisory Committee, and Family Partner Engagement and Leadership Committee. Furthermore, the DCFW SMD will explore across DCFW how to engage parents/caregivers of CYSHCN and youth with SHCN in developing content for use as part of larger presentations for health care professional trainings for LHDs, hospitals and other settings where children receive care. This content would be used to highlight the importance of meaningful family and youth engagement in a variety of different health care topics.

The NC EHDI program will continue to maintain its website with entire sections dedicated to the stakeholders involved in the EHDI continuum, including birthing facilities and midwives, pediatric audiologists, primary care providers and families.NC has an active multidisciplinary EHDI Advisory Committee that is co-chaired by a parent of a child with hearing loss and a professional who works with the DHH population. Committee members represent EHDI system key stakeholders including families, birthing facilities, the NC Division of Services for the Deaf and Hard of Hearing (DSDHH), pediatric audiologists, EI providers, family support organizations, DPI, home visiting programs, Leadership Education for Neurodevelopmental and Related Disabilities (LEND) program, pediatricians, NC Association of the Deaf (NCAD), Medicaid, and university educators involved in the training of speech language pathologists, audiologists and teachers of the DHH. The Committee will continue to meet quarterly to provide guidance, support, and leadership to the NC EHDI Program. The Advisory Committee will be involved in implementing the activities and strategies identified from the needs assessment completed in FY25.

The EHDI Program will enhance collaboration with other early childhood programs and initiatives to continue to develop efficient and effective ways to expand hearing screening beyond the newborn period up to at least three years of age. Additionally, the EHDI Program will work with educational programs serving DHH children to focus on language acquisition and other language and developmental outcomes for DHH children. The EHDI Program will continue to work collaboratively with the DSDHH to implement a new Deaf Role Model/Mentorship Program in NC, complete with a revised and expanded DHH Heroes initiative. This program is designed to actively involve Deaf adults with families of young DHH children to enhance/improve language development, provide additional resources for families to learn and use ASL, and provide opportunities for families to learn about and engage with the Deaf community.

WCHS staff members will continue to coordinate the Governor’s Commission on CSHCN and subcommittee meetings bimonthly in FY26, which includes scheduling and agenda creation, documenting meeting discussions, and providing feedback and recommendations to key state leaders. The Commission will continue to bring leadership from Medicaid’s Standard and Tailored Plan contractors to the table to discuss progress, opportunities, and challenges in serving CYSHCN across the state. Commission members will provide feedback and recommendations on critical issues, including emergency preparedness, and continue to monitor progress on the quality and availability of health care services for CYSHCN. In addition, CYSHCN Help Line data will be presented at Commission meetings to identify trends and needs among family members and providers.

To initiate the development of a revised CYSHCN Strategic Plan in FY26, several key activities will be designed to establish a strong foundation. First, a thorough assessment of funding resources and staff capacity will be conducted to ensure achievable expectations and inform the formation of the CYSHCN Strategic Plan Section workgroup. This workgroup will be carefully assembled, with attention to member selection, timeline, meeting cadence, and goal setting. Subsequently, the workgroup will be oriented to strategic plan development principles, enabling them to effectively analyze the alignment between past WCHS Strategic Plans for CYSHCN, and also to the six core outcomes that serve as indicators of a well-functioning system of services for CYSHCN. This analysis will identify critical gaps and areas for integration, leading to the development of focused subcommittees around key priorities. A summit will be held by the end of FY26, and invited participants will include WCHS staff members, family partners, youth, agency representatives, and other partners to review the available data and prioritize key initiatives to be included in the Strategic Plan.

WCHS staff members will develop an outreach plan to recruit parent support organizations that will host training curricula included in the Parent Training Cadre (Parent Leadership, Sexual Health, Dental Home, and Medical Home). In FY26, WCHS staff members will identify potential trainer recruitment based on identified needs (geography, language, etc.). Newly recruited trainers will receive coaching/training opportunities, and experienced trainers will continue to receive training updates that align with best practices. WCHS staff members will utilize post-training survey results submitted by training attendees to make improvements to curricula.

The Community Outreach Coordinator's ongoing co-chairmanship of the quarterly NC Coalition to Promote Health Insurance for Children meetings will continue in FY26. This role, shared with the NC Pediatric Society's Executive Director and supported by the CYSHCN Access to Care Specialist, facilitates a forum for statewide collaboration. Meeting agendas will focus on enhancing participant knowledge of key resources, sharing critical updates from different agencies, and fostering a comprehensive strategy to improve children's health insurance access across North Carolina.

In FY26, the DCFW SMD will work with the SHCs Program Manager to lead at least one discussion with staff at funded SHCs about potential strategies to help YSHCN with health care transition (self-management of care and planning for transfer from pediatric to adult health systems of care). The SMD and SHCs Program Manager will

explore use of a survey of SHCs to assess ideas and needs from SHCs related to health care transition from pediatric to adult care. In addition, the new peer-to-peer training curriculum *Teaching Parents of Children and Youth with Disabilities About the Medical Home Approach* includes one module on Healthcare Transition, with objectives focused on identifying differences in pediatric healthcare versus adult healthcare, introducing a Healthcare Transition timeline, and providing tools that help families to prepare for Healthcare Transition.

The WCHS will continue to maintain a statewide toll-free CYSHCN Help Line (available Monday through Friday during regular business hours) and email account to assist families and providers with services for CYSHCN in FY26. Help Line staff will respond to CYSHCN Help Line inquiries within one business day and utilize the Language Access Line for non-English speakers. The Help Line position is currently vacant, but efforts are underway to fill the position. Continuous backup coverage will be provided by WCHS staff until the position is filled. Help Line users will be invited to complete a services satisfaction survey via a survey link.

CYSHCN PN5 Objective 2 By 2030, increase the percentage of children ages 4 months to 5 years with sickle cell disease who are placed on prophylactic antibiotics by 3 percentage points from 86% (2023 baseline) to 89%.

In FY26, the Sickle Cell Education Consultant will develop a flyer about a provider webinar that outlines the importance of prophylactic antibiotics. Also, the flyer will be added to the sickle cell newborn packet that parents of newborns with sickle cell disease receive as part of the initial contact/visit with the assigned Sickle Cell Educator Counselor or case manager. A web link will be included on the flyer which will be posted on the SC Program's website. In addition, a field will be added in the WCSWeb database to capture the date(s) the Educator Counselors/Case Managers discuss the importance of prophylactic antibiotics with parents. Data analytics on web traffic and the number of providers who accessed and/or viewed the webinar will be tracked. Finally, the Sickle Cell Program Supervisor or Data Manager will reach out directly to primary care providers of newborns with an abnormal hemoglobin result on newborn screening to ensure proper follow up inclusive of referral to specialty care (hematology) and confirmatory testing.

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - Compensated Family Engagement and Leadership Opportunities

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	55.0	60.0	65.0	70.0	75.0

Evidence-Based or –Informed Strategy Measures

None

SPM 4 - Counties who Have Utilized NC-PAL or NC MATTERS

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	74
Numerator	
Denominator	
Data Source	NC PAL and NC Matters internal program reports
Data Source Year	2024
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	80.0	85.0	90.0	95.0	100.0

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (North Carolina) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Engage individuals and families with lived experience, as well as community-based organizations, as partners in the development and implementation of people-centered programs and policies that reduce
SPM
SPM 3 - Compensated Family Engagement and Leadership Opportunities
Five-Year Objectives
CC/SB PN6 Objective 1 By 2030, increase by 20% from baseline (TBD in FY26) the percent of WICWS and WCHS staff who have used any tool or resource in their work to address disparities and improve health outcomes for all individuals.
CC/SB PN6 Objective 2 By 2030, increase by 10% from baseline (TBD in FY26) the percent of Title V programs that offer compensated family engagement and leadership opportunities
CC/SB PN6 Objective 3 By 2030, 75% of Title V contractors will have a plan to identify and address health disparities and/or improve health outcomes for all individuals as part of their contract with NC DHHS.

Strategies
CC/SB PN6 1.1 Conduct organizational assessment to determine current tools and resources available to staff and opportunities to address current gaps.
CC/SB PN6 1.2 Conduct baseline assessment among WICWS, WCHS, and Title V staff regarding their current use of tools in their work.
CC/SB PN6 1.3 Develop and publish a resource center with tools on the Title V website for staff to improve health outcomes for all individuals into their work within core elements of public health work including program planning, community engagement, procurement, and data collection and analysis.
CC/SB PN6 1.4 Work with DPH and DCFW leadership to embed opportunities for staff to engage in ongoing learning and dialogue, such as workshops, affinity groups, and town hall meetings, to promote common language and shared understanding of improving health outcomes for all individuals along with opportunities for exposure and interaction with individuals with lived experiences and share success stories/barriers, etc.
CC/SB PN6 2.1 Understand and better coordinate current efforts across NCDHHS divisions to partner with and engage communities, families, fathers, and youth at the systems and program level.
CC/SB PN6 2.2 Build and sustain relationships and trust with families of different backgrounds and life experiences to share voice and power in the design and delivery of services.
CC/SB PN6 2.3 Ensure communication tools, such as marketing materials and intake forms for maternal and child health programs, are representative of all family structures and available in multiple languages.
CC/SB PN6 2.4 Develop best practices for virtual engagement of families, fathers, and youth that maintain high quality opportunities.
CC/SB PN6 2.5 Support the NC Perinatal Health Strategic Plan Collective Village to Village work group in conducting a Community Engagement Community of Practice to include topics such as power sharing, trust building, resource sharing, etc.
CC/SB PN6 2.6 Develop and implement best practices for sustainable compensation for people with lived experience who provide direction for Title V activities.
CC/SB PN6 3.1 Review current contracts to establish understanding of current practices surrounding health disparities and/or improving health outcomes for all individuals.
CC/SB PN6 3.2 Develop and offer technical assistance sessions/office hours for contracted partners in collaboration with people from the community they are serving to review current activities and determine how to incorporate addressing improving health outcomes for all and community health factors.
CC/SB PN6 3.3 Examine current procurement practices and determine if changes need to be made to ensure fair practices are in place and community-based organizations are able to apply for contracts.
CC/SB PN6 3.4 WICWS and WCHS will require all staff, clinical and non-clinical, from LHDs and other contracted partners, to participate in at least one training annually focused on health disparities to support individual competencies and organizational capacity. This requirement is part of their agreement addenda. LHDs are provided with a list of low-cost trainings or continuing education opportunities.

ESMs	Status
No ESMs were created by the State. ESMs are optional for this measure.	

State Action Plan Table (North Carolina) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Improve access to mental and behavioral health services for maternal and child health populations

SPM

SPM 4 - Counties who Have Utilized NC-PAL or NC MATTERS

Five-Year Objectives

CC/SB PN7 Objective 1 Increase calls to NC Maternal Mental Health MATTERS (Making Access to Treatment, Evaluation, Resources, and Screening Better) psychiatry access line by 15% annually.

CC/SB PN7 Objective 2 Increase calls to the pediatric NC Psychiatry Access Line (NC-PAL) by 20% annually.

CC/SB PN7 Objective 3 Increase the percent of mental/behavioral health screenings completed at designated prenatal and/or postpartum appointments at a local health department (Baseline to be determined during FY26 using data from LHD/HSA).

CC/SB PN7 Objective 4 Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department (LHD/HSA).

Strategies

CC/SB PN7 1&2.1 NC MATTERS will continue to train and educate NC professionals (health care, human service, etc.) in a variety of ways including: hosting a cohort-based Maternal Mental Health Fellowship opportunity to improve access and capacity for addressing perinatal behavioral health; sharing toolkits and promotional materials through targeted outreach; conducting a statewide media campaign to promote NC MATTERS and HRSA's National Maternal Mental Health Hotline; and offering online modules covering core components of mental health care, including mood and anxiety disorders, substance use disorders, barriers to care, and more.

CC/SB PN7 1&2.2 NC-PAL will continue pediatric practice engagement, inclusive of Lunch and Learn series and developing practice implementation cohort to focus on enhancing screening and supporting social-emotional health. NC-PAL will continue providing training and technical assistance to Part C Early Intervention Children's Developmental Services Agencies (CDSAs) providers on supporting social-emotional and early relational health.

CC/SB PN7 1&2.3 Increase attendance for the REsource for Advancing Children's Health (REACH) Institute's Patient-Centered Mental Health in Pediatric Primary Care (PPP) courses.

CC/SB PN7 1&2.4 WICWS Women's Health Social Work Consultant (WHSWC) will convene a LHD Community of Practice to engage LHD behavioral health providers in learning opportunities, such as case studies, to enhance their practice and ability to identify, treat, or refer issues related to perinatal mental health and substance use disorders.

CC/SB PN7 1&2.5 WCHS and WICWS staff members promote NC-PAL/NC MATTERS to all LHDs and CBOs and can provide more detailed education sessions as requested.

CC/SB PN7 1&2.6 The Perinatal Care Region I Perinatal Nurse Champion will create educational materials /resources for OB providers related to maternal mental health screening and recruit up to 5 OB/GYN practices to participate in postpartum maternal mental health screenings simulation training.

CC/SB PN7 1&2.7 The NC MATTERS Stakeholders Network, which includes Title V representatives, will help identify outreach strategies to clinics and/or providers who care for pregnant and postpartum women.

CC/SB PN7 3&4.1 WICWS will provide maternal mental health and behavioral health trainings, orientation, and technical assistance for LHDs and community-based organizations that serve pregnant and/or postpartum women annually.

CC/SB PN7 3&4.2 WICWS Regional Social Work Consultant will provide education and support for the CMHRP Care Managers inclusive of the Perinatal Mental Health Pathway.

CC/SB PN7 3&4.3 WCHS Regional CMARC Nurse Consultants will provide education and support for the CMARC Care Managers inclusive of behavioral health.

CC/SB PN7 3&4.4 Provide education and technical assistance to LHDs and education to other statewide partners about the importance of recommended and required components of the annual well adolescent visit with an emphasis on screening and confidentiality related to mental health and risk for suicide and anticipatory guidance on emotional wellness and social connectedness.

CC/SB PN7 3&4.5 Partner with NC DPI and other collaborators on statewide mental health initiatives including the School Mental Health Initiative and Social Emotional Learning in schools.

CC/SB PN7 3&4.6 School Health Centers will continue to provide mental health services (in-person and virtual).

CC/SB PN7 3&4.7 Regional School Health Nurse Consultants provide school nurse professional development related to behavioral and mental health by means of courses and school nurse conference topics.

CC/SB PN7 3&4.8 Increase use of NCCARE360 for referrals by LHDs.

CC/SB PN7 3&4.9 Work collaboratively with the NC Comprehensive Suicide Prevention Team and the Youth Suicide Prevention Coordinator to provide the following trainings: Youth Mental Health First Aid Training (YMHFA); Applied Suicide Intervention Skills Training (ASIST), and Counseling on Access to Lethal Means (CALM).

CC/SB PN7 3&4.10 DCFW Early Mental Health Action Team (EMHAT) will continue to develop and implement Action Plan strategies to enhance internal and external alignment of IECMH-related supports across programs.

CC/SB PN7 3&4.11 Triple P LIAs will continue to support practitioners to deliver Triple P to parents and caregivers of children age 0-17 years about promoting their child's development.

CC/SB PN7 3&4.12 Support work by the NC Perinatal Health Strategic Plan Collective to carry out strategies in the Perinatal Health Strategic Plan to increase access to mental and behavioral health.

CC/SB PN7 3&4.13 Home visiting programs will conduct depression and intimate partner violence screenings for primary caregivers.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

2021-2025: State Performance Measures

2021-2025: SPM 5 - Ratio of black infant deaths to white infant deaths

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		2.3	2.5	2.3	2.1
Annual Indicator		2.7	2.4	2.7	3
Numerator		12.8	12.1	12.9	13.6
Denominator		4.8	5.1	4.7	4.5
Data Source		NC Vital Statistics/SCHS	NC Vital Statistics/SCHS	NC Vital Statistics/SCHS	NC Vital Statistics/SCHS
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Priority 8 – Improve health for all individuals through addressing disparities and non-medical drivers of health.

The NC Title V Program is committed to increasing health for all, eliminating disparities, and addressing community health factors as cited in Priority Need 8. In previous MCH Block Grant applications, the NC Title V Program showed this commitment by working to address disparities within each of the priorities related to population domains, but in the 2020 Needs Assessment, it was clear that a separate priority was needed specific to ensuring that improving health for all, inclusive of populations who experience profound disparities, was required. While there are racial, ethnic, and geographic disparities found in too many different MCH outcomes, the selected SPM for this priority need, the ratio of Black infant deaths to white infant deaths, is a sentinel measure. Unfortunately, while mortality rates for Black and white infants both were at then historic lows in 2018 at 12.2 and 5.0 per 1,000 infants, respectively, NC has not shown any progress in reducing the Black:white disparity ratio. The disparity ratio between non-Hispanic Black and non-Hispanic white infant death rates rose from 2.46 in 2018 to 3.02 in 2023. Any small gains made during this time were generally due to an increase in the white infant mortality rate rather than a decrease in the Black infant mortality rate. The non-Hispanic Black rate did drop to 12.1 in 2021, but was back up to 13.6 in 2023. The non-Hispanic white infant mortality rate was 4.5 in 2023. In addition to being an SPM, reducing this disparity ratio is a performance measure in the DPH and NCDHHS Strategic Plans, an overarching objective in the Perinatal Health Strategic Plan, a goal of the NC ECAP, and an indicator in Healthy North Carolina 2030.

The WICWS houses several programs/initiatives (Healthy Beginnings, Healthy Start Baby Love Plus, Southeastern NC Healthy Start, ICO4MCH, and the Reducing Infant Mortality in Communities Program) focused on reducing infant mortality and the Black:white disparity ratio as well as differences with other groups. Descriptions of these programs and their achievements and plans can be found in the Perinatal/Infant Health Domain.

Improving Health for All

NC Title V programs continued to review data and outcomes related to MCH populations. As we worked to improve health for all individuals and families, it was evident that we needed to address disparities in our outcomes. Collaborations continued with our Office of Rural Health, Office of Workforce Engagement, and Office of Health Disparities (OHD) to ensure that program elevated individuals with more disparate outcomes. An organizational framework was intended to catalyze action and started with placing communities at the center. Other pillars of the framework are - Changes to Policies, Systems, and Environments; Leverage Data-Driven Strategies; Catalyze Multi-Sector Collaboration; and Build Sustainability and Organizational Capacity. Title V will continue to determine its role within this framework moving forward.

Additional NC Title V Program Plans and Activities

Training modules continued to be available to all Cabinet agency employees, which includes all NCDHHS employees, through the Learning Management System during FY24. The training included 14 e-learning modules totaling 75 minutes in duration. The modules covered a range of topics to address challenges with improving health for all including addressing disparities in outcomes. All WICWS staff are also required to complete at least eight hours of training annually related to improving health for all/disparities/SDOH.

The CMHRP program provides training to newly hired CMHRP Care Managers on health disparities and social determinants of health during the quarterly CMHRP New Hire Orientation training. This training incorporates how social determinants of health may impact infant mortality as well as health disparities. The training also includes education on care management functions such as collaboration with prenatal care providers to improve quality of care and reduce barriers to care, thus, potentially improving chances for a full term, healthy weight birth outcome. On-going training will be provided to care managers on health disparities linked to pre-term and low-birth weight and how to minimize those factors through the care management/patient relationship which offers advocacy, education, and linkage to resources. This training is provided through quarterly webinars and monthly Program Updates.

In the scope of work in the AA and contracts with LHDs, universities, hospitals, and community-based organizations for all programs in the WICWS, inclusive of maternal health, family planning, sickle cell, preconception health, TPPI, etc., some of which are funded completely by Title V, the WICWS includes the following requirement:

- All staff, clinical and non-clinical, shall participate in at least one training annually focused on health disparities or social determinants of health to support individual competencies and organizational capacity to promote health for all.

As mentioned in the MCH Workforce Development section of this report, the WICWS reinstated the Reading Circle in FY23. The Reading Circle provides staff members with an opportunity to engage in discussions, broadening their points of view by examining and building on the ideas of others. The books explore various cultural topics and situations. In October 2023, the group read and discussed *Take My Hand* by Dolen Perkins-Valdez, which is a fictionalized retelling of a 1970s Supreme Court case concerning the involuntary sterilization of Erica and India Williams, ages 12 and 14, in Montgomery Alabama. Reading Circle participants were reminded of North Carolina's own tragic history around forced sterilization and were reminded that we cannot move forward without acknowledgment of this past and its repercussions. The Reading Circle read *Heaven and Earth Grocery Store* by James McBride in February 2024. This is a moving fiction novel detailing life in small town Pennsylvania with prominent Black and Jewish communities and how they live and work together and support each other despite their differences. While the book is set in the 1920s and 1930s, the story and its message were applicable to the world today.

Improving health outcomes was highlighted as a priority area of Title X (Federal Family Planning program) in FY23. To assist with this work, the WICWS was able to create a Patient Experience (PE) Coordinator position to connect with LHDs providing Title X services across NC. The position was filled in May 2023. Prior to filling the position, the RHB sent out an Improving Health Outcomes Training Survey in February 2023 to all NC Title X Family Planning Clinic staff within the LHDs. The survey, based off a previous DPH Survey, was used to assess various topics around improving health outcomes, including knowledge, practices, policies, and training needs. The PE Coordinator has used these results in FY24 to plan trainings for LHDs, including exploring common non-medical drivers of health needs among people of reproductive age and a trauma-informed webinar series that has highlighted various best practices in trauma-informed design. LHDs will be surveyed annually to determine their training needs, and these will be prioritized throughout the year through webinars, toolkits, and other forms of technical assistance.

LHDs funded for the first time under the ICO4MCH Program are required to conduct a Health Impact Assessment (HEIA) with at least one of three selected evidence-based strategies (EBS). HEIA implementation by each LHD evaluated the impact of the selected EBS on the local health disparities and provided guidance on how to modify the program and/or evaluation plan. The ICO4MCH Program Manager provided TA and support in HEIA implementation at each ICO4MCH site. The HEIA encourages focus on a particular policy/program and its impact on health disparities. The tool allows a team to think outside the box and consider all factors that could potentially impact the health of populations. The HEIA helps facilitate conversations about factors that support or weaken health, including the root causes of disparities. Information gathered throughout this process will provide community perspective and guide LHD teams in strategic planning to modify an existing or proposed policy/program. The HEIA will help to develop concrete methods and action steps aimed at improving policies/programs in the hope of reducing health disparities within the impacted population(s).

NCODH also continued collaboration with the NC OHD to address inclusion of people with disabilities and CYSHCN in efforts to address cultural competency planning and communication efforts. NCODH advocated for the inclusion of disability data in the OHD Health Disparities Analysis Report which was released in fall 2024. Additionally, the Title V CYSHCN Director reviewed the OMH Health Disparities report alongside the EI Deputy Director for DCFW. NCODH collaborated with the Division of Services for the Deaf and Hard of Hearing and the NCDHHS Data Office to propose a project to the Duke University Sanford School of Public Policy on data collection within DHHS. The project recommendations will be used to develop plans for improved disability data collection within NCDHHS.

As shared earlier, addressing SDoH is foundational to the NCDHHS priorities, and the Perinatal Health Strategic and Early Childhood Action Plans. It also is a priority for NCDHHS to focus on whole-person health as NC has moved into Medicaid transformation, particularly with the HOPs. The NC Title V Program will continue to address SDoH as part of its programs and support the work being done by NCDHHS to expand HOPs meant to address housing instability, food insecurity, lack of transportation, interpersonal violence, and toxic stress for eligible Medicaid beneficiaries. Additionally, the NC Title V Program will continue to promote the use of NCCARE360 to connect individuals to community resources in addition to larger efforts to ensure onboarding of community-based

organizations and a sustainable referral network.

Food Insecurity and Nutrition/Physical Activity

Because data sources to measure nutrition insecurity (which is a new term being used to emphasize the importance of nutritious foods versus any foods) are lacking, data sources that measure food insecurity will continue to be used, while still elevating the important role of nutrition security. Data for CCSB Objective 8B (By 2025, decrease the percent of children living across North Carolina in food insecure homes by 6% from the 20.9% [baseline 2016] to 17.5% according to data provided by Feeding America and cited in the NC Early Childhood Action Plan.). Recent data shows that NC is trending in the wrong direction as the percentage decreased to 15.4% in 2021 but increased to 19.6% in 2022. According to the new Food Sufficiency NPM, NC (70.3%) is similar to the nation (68.6%) in the percent of children, ages 0 through 11, whose households were food sufficient per the 2022-23 NSCH. More CYSHCN in NC (67.1%) indicated that they were food sufficient than nationally (58.5). 2022-23 NCHS results also indicate that in the 6 to 11 year age range, only 25.6% of parents in NC and nationally reported that their children were active at least 60 minutes per day. Almost 14% of respondents to the 2023 NC BRFSS stated that it was often or sometimes true that the food they bought just didn't last and they didn't have money to get more.

The NC Title V Program sees working in the area of food insecurity with a focus on access to healthy food for all as a priority for the MCHBG and as a NCDHHS priority. Even before COVID-19, many actions at the state and division level have occurred since 2019 to elevate this to an even greater priority. This includes NCDHHS's work on:

- Food Insecurity Screening (required through Medicaid and voluntarily encouraged for all providers)
- Food Insecurity (and other SDoH) referral and follow up through NCCARE360
- Medicaid Transformation through the Healthy Opportunities Pilots which includes a focus on food insecurity and healthy food access.
- NC ECAP released in 2019 which has prioritized food security as one of ten goals. The NC Title V Program has adopted the goal (CCSB 8B) from this plan which includes that by 2025, the percent of children living across North Carolina in food insecure homes will decrease by 6% from 20.9% to 17.5% according to data provided by Feeding America and cited in the NC Early Childhood Action Plan. This indicator was highlighted along with key NCDHHS activities impacting the indicator in the *NC ECAP 2024 Update*.

COVID-19 caused a great deal of stress and hardship for individuals, children, and families in NC, with a disproportionate burden on historically marginalized populations. Food insecurity has increased, especially among children. The NC Title V Program continued to work with multiple partners to ensure innovative ways to feed children and families during and post-pandemic. NC requested multiple waivers and quickly implemented USDA-approved flexibilities across programs such as WIC, Child Nutrition Programs (CACFP and School Nutrition Programs), SNAP and Pandemic-EBT. One purpose of creating the DCFW was to bring together most of the federal nutrition assistance programs administered by NCDHHS including WIC, CACFP, SNAP (referred to in NC as Food & Nutrition Services [FNS]) and SNAP-Ed into closer alignment and synergy to address whole child and family health and nutrition (including food/nutrition security). In FY24 many collaborative projects were continued or started including data sharing agreements between SNAP/FNS, WIC, and Medicaid to increase cross-program referral and enrollment.

On April 28, 2023, the NCDHHS State Action Plan for Nutrition Security (2023-2024) was released. The action plan outlines an innovative, multi-pronged strategy to decrease the number of North Carolinians currently experiencing food insecurity. The action plan leverages the work of multiple programs (e.g., FNS, WIC, and Medicaid) to cohesively support whole-person health, brings together efforts by various divisions across NCDHHS, and builds upon significant initiatives already implemented by NCDHHS during the pandemic. Actions include:

- increasing the reach of NCDHHS' nutrition programs
- building connections between health care and nutrition supports; and
- increasing breastfeeding support and rates.

Leaders and staff within DCFW, DPH, and Medicaid are keeping and reporting on metrics in the plan including:

- Increase cross-enrollment across FNS, WIC, and Medicaid by increasing nutrition security for Medicaid members by connecting them to critical services such as FNS and WIC. Proactive Communications via text,

email and voice call are sent to Medicaid beneficiaries who are likely eligible but not enrolled in WIC or FNS to alert them they may be eligible for WIC or FNS and should consider applying.

- Improve the participant experience in WIC by continuing to expand the counties utilizing the telehealth system
- Implement Healthy Opportunities Pilot
- Grow NCCARE360 network
- Provide breastfeeding training for WIC staff
- Launch a statewide breastfeeding hotline

The State Action Plan for Nutrition Security was cited as a promising approach in the MCH Food Sufficiency What Works Evidence Accelerator document created by the National Center for Education in Maternal and Child Health.

In FY24, the PNC continued to co-lead the HOP Food Services Operational Guidelines and Best Practices Working Group and also served as a nutrition subject matter expert. The purpose of this group is to work closely with HOP leadership in DHB/Medicaid to develop operational guidance on nine HOP food services that are being administered in three pilot regions (33 counties) across NC. This working group is made up of HOP representatives and content experts on food access and security, nutrition and dietetics, care management, healthcare, food safety, local agriculture and protein aggregation, and federal/state food assistance programs. The PNC worked with DHB staff to plan and co-lead HOP Food Service Working Group leadership meetings throughout the year and into FY25. As part of this work, the PNC partnered with Food Safety experts within the Environmental Health Section of DPH and NC Department of Agriculture on guidance documents useful within and outside of HOP.

Based on the PNC's nutrition expertise and involvement in HOP (as part of NC's 1115 waiver), she was asked by the Association of State Public Health Nutritionists (ASPHN) to be a featured speaker at their national conference on June 10, 2024, under the topic of Food as Medicine. The PNC collaborated with DHB in the presentation preparation and approval. The presentation *Overview of North Carolina's 1115 Medicaid Transformation Waiver Program (Healthy Opportunities Pilots) & Operationalizing the Nine 'Food/Nutrition' Services* was well received by the 110 attendees.

In FY24, the PNC also actively participated in the development and implementation of the Carolinas Food Access Survey as part of the North Carolina State Nutrition Action Coalition (NC SNAC). This survey was completed in the spring of 2024 as a result of the partnership between the NC SNAC, the South Carolina State Nutrition Action Coalition, and Feeding the Carolinas. Conducted across 17 sites in SC & NC, this survey set out to identify food security gaps and nutrition needs within the Carolinas. A total of 710 people participated in the survey. Survey results shared in summer 2024 indicated that 66% of NC respondents were at risk for being food insecure, with 60% responding that it was sometimes or often true that "within the past 12 months, the food we bought just didn't last and we didn't have money to get more."

In FY24, the PNC continued active involvement and leadership in the NC Farm to Preschool Network (NCF2PN) and the Farm to School Coalition of NC (two state-wide Coalitions). The PNC serves in a variety of leadership roles within the Network (serving on the Advisory Committee; Resources workgroup, Systems Change Workgroup, etc.) and the Coalition Steering Committee. The PNC also recruited and onboarded 2 nutrition consultants from DCFW Child and Adult Care Food Program (CACFP) and CDIS to serve on the Steering Workgroup. This allowed the CDIS to have greater connections with Farm to Early Care and Education (ECE) which likely contributed to their State Physical Activity and Nutrition (SPAN) grant competitive RFA application and in turn has provided additional support, funding and resources going towards Farm to ECE in NC. Farm to ECE is an innovative evidence-based approach that gives young children increased exposure and access to local produce, opportunities to learn about nutrition and agriculture, and hands-on learning through gardening. ECEs refer to preschools, child care centers, family child care homes, Head Start, and more. In late FY24, the PNC and other Network leaders applied for the FARMWISE grant from Association of State Public Health Nutritionists (ASPHN) which will support enhancements to NC's Farm to CACFP work. One project of the Network and Coalition is the NC Crunch. The PNC co-led the DCFW NC Crunch event on October 18, 2023, which included planning meetings, communications and coordination with DCFW leaders and colleagues, DHHS Communications and the local ECE provider and staff at the location The PNC also contributed to the ESMMNC Partner showcase meeting on March 19, 2024, by putting together the NC Farm to Preschool Network and Farm to School Coalition of NC exhibit shared with about 40 attendees.

During FY24, the PNC continued active involvement in the ASPHN through the MCH Nutrition Council, the Steering Committee for the MCH Nutrition Council, the Inclusivity and Accessibility Workgroup and the Fruit and Vegetable Nutrition Council. The PNC also continued collaborative partnerships with the GoNAPSACC, the CDIS SPAN grant staff, Division of Health Benefits/Medicaid, ESMMNC, the State Child Care Nurse Consultant (SCCNC), the Community Nutrition Services Section which includes WIC and CACFP, the State Nutrition Action Coalition, and other internal and external partners in addressing similar nutrition and physical activity strategies by routinely communicating and partnering in a more coordinated way and pooling resources for greater impact.

Based on nutrition expertise and relationships with other Divisions, in FY24, the PNC was asked to present at the 2024 NC Medicaid Quality Symposium. On May 7, 2024, the PNC presented Balancing the Scales to Weight Inclusive, Whole Child Approaches Supporting Nutrition and Physical Activity. The learning objectives were to:

- Define weight normative and weight inclusive approaches.
- Identify emerging and best practices and resources to support healthy behaviors (nutrition and physical activity) and reduce weight stigma within communities and settings (healthcare, schools, media, etc.) for children, adolescents, and adults.
- Begin to apply and/or share learning and experiences with others, using a weight-inclusive and compassionate lens, to support whole person/whole community health.

Priority Need 6 - Engage individuals and families with lived experience, as well as community-based organizations, as partners in the development and implementation of people-centered programs and policies that reduce health disparities and address community health factors

The Needs Assessment process showed great support for a cross-cutting priority need to improve community health factors across all population domains as well as more intention to engage individuals and families with lived experience as partners in the work of the Title V Program. SPM 3 (Percent of Title V programs that offer compensated family engagement and leadership opportunities) was created as a way to help hold the Title V Program accountable to follow through with this intention. The Title V Initiatives and Operations Manager conducted a survey of Title V Program staff to determine a baseline for SPM 3 in spring 2025, and final analysis will be available during FY26.

CC/SB PN6 Objective 1 By 2030, increase by 20% from baseline (TBD in FY26) the percent of WICWS, WCHS, and Title V Staff who have used any tool or resource in their work to address disparities or improve health outcomes for all individuals.

The survey mentioned above also included questions to determine if staff currently use any tool or resource to address disparities or improve health outcomes for all in their work. Title V staff will follow up with specific individuals to document the tools and resources they are using as applicable. Examples are the HEIA tool currently being used by the ICO4MCH and Healthy Beginnings program and the Maternal and Infant Health Data Dashboard. Once the assessment is complete, Title V staff will complete an organizational assessment across both DPH and DCFW to determine if any additional tools or resources are available for staff to utilize. Once these two assessments are completed, Title V staff will map out the findings and engage with WICWS and WCHS leadership to determine the best way to disseminate the information to all staff.

The Title V staff will also work with DPH and DCFW leadership to promote professional development opportunities but also help to create work opportunities and other spaces where staff members can share challenges and successes in improving health outcomes and learn from one another. The PHSP Collective is but one example of that type of opportunity.

CC/SB PN6 Objective 2 By 2030, increase by 10% from baseline (TBD in FY26) the percent of Title V programs that offer compensated family engagement and leadership opportunities

Title V Program staff members understand the importance of working with people with lived experience to improve programs and policies so that they can help improve health outcomes for all people and population groups. While there are robust family and community partnerships within most Title V Programs, only some of these partnerships include compensation for family members and people with lived experience, and even when compensation is provided, it is often not enough to engage a wide sample of the populations being served through Title V. The survey mentioned above captures information about existing WICWS and WCHS programs that currently offer compensation for families. Title V staff will analyze and disseminate the findings from this survey to leadership.

During FY26, the Title V Program will assess how people with lived experience are being compensated throughout NCDHHS and incorporate any best practices learned to improve the current system of compensation. Ongoing efforts to build sustained relationships with Family Partners will continue and staff members will look for additional opportunities to create these relationships. A plan to ensure that communication tools are representative of all family structures and available in multiple languages will be created by a team of Title V Program staff, and best practices for virtual engagement of families and partners will be explored and developed. Specific efforts will focus on engagement with populations that have historically been underrepresented in NC and in Title V programs.

The PSHP Collective's V2V will present a Community Engagement CoP opportunity, where people with lived experience, community-based organizations, direct service providers, doulas, community health workers, etc. will come together to share best practices, as well as collaborate on new ideas, surrounding community engagement and perinatal health in NC. Fifteen participants were selected in May 2025, and they will participate in five sessions between August 26 and December 9 on the following topic areas: trust building, power sharing, advocacy, and resource sharing. V2V members are being compensated to create and teach the curriculum, and a member of the PSHP Collective Data and Evaluation Work Group is being contracted to evaluate the CoP. The goal is to be able to create a toolkit of best practices by the spring of 2026 that will be shared with Title V Program staff members as well as other NCDHHS staff.

WCHS will continue to fund family peer/partner training and support programs through Youth & Family Voices

Amplified. These trainings include self/child advocacy and integration into the community (i.e. community collaboratives).

PN6 Objective 3 By 2030, 75% of Title V contractors will have a plan to identify and address health disparities and/or improve health outcomes for all individuals as part of their contract with NCDHHS

As part of its mission to improve health outcomes for all individuals, the NC Title V Program is committed to working with its contractors (LHDs, FQHCs, colleges and universities, and other CBOs) to ensure that this mission is carried out through the contracted work. During FY26, Title V Program staff members will review current contracts to establish understanding of current practices surrounding health disparities and/or improving health outcomes for all individuals. Based on that review, staff members will develop and offer technical assistance sessions/office hours for contracted partners in collaboration with people from the community they are serving to review current activities and determine how to incorporate addressing improving health outcomes for all and community health factors. Title V staff will work with contract administrators to ensure requirements are edited to include this work.

In addition, Title V Program staff will examine current procurement practices and determine if changes need to be made to ensure fair practices are in place and community-based organizations are able to apply for contracts. The HEIA tool might be used for this assessment.

WICWS and WCHS will require all staff, clinical and non-clinical, from LHDs and other contracted partners, to participate in at least one training annually focused on health disparities to support individual competencies and organizational capacity. This requirement is part of their agreement addenda. LHDs are provided with a list of low-cost trainings or continuing education opportunities.

Priority Need 7 - Improve access to mental and behavioral health services for maternal and child health populations

Another Cross-Cutting/Systems Building Priority Need is one that was similar to a priority need in the Adolescent Health Domain in the 2021-25 State Action Plan but has been enhanced to improve access to mental and behavioral health services across all maternal and child health population groups. The selected performance measure for this priority need is SPM 4 (Percent of counties who have providers who have utilized the NC Psychiatry Access Line NC-PAL or NC Maternal Mental Health MATTERS [Making Access to Treatment, Evaluation, Resources, and Screening Better] psychiatry access lines.).

PN7 Objective 1 Increase calls to NC Maternal Mental Health MATTERS (Making Access to Treatment, Evaluation, Resources, and Screening Better) psychiatry access line by 15% annually

PN7 Objective 2 Increase calls to the pediatric NC Psychiatry Access Line (NC-PAL) by 20% annually

NC Maternal Mental Health MATTERS (NC MATTERS) will continue to drive calls to the perinatal psychiatry access line through education and training in FY26. Healthcare and human service professionals can engage with NC MATTERS in a variety of ways including:

- NC MATTERS will offer a Maternal Mental Health Fellowship for up to 35 health and human service professionals who care for women during pregnancy and/or postpartum. The Fellowship is an intensive cohort-based training and mentorship opportunity with the goal of increasing their confidence and capacity in screening, assessing, and treating perinatal behavioral health concerns.
- The NC MATTERS program will conduct up to twelve focused outreach activities to increase awareness of NC MATTERS provider toolkits (i.e., Perinatal Anxiety, Perinatal ADHD, Zuranolone, Maternal Sleep, Maternal Suicide and Risk Assessment), mental health care packages for patients, and other applicable materials.
- NC MATTERS will maintain a social media campaign in FY26 to promote the psychiatric access line among health care professionals as well as to promote the National Maternal Mental Health Hotline among pregnant and postpartum women.
- NC MATTERS will host one statewide conference, Optimizing Outcomes: Maternal Mental Health and Substance Use Disorders Summit, in collaboration with Wake Area Health Education Center (AHEC).

NC-PAL will conduct focused outreach and build strategic networks with primary care providers and/or staff in CDSAs in FY26. NC-PAL staff will design, plan and implement educational opportunities for staff from primary care settings, schools, and CDSAs. Staff education will include but are not limited to attachment, aggression, autism, developmental concerns, anxiety, irritability, parenting, trauma, social and emotional learning, among others. NC-PAL will design partnerships with CDSA programs and primary care providers across the state that would include meeting regularly with EI teams to provide education and support with consultation. NC-PAL staff will participate regularly (monthly) in statewide IECMH meetings. In addition, NC-PAL will continue consultation and education with

up to five primary care practices and provide consultation with and without observation with three additional CDSA programs for FY26.

NC-PAL will work with their western and eastern NC hubs (MAHEC and NC Statewide Telepsychiatry Program [NC-STeP]) to conduct outreach to providers in those geographic areas to increase interest and attendance at the REsource for Advancing Children's Health (REACH) training opportunities. In FY26, NC-PAL will conduct ten REACH Patient-Centered Mental Health in Pediatric Primary Care (PPP) Mini-Fellowship trainings for NC primary care providers. Staff members will train two clinicians with pediatric and/or psychiatry training to deliver the REACH PPP Mini Fellowship training to increase the capacity of the NC-PAL program to deploy this training. To address multiple populations of children, NC-PAL will work to develop a program plan for implementing other educational models. Activities may or may not include training staff members and designing ECHO training or other training for future implementation/deployment. NC-PAL will also participate in presentations at practices, professional conferences and other CME training courses for providers.

In FY26, the WICWS State Social Work Consultant (SSWC) will convene a Community of Practice for LHD behavioral health providers. These sessions will include case studies, best practices, and peer discussions to enhance their ability to identify, treat, or refer women experiencing perinatal mental health and substance use disorders. The SSWC will also facilitate resource-sharing and ongoing collaboration among LHDs to strengthen behavioral health services for pregnant and postpartum women.

To increase awareness of the NC-PAL and NC MATTERS programs in FY26, staff members will continue to offer informational and educational opportunities and resources to LHDs and CBOs as it relates to maternal and child mental health care. Psychiatrists and behavioral health specialists from each program will serve as subject matter experts for the content being provided. Upon request, NC PAL and NC MATTERS program staff will assist with training development and/or delivery to enhance specialized knowledge and skills. Information about NC MATTERS will be included in all trainings offered to LHD staff by Maternal Health and Reproductive Health Nurse Consultants.

The NC Perinatal Nurse Champion (PNC) at MAHEC will support increasing calls to NC MATTERS psychiatry access line by creating educational materials and resources that direct Perinatal Care Region I obstetric providers to call the line to consult with a perinatal psychiatrist. MAHEC, in collaboration with NC MATTERS, will develop comprehensive resources, such as rack cards and protocols, to guide OB/GYN providers in conducting maternal mental health screenings during postpartum visits. The PNC will provide targeted training to obstetrical practices in the region focused on postpartum best practices and evidence-based maternal mental health screenings. The PNC will recruit up to five OB/GYN practices to participate in this initiative, which will include cultivating a collaborative approach that emphasizes the importance of regular postpartum appointments and equips providers with the necessary tools to support maternal mental health in the postpartum period.

The purpose of the NC MATTERS Stakeholders Network is to collaborate with a select group of professionals and persons with lived experiences who can assist NC MATTERS in making strategic decisions to improve program services; facilitate networking opportunities including sharing of resources to enhance referral patterns; and move mental health and substance use related recommendations into implementation. In FY26, the NC MATTERS Stakeholders Network will meet up to three times to review data related to call volume, practice engagement, and projects like the NC MATTERS Maternal Mental Health Fellowship and National Maternal Mental Health Hotline media campaign. These data continue to inform NC MATTERS outreach strategies to clinics and/or providers who care for perinatal patients.

PN7 Objective 3 Increase the percent of mental/behavioral health screenings completed at designated prenatal and/or postpartum appointments at a local health department

PN7 Objective 4 Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department

WICWS will continue to provide maternal mental health and behavioral health trainings, orientation, and TA for LHDs and CBOs that serve pregnant and/or postpartum women. CMHRP will collaborate with the SSWC to provide at least one perinatal mental health training during FY 26.

The needs of WCHS RCHNCs will be assessed to increase knowledge and skills to provide education and support for the CMARC Care Managers inclusive of perinatal, infant and early childhood mental health. The RCHNCs will continue to provide TA and education on use of the several CMARC program screening tools that include assessing for and addressing concerns for parental, infant and early childhood mental health.

The Child Health Program will provide a statewide training on the current Health Check Program Guide recommendations and requirements for LHD Child Health (CH) Clinical staff. An adolescent health statewide webinar will also be made available to educate CMARC care managers and LHD child health clinical staff to include behavioral health/mental health screening, confidentiality and anticipatory guidance related to emotional wellness/social connectedness. Child Health Nurse Consultants will continue to provide technical assistance to LHD child health clinical staff related to confidentiality, minor's consent, and depression and suicide risk screening as part of adolescent well visits.

To support the sustained delivery of mental health services within SHCs, the SHC Consultant will proactively identify and promote accessible funding opportunities aimed at expanding and strengthening the mental health workforce. In addition, the Consultant will facilitate access to high-quality, evidence-based trainings focused on adolescent behavioral health best practices to support ongoing professional development of SHC staff. Utilizing collected mental health data, the SHC Consultant will assess service utilization, identify gaps, and pinpoint areas of unmet need. These insights will guide targeted support and resource allocation to maximize impact. By implementing these strategies, SHCs will be better equipped to meet students where they are, both physically and emotionally, ensuring continuous access for all adolescents to high-quality mental health care across in-person and virtual settings.

The RSHNC will include concepts and topics that support best practice related to behavioral health of school age children within the Roles and Responsibilities course offered to school nurses. This course utilizes the National School Nurse Association Framework to provide education topics including care coordination, quality improvement and public health. The behavioral health needs of students are integrated into each of these topics. Additionally, the 2025 Annual School Nurse Conference will include speaker(s) who provide evidence-based presentation(s) regarding behavioral health needs of children and youth and current trends. The role of the school nurse will be an essential focus of the conference presentation(s) to promote behavioral health best practices.

In FY26, the CMARC program will continue to require and promote the NCCARE360 training to new and seasoned CMARC Care Managers. The Child Health and CMARC Programs will provide a statewide webinar related to community partners including NCCARE360. The NFP home visiting programs implemented through LHDs will continue to refer clients through NCCARE360. Additionally, Triple P LIAs will explore the use of referring clients through NCCARE360 building on a budding partnership with NCCARE360.

The WCHS School Behavioral Health Clinical Consultant and System of Care Lead Coordinator will meet regularly with the Youth Suicide Prevention Coordinator to coordinate, promote, and deliver trainings. They will also meet with other partners in NCDHHS, including NC Comprehensive Suicide Prevention Team to promote trainings and opportunities to support student mental health such as: Youth Mental Health First Aid trainings taking place state-wide for school staff and staff from youth-serving organizations; telebehavioral health offerings taking place across the state in school settings; peer mentorship opportunities for students through the Somethings digital mental health platform; and formal and informal liaisons with DPI's Healthy Schools Team to ensure cross-departmental collaboration and coalescence in prioritization of student mental health.

The Early Mental Health Action Team (EMHAT) will continue to develop and implement Action Plan strategies to enhance internal and external alignment of IECMH-related supports across programs. In FY26, EMHAT will develop and implement action steps for the following identified strategies:

1. Increase policy and organizational support and grow internal collaboration around IECMH
2. Increase workforce development through provider training and endorsement programs to support infant and early childhood social emotional health
3. Create a shared vision around IECMH between the Division of Child Development and Early Education (DCDEE) and DCFW and begin to meet to align processes for awareness

Triple P will continue to be promoted and delivered via the LIAs to parents and caregivers of children ages 0-17. The evidence-based program will help parents and caregivers learn how to manage their children's behavior, prevent problems, build strong relationships, respond to their children's requests in a positive way, help their children learn to solve problems on their own, use effective discipline strategies, have realistic expectations for their children's behavior, maintain a sense of self-esteem, and understand the importance of caring for themselves. Education and support include, but are not limited, to Triple P Baby, Teen, and Fear-less (anxiety management).

During FY26, at least one presentation will be provided to the PHSP Collective to assist with increasing awareness of the PHSP strategies related to access to mental and behavioral health. This will include partners sharing information about their programs and activities.

In FY26, the MIECHV and non-MIECHV home visiting programs will continue to conduct the Patient Health Questionnaire (PHQ-9) to ask all enrolled participants about symptoms like sadness, sleep issues, and fatigue to

measure depression severity. Home visiting programs will, at minimum, conduct the PHQ-9 within three months of an infant's birth for all participants who enrolled into home visiting prenatally; and within three months of enrollment for all other participants. Any participants who score a 10 or higher will be given a referral for mental health counseling and services by their home visitor, who will then continue to reassess their participant's mental health and well-being for the duration of their enrollment in the home visiting program.

The MIECHV and non-MIECHV home visiting programs will continue to conduct the Hurt, Insult, Threaten, Scream (HITS) Questionnaire to assess all enrolled participants for their risk and experience with intimate partner violence (IPV). Home visiting programs will, at minimum, conduct the HITS Questionnaire within six months of enrollment. Any participant who is at risk of or experiencing IPV will be given a referral for IPV resources and services by their home visitor, who will then continue to reassess their participant's IPV and safety situation for the duration of their enrollment in the home visiting program.

The LHDs provide Home Visit for Postnatal Assessment (HVPNA) services as a key strategy for reaching families early after delivery with preventative and anticipatory services, timely referral of problems, education on birth spacing, and linking them with women's preventative health services. HVPNA nurses will conduct postpartum depression screening for each postpartum woman receiving a home visit.

III.F. Public Input

In addition to the NC Title V Needs Assessment process which provided many opportunities for public input on the development of the 2026-2030 Priority, the NC Title V Program seeks public input on the MCH Block Grant Application/Annual Report in several ways. In January 2025, the NC Title V Maternal and Child Health Block Grant website was updated with a section entitled “We’d like to hear from you!” where users are able to submit comments or questions to the NC Title V Office. As of July 2025, two comments have been received and addressed by Title V staff. The website will also be updated with the new 2026-2030 Priority Needs in summer 2025. The Application/Annual Report is posted on the website in July/August and sent to partnering agencies (including March of Dimes state chapter, NC Child, AHECs, etc.) to provide feedback to the Title V Office. While comments on the block grant application itself are minimal, ongoing communication with these agencies include information about the block grant and impacts of policies and activities carried out by the NC Title V Program. Also, the Title V Director presents an update on the MCHBG to various partners and works to align efforts as much as possible to ensure maximum impact while being good stewards of resources. The Title V Program has developed a funding summary for discussions with local health departments and other partners and is working on publishing a short summary with highlights for partners to complement ongoing conversations. Since NC’s application is predicated on the work of NCDHHS priorities, the Perinatal Health Strategic Plan and the CYSHCN Strategic Plan, public input was built into this application at its inception. Partners, including family representatives, from around the state have and will continue to be engaged as the plans are implemented. Another method for gaining public input on the application is sharing portions of the document with members of the WCHS Family Partnership who provide feedback and contribute to the State Action Plan narratives. Ongoing public input is obtained throughout the year as NC Title V Program staff members work with both state and non-governmental agencies to improve programs and services.

III.G. Technical Assistance

NCDHHS appreciates the support from HRSA in obtaining technical assistance from the National MCH Workforce Development Center in the development of an inter-agency memorandum of agreement (IMOA) between DPH, which is responsible for the administration and oversight of the Title V MCH program, and DCFW, which partners with DPH in the management of the Title V investments for children, including CYSHCN. The IMOA was designed to codify the respective roles and responsibilities of each division regarding implementation of the Title V program. The goal is to ensure that North Carolina's Title V MCH program will continue to meet program legislative requirements long-term, especially in the event of DPH or DCFW leadership change.

Potential future areas of needed technical assistance for the NC Title V Program are:

1. Measuring impact of reproductive health policy changes including federal and state policies and access to care
2. Successful examples and tools of programs and policies to address disparities and improve health outcomes for all individuals, including measuring change while implementing these programs or policies
3. Fetal and Infant Mortality Review and other ways to strengthen child fatality prevention systems
4. Updating the CYSHCN Strategic Plan building on lessons learned as participants in the National Center for a System of Services for CYSHCN Learning Collaborative
5. Developing a medical home training for providers
6. Developing strategies to widely promote and disseminate information about Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
7. Elevating father engagement in programming

In addition, the NC Title V Program wholeheartedly supports the multi-state *MCH Capacity Building in Central Appalachia* technical assistance request described below:

People in Appalachia have worse health and health outcomes than those living in the rest of the United States, including rates of obesity and diabetes (1). Infants born to women in Appalachia have worse birth outcomes, as measured by rates of preterm birth, low birthweight, and infant mortality than those born to women in the rest of the United States. These adverse outcomes are associated with higher levels of teen childbearing, lower educational attainment, and less timely or no prenatal care. Additionally, there are persistent economic disparities in the region, as the Appalachian counties of these states reflected higher poverty rates compared with the rest of the United States.

In March 2025, Title V Directors and key program staff representing Central Appalachia came together for a half-day meeting to develop a multi-state approach to address maternal and child health (MCH) disparities in Appalachian communities. The team reviewed data and discussed opportunities for collaboration and impact. One key opportunity proposed was a 2-day summit to promote MCH successes and challenges paired with workforce trainings led by Appalachian local health department staff and community partners. Additional partners for outreach include East Tennessee State University, Appalachian Regional Commission, hospital associations (Ballad Health), and payors. This technical assistance request includes an ask for funding to support the planning and execution of a 2-day summit for building MCH capacity in Central Appalachia. Additional asks include coordination with CDC to provide Appalachian-specific PRAMS and pregnancy-related mortality trends. Additional NC partners will be included in the future.

1. Driscoll AK, Ely DM. Maternal Characteristics and Infant Outcomes in Appalachia and the Delta. Natl Vital Stat Rep. 2019 Sep;68(11):1-15. PMID: 32501206.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - North Carolina DHB-DPH-DCFW Medicaid Title V Administration MOA and A1.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Glossary of Acronyms Used in the FY26 NC MCHBG Application.pdf

Supporting Document #02 - Appendix A IMOA DPH DCFW.pdf

Supporting Document #03 - Appendix B - FY24 Table of WCHS Programs Activities Positions by Population Domain and Funding Source.pdf

Supporting Document #04 - Appendix C NC 2025 Title V Needs Assessment Background Documents.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FY26 NC MCHBG Application O-Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: North Carolina

	FY 26 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 18,401,714	
A. Preventive and Primary Care for Children	$ 6,933,924	(37.6%)
B. Children with Special Health Care Needs	$ 7,242,971	(39.3%)
C. Title V Administrative Costs	$ 374,580	(2.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 14,551,475	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 46,722,583	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 87,292,481	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 134,015,064	
A. Your State's FY 1989 Maintenance of Effort Amount $ 29,063,379		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 152,416,778	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 24,211,468	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 176,628,246	

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 1,500,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 620,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,221,097
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program	$ 897,685
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 7,499,366
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,175,305
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 218,729
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 80,338
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 1,555,977
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 897,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,568,788
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Children's Health Insurance Program Reauthorization Act (CHIPRA)	$ 248,906
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,753,541
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Child Care and Development Block Grant (CCDBG)	$ 62,205
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sickle Cell Data Collection	$ 476,611
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Triple P	$ 1,000,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start Enhanced Grant	$ 1,100,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > American Rescue Plan Act Public Health Workforce	$ 235,920

	FY 24 Annual Report Budgeted		FY 24 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 18,871,732 (FY 24 Federal Award: $ 18,401,714)		$ 16,501,293	
A. Preventive and Primary Care for Children	$ 6,933,924	(36.7%)	$ 6,155,703	(37.3%)
B. Children with Special Health Care Needs	$ 7,405,979	(39.2%)	$ 6,397,173	(38.7%)
C. Title V Administrative Costs	$ 211,572	(1.1%)	$ 374,580	(2.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 14,551,475		$ 12,927,456	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 46,722,582		$ 49,684,655	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 65,322,845		$ 1,128,601	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 70,327,754		$ 87,292,481	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 182,373,181		$ 138,105,737	
A. Your State's FY 1989 Maintenance of Effort Amount $ 29,063,379				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 201,244,913		$ 154,607,030	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 435,531,229		$ 448,981,414	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 636,776,142		$ 603,588,444	

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 129,675	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 2,012,757	$ 937,459
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 233,373,435	$ 196,238,439
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 12,447,118	$ 11,232,276
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 259,448	$ 35,608
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood	$ 298,628	$ 304,446
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 443,071	$ 519,070
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,935,419	$ 2,852,276
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 6,050,110	$ 6,789,049
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 2,984,496	$ 2,605,243
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,071,406	$ 2,375,803
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 241,952	$ 254,449

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Children's Health Insurance Program Reauthorization Act (CHIPRA)	$ 251,686	$ 17,797
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 18,935,466	$ 105,551,824
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 110,138,430	$ 110,138,430
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,756,901	$ 823,038
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 3,538,541	$ 184,868
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > SIckle Cell Funding	$ 252,294	$ 399,614
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > COVID Immunization Funding	$ 36,410,396	$ 7,621,725

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: There were several position vacancies at different points in the year which were difficult to fill, resulting in underspent funds for these categories. Staff worked to utilize the funding for temporary staff to complete the duties of the vacant positions as well as other allowable expenses including equipment (laptops, printers, etc.) and professional development for existing staff (trainings, conference attendance, etc.) Several contracts with external partners were delayed in execution, resulting in underspending as well. These excess amounts have been awarded in the current fiscal year (FY24-25) and spent in alignment with the two-year allowance for spending Block Grant dollars.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Several contracts with external partners were delayed in execution, resulting in underspending as well. These excess amounts have been awarded in the current fiscal year (FY24-25) and spent in alignment with the two-year allowance for spending Block Grant dollars.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Several contracts with external partners were delayed in execution, resulting in underspending as well. These excess amounts have been awarded in the current fiscal year (FY24-25) and spent in alignment with the two-year allowance for spending Block Grant dollars.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: The variance is due to pay and benefit increases passed by the NC General Assembly.	
5.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2024**

	Column Name:	**Annual Report Expended**
	Field Note: The amount budgeted in in Other Funds included WIC funds and other areas that are no longer under the purview of the Title V Program. When the budgeting was done, we did not know that these programs would be moved.	
6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: The amount of program income is collected via a survey of local health departments. More LHDs responded this year to the survey than last. Also, the amount of program income will fluctuate based on individuals served at LHDs.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: North Carolina

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 1,242,236	$ 1,061,852
2. Infants < 1 year	$ 1,465,770	$ 1,179,826
3. Children 1 through 21 Years	$ 6,933,924	$ 6,155,703
4. CSHCN	$ 7,242,971	$ 6,397,173
5. All Others	$ 1,142,233	$ 1,332,159
Federal Total of Individuals Served	$ 18,027,134	$ 16,126,713

IB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 13,559,599	$ 10,629,057
2. Infants < 1 year	$ 4,457,121	$ 3,910,556
3. Children 1 through 21 Years	$ 11,562,067	$ 15,969,698
4. CSHCN	$ 7,528,728	$ 9,286,761
5. All Others	$ 8,591,694	$ 9,845,346
Non-Federal Total of Individuals Served	$ 45,699,209	$ 49,641,418
Federal State MCH Block Grant Partnership Total	$ 63,726,343	$ 65,768,131

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: North Carolina

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 14,588,195	$ 13,513,729
3. Public Health Services and Systems	$ 3,813,519	$ 2,987,564
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 18,401,714	$ 16,501,293

IIB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 2,677,193	$ 797,825
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,732,476	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 944,717	$ 797,825
2. Enabling Services	$ 33,214,759	$ 38,798,767
3. Public Health Services and Systems	$ 6,870,891	$ 9,250,677
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Other		$ 797,825
Direct Services Line 4 Expended Total		$ 797,825
Non-Federal Total	$ 42,762,843	$ 48,847,269

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: North Carolina

Total Births by Occurrence: 122,463 **Data Source Year: 2023**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	122,463 (100.0%)	2,346	297	288 (97.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase Synthase Deficiency	Homocystinuria
Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)
Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia
S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy	

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn Hearing	121,258 (99.0%)	4,891	243	243 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Title V Program provides long-term follow-up for people with Sickle Cell disease and provides short-term follow-up for the other genetic conditions. Long-term follow-up and medical management is transitioned to sub-specialists.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: The actual number of newborn screening tests reported by the State Lab was 122,693. The reason that the screening percentage is over 100% is that the State Lab receives repeat samples that are not able to be linked to their original which can occur if it is not marked as a repeat and is collected within five days of birth or if the demographic data is sufficiently different, such as an error in the date of birth from one sample to another or a change in mother's name (linking is a manual process performed upon receipt). The lab may also receive screens on children not born in NC as pediatricians offices can send a Newborn Screen for infants <6 months old who have relocated to NC.	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: Only males with XALD are referred for treatment (not females), 1 MPS pseudo variant vs Carrier patient was not referred for treatment.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: North Carolina

Annual Report Year 2024

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	13,728	50.0	0.0	1.0	4.0	45.0
2. Infants < 1 Year of Age	4,486	73.0	0.0	0.0	3.0	24.0
3. Children 1 through 21 Years of Age	57,436	71.0	0.0	1.0	10.0	18.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	30,910	82.0	0.0	0.4	17.3	0.3
4. Others	8,382	29.7	0.0	18.6	0.3	51.4
Total	84,032					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	120,082	No	121,013	90.0	108,912	13,728
2. Infants < 1 Year of Age	122,439	No	123,148	99.0	121,917	4,486
3. Children 1 through 21 Years of Age	2,804,676	No	2,844,255	9.4	267,360	57,436
3a. Children with Special Health Care Needs 0 through 21 years of age^	848,331	No	860,011	3.9	33,540	30,910
4. Others	7,910,213	No	8,080,469	0.8	64,644	8,382

^Represents a subset of all infants and children.

Form Notes for Form 5:

Data from programs that transitioned to the new Division of Child and Family Well-Being are no longer included in this form.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2024**
	Field Note: Data source is Special Report of LHD-HSA data run by State Center for Health Statistics.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2024**
	Field Note: Data source is Special Report of LHD-HSA data run by State Center for Health Statistics.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note: Data source is Special Report of LHD-HSA data run by State Center for Health Statistics.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note: This is based on FY24 CMARC data from the CareImpact database and FY24 CYSHCN Help Line calls. The CMARC data are only available by Medicaid or non-Medicaid status (which are counted as uninsured).	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2024**
	Field Note: This is a prorated count of women served in local health department Family Planning clinics through Title V funding taken from the 2024 Family Planning Annual Report.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2024**
	Field Note: Approximately 90% of obstetrical care providers (public and private) in the state are participants in the Pregnancy Management Program.	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2024**

	Field Note: Population Source: 2024 SCHS Provisional Birth Files Resident as of March 26, 2025.	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2024**
	Field Note: 99% of all infants received newborn hearing screening.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2024**
	Field Note: Population Source: 2024 SCHS Provisional Birth Files Occurrent as of March 26, 2025.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: Includes: 5 year-olds in 2024 per Census Bureau Population Estimates as all have received kindergarten health assessments and immunizations histories have been reviewed (124,919); the number of 12 year-olds in 2024 per Census Bureau Population Estimates as all are required by law to have received immunizations for school (131,555); the number of newborn visiting infants/children seen in FFY24 (2243); and number of children served by Triple P in FY24 (9719). In previous years, the average WIC Monthly Participation Rate for Children was included, but as WIC has moved to a different section within DCFW, it is no longer included here.	
6.	**Field Name:**	**Children 1 through 21 Years of Age Denominator**
	Fiscal Year:	**2024**
	Field Note: Population Source: US Census Bureau Population Estimates, 2024 (sc-est2024-alldata6).	
7.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: Includes CMARC, CYSHCN Help Line and Help Line Outreach. This used to include number of children served through the Early Intervention's Infant Toddler Program, but as that Section was moved to DCFW it is no longer included.	
8.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Denominator**
	Fiscal Year:	**2024**
	Field Note: Population Source: US Census Bureau Population Estimates, 2024 (sc-est2024-alldata6) 0 through 21 x 2022-23 NSCH CSHCN Prevalence (29%)	

9.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2024**
	Field Note: Includes Preconception Health Peer Educators; Sickle Cell Clients who are over age 20; Family Planning Clients (men and women) over age 20 (potential overlap with children here, but not much); NC Healthy Start Baby Love Plus interconception care clients; people served by NCQuitline who are 25 and older; and preconception/interconception services provided through ICO4MCH.	
10.	**Field Name:**	**Others Denominator**
	Fiscal Year:	**2024**
	Field Note: Population Source: US Census Bureau Population Estimates, 2024 (sc-est2024-alldata6) all over 21.	

Data Alerts:

1.	Children with Special Health Care Needs 0 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: North Carolina

Annual Report Year 2024

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	120,065	60,999	24,992	23,778	1,346	4,985	137	3,513	315
Title V Served	118,864	60,389	24,742	23,540	1,332	4,935	136	3,478	312
Eligible for Title XIX	61,126	20,514	18,492	17,394	1,004	1,271	80	2,212	159
2. Total Infants in State	120,602	58,078	26,312	23,583	1,410	4,434	76	6,709	0
Title V Served	119,396	57,497	26,049	23,347	1,396	4,390	75	6,642	0
Eligible for Title XIX	67,599	23,168	20,071	19,175	1,073	1,453	82	2,393	184

Form Notes for Form 6:

Data on the number of deliveries in the state and how many births and infants are eligible for Title XIX were obtained from the 2023 NC Composite Linked Birth File. The number of infants in the state is from the US Census Bureau (State Characteristics Datasets: 2023 Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and Two or More Races) by Age, Sex, and Hispanic Origin). The number of Title V served by race is obtained by multiplying the percentage of newborns screened for hearing in 2023 (99%) by the total number of deliveries and infants.

Field Level Notes for Form 6:

None

Form 7
Title V Program Workforce

State: North Carolina

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	231
1a. Total Number of FTEs (State Level)	26
1b. Total Number of FTEs (Local Level)	205
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	1
3. Total Number of FTEs eliminated in the past 12 months	0
4. Total Number of Current Vacant FTEs	4
4a. Total Number of Vacant MCH Epidemiology FTEs	0
5. Total Number of FTEs onboarded in the past 12 months	2

B. Training Needs (Optional)	
1	Improving health outcomes for all
2	Monitoring and evaluation
3	Data analysis
4	Program development

Form Notes for Form 7:

None

Field Level Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: North Carolina

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4. State Youth Leader (Optional)	
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5. SSDI Project Director	
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6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(800) 737-3028

Form Notes for Form 8:

None

Form 9
List of Priority Needs – Needs Assessment Year

State: North Carolina

Application Year 2026

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Promote comprehensive reproductive health care including postpartum care and support	New
2.	Prevent infant/fetal deaths	Revised
3.	Promote safe and nurturing relationships for children and adolescents	Revised
4.	Improve access to quality whole child and adolescent health care	New
5.	Ensure all CYSHCN and families receive care in a well-functioning system	New
6.	Engage individuals and families with lived experience, as well as community-based organizations, as partners in the development and implementation of people-centered programs and policies that reduce	New
7.	Improve access to mental and behavioral health services for maternal and child health populations	Revised

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: North Carolina

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	90.4	2.9	1,018	112,607
2021	101.0	3.0	1,135	112,416
2020	85.7	2.8	928	108,247
2019	76.9	2.7	840	109,213
2018	74.0	2.6	815	110,129
2017	76.0	2.6	847	111,408
2016	81.7	2.7	910	111,443
2015	69.3	2.9	580	83,675
2014	69.3	2.5	774	111,700
2013	67.0	2.5	725	108,283
2012	75.7	2.6	831	109,796
2011	81.2	2.7	902	111,084
2010	78.3	2.6	890	113,693
2009	70.6	2.5	832	117,863
2008	62.8	2.3	769	122,538

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2023	29.8	2.2	178	597,565
2018_2022	26.7	2.1	159	596,437
2017_2021	25.4	2.1	151	595,000
2016_2020	20.7	1.9	123	595,313
2015_2019	18.2	1.7	109	599,426
2014_2018	17.9	1.7	108	601,676

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM MM - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	14.8	0.2	5,238	353,896
2022	15.0	0.2	5,167	344,930
2021	16.0	0.2	5,474	342,077
2020	17.3	0.2	5,841	338,541
2019	18.2	0.2	6,168	338,155
2018	18.7	0.2	6,303	336,190
2017	20.6	0.3	6,845	331,778
2016	21.8	0.3	7,190	329,556
2015	23.5	0.3	7,641	324,650
2014	25.9	0.3	8,280	319,520
2013	28.4	0.3	9,020	317,937
2012	31.7	0.3	10,077	317,673
2011	34.8	0.3	11,070	318,457
2010	38.4	0.4	12,309	320,963
2009	43.7	0.4	14,093	322,835

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM TB - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	9.4 %	0.1 %	11,297	119,980
2022	9.4 %	0.1 %	11,457	121,487
2021	9.4 %	0.1 %	11,365	120,397
2020	9.5 %	0.1 %	11,090	116,653
2019	9.3 %	0.1 %	11,047	118,659
2018	9.2 %	0.1 %	10,970	118,871
2017	9.4 %	0.1 %	11,268	120,039
2016	9.2 %	0.1 %	11,127	120,712
2015	9.1 %	0.1 %	11,023	120,775
2014	8.9 %	0.1 %	10,720	120,903
2013	8.8 %	0.1 %	10,432	118,913
2012	8.8 %	0.1 %	10,563	119,749
2011	9.0 %	0.1 %	10,839	120,309
2010	9.1 %	0.1 %	11,109	122,271
2009	9.0 %	0.1 %	11,454	126,773

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks gestation) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	10.7 %	0.1 %	12,890	120,027
2022	10.7 %	0.1 %	13,006	121,503
2021	10.8 %	0.1 %	13,032	120,418
2020	10.8 %	0.1 %	12,601	116,691
2019	10.7 %	0.1 %	12,646	118,688
2018	10.4 %	0.1 %	12,340	118,888
2017	10.5 %	0.1 %	12,591	120,070
2016	10.4 %	0.1 %	12,542	120,729
2015	10.2 %	0.1 %	12,297	120,789
2014	9.7 %	0.1 %	11,781	120,907
2013	9.9 %	0.1 %	11,800	118,896
2012	10.1 %	0.1 %	12,056	119,723
2011	10.2 %	0.1 %	12,278	120,264
2010	10.4 %	0.1 %	12,758	122,302
2009	10.6 %	0.1 %	13,437	126,810

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PTB - Notes:

None

Data Alerts: None

NOM - Stillbirth rate per 1,000 live births plus fetal deaths - SB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.7	0.2	696	122,258
2021	5.4	0.2	652	121,118
2020	5.8	0.2	680	117,410
2019	6.6	0.2	784	119,509
2018	6.7	0.2	802	119,756
2017	6.6	0.2	803	120,928
2016	6.8	0.2	824	121,603
2015	7.0	0.2	857	121,700
2014	7.4	0.3	906	121,881
2013	6.3	0.2	759	119,761
2012	6.6	0.2	797	120,628
2011	6.1	0.2	739	121,128
2010	6.5	0.2	801	123,151
2009	6.6	0.2	839	127,684

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SB - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	6.3	0.2	766	121,910
2021	6.1	0.2	743	120,815
2020	6.6	0.2	771	117,060
2019	6.9	0.2	826	119,096
2018	6.9	0.2	818	119,366
2017	7.2	0.2	864	120,538
2016	7.5	0.3	908	121,194
2015	7.5	0.3	904	121,280
2014	7.8	0.3	953	121,436
2013	7.5	0.3	900	119,390
2012	7.5	0.3	896	120,250
2011	7.3	0.3	879	120,767
2010	7.2	0.2	888	122,750
2009	7.7	0.3	981	127,272

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	6.8	0.2	825	121,562
2021	6.7	0.2	809	120,466
2020	6.8	0.2	790	116,730
2019	6.8	0.2	805	118,725
2018	6.8	0.2	803	118,954
2017	7.0	0.2	845	120,125
2016	7.2	0.3	874	120,779
2015	7.3	0.3	888	120,843
2014	7.1	0.2	864	120,975
2013	7.0	0.2	832	119,002
2012	7.4	0.3	886	119,831
2011	7.2	0.3	867	120,389
2010	7.1	0.2	867	122,350
2009	7.9	0.3	1,004	126,845

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	4.4	0.2	534	121,562
2021	4.2	0.2	510	120,466
2020	4.6	0.2	541	116,730
2019	4.6	0.2	549	118,725
2018	4.3	0.2	507	118,954
2017	4.7	0.2	568	120,125
2016	4.9	0.2	591	120,779
2015	4.9	0.2	595	120,843
2014	4.9	0.2	595	120,975
2013	5.1	0.2	601	119,002
2012	4.9	0.2	588	119,831
2011	5.0	0.2	597	120,389
2010	5.0	0.2	608	122,350
2009	5.3	0.2	673	126,845

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	2.4	0.1	291	121,562
2021	2.5	0.1	299	120,466
2020	2.1	0.1	249	116,730
2019	2.2	0.1	256	118,725
2018	2.5	0.1	296	118,954
2017	2.3	0.1	277	120,125
2016	2.3	0.1	283	120,779
2015	2.4	0.1	293	120,843
2014	2.2	0.1	269	120,975
2013	1.9	0.1	231	119,002
2012	2.5	0.1	298	119,831
2011	2.2	0.1	270	120,389
2010	2.1	0.1	259	122,350
2009	2.6	0.1	331	126,845

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	228.7	13.7	278	121,562
2021	200.1	12.9	241	120,466
2020	251.9	14.7	294	116,730
2019	263.6	14.9	313	118,725
2018	239.6	14.2	285	118,954
2017	275.5	15.2	331	120,125
2016	287.3	15.5	347	120,779
2015	294.6	15.6	356	120,843
2014	300.1	15.8	363	120,975
2013	291.6	15.7	347	119,002
2012	291.2	15.6	349	119,831
2011	296.5	15.7	357	120,389
2010	277.9	15.1	340	122,350
2009	328.7	16.1	417	126,845

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births - IM-SUID

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	122.6	10.1	149	121,562
2021	150.2	11.2	181	120,466
2020	103.7	9.4	121	116,730
2019	112.0	9.7	133	118,725
2018	111.8	9.7	133	118,954
2017	111.6	9.6	134	120,125
2016	115.1	9.8	139	120,779
2015	113.4	9.7	137	120,843
2014	118.2	9.9	143	120,975
2013	97.5	9.1	116	119,002
2012	115.2	9.8	138	119,831
2011	100.5	9.1	121	120,389
2010	95.6	8.8	117	122,350
2009	113.5	9.5	144	126,845

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	6.7	0.2	758	113,285
2021	8.2	0.3	922	112,855
2020	8.4	0.3	910	108,882
2019	9.2	0.3	994	108,580
2018	10.2	0.3	1,122	109,886
2017	10.6	0.3	1,193	112,365
2016	9.5	0.3	1,069	112,926
2015	9.2	0.3	779	84,898
2014	8.2	0.3	925	112,507
2013	6.5	0.2	706	109,244
2012	5.3	0.2	590	111,005
2011	4.3	0.2	479	112,134
2010	3.5	0.2	403	114,608
2009	2.7	0.2	328	121,257
2008	1.8	0.1	224	125,615

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness - SR

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	58.6 %	4.3 %	209,286	357,199

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	15.0 %	1.5 %	325,929	2,173,193
2021_2022	13.4 %	1.3 %	288,803	2,156,036
2020_2021	12.3 %	1.3 %	263,997	2,147,928
2019_2020	10.7 %	1.4 %	231,587	2,163,963
2018_2019	10.8 %	1.2 %	232,348	2,143,124
2017_2018	10.9 %	1.5 %	236,185	2,176,314
2016_2017	10.9 %	1.4 %	241,002	2,201,991

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	21.3	1.4	240	1,124,853
2022	26.1	1.5	287	1,098,719
2021	17.3	1.3	191	1,102,517
2020	17.0	1.2	190	1,120,625
2019	19.3	1.3	216	1,119,745
2018	17.2	1.2	193	1,119,672
2017	17.6	1.3	198	1,122,462
2016	19.0	1.3	214	1,125,637
2015	20.3	1.3	229	1,127,226
2014	18.5	1.3	210	1,132,467
2013	19.3	1.3	220	1,137,991
2012	18.3	1.3	209	1,141,962
2011	18.1	1.3	207	1,144,798
2010	19.2	1.3	220	1,144,649
2009	20.4	1.3	232	1,139,298

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	46.0	1.8	638	1,386,224
2022	46.1	1.8	630	1,365,486
2021	47.9	1.9	658	1,373,885
2020	38.3	1.7	520	1,355,997
2019	34.3	1.6	464	1,353,801
2018	32.9	1.6	444	1,348,386
2017	34.8	1.6	464	1,335,106
2016	37.5	1.7	496	1,322,412
2015	31.0	1.5	407	1,311,470
2014	33.9	1.6	442	1,304,805
2013	31.0	1.5	404	1,301,668
2012	31.3	1.6	406	1,299,173
2011	36.1	1.7	468	1,296,193
2010	34.6	1.6	446	1,290,695
2009	37.7	1.7	485	1,288,104

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021-2023	15.0	0.8	318	2,126,620
2020_2022	15.1	0.9	316	2,092,187
2019_2021	15.4	0.9	320	2,075,212
2018_2020	13.9	0.8	287	2,061,614
2017_2019	13.3	0.8	273	2,048,817
2016_2018	13.8	0.8	280	2,030,330
2015_2017	14.9	0.9	299	2,007,053
2014_2016	16.0	0.9	318	1,983,550
2013_2015	14.9	0.9	292	1,965,337
2012_2014	14.7	0.9	288	1,955,097
2011_2013	15.2	0.9	297	1,955,777
2010_2012	17.1	0.9	335	1,963,873
2009_2011	19.2	1.0	380	1,976,599
2008_2010	21.2	1.0	420	1,980,406
2007_2009	23.9	1.1	471	1,967,040

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 10 through 19 per 100,000 - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	7.0	0.4	287	4,125,595
2020_2022	6.9	0.4	283	4,095,368
2019_2021	6.5	0.4	267	4,083,683
2018_2020	6.1	0.4	246	4,058,184
2017_2019	5.8	0.4	235	4,037,293
2016_2018	6.0	0.4	240	4,005,904
2015_2017	5.6	0.4	224	3,968,988
2014_2016	5.7	0.4	226	3,938,687
2013_2015	5.2	0.4	203	3,917,943
2012_2014	4.9	0.4	193	3,905,646
2011_2013	4.3	0.3	169	3,897,034
2010_2012	4.2	0.3	165	3,886,061
2009_2011	4.5	0.3	176	3,874,992

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	13.7	0.6	565	4,125,595
2020_2022	13.4	0.6	550	4,095,368
2019_2021	11.6	0.5	473	4,083,683
2018_2020	9.4	0.5	380	4,058,184
2017_2019	7.5	0.4	302	4,037,293
2016_2018	7.6	0.4	304	4,005,904
2015_2017	6.8	0.4	270	3,968,988
2014_2016	7.0	0.4	274	3,938,687
2013_2015	6.3	0.4	248	3,917,943
2012_2014	6.1	0.4	237	3,905,646
2011_2013	5.9	0.4	230	3,897,034
2010_2012	5.6	0.4	217	3,886,061
2009_2011	6.1	0.4	238	3,874,992
2008_2010	6.1	0.4	234	3,852,482
2007_2009	6.5	0.4	249	3,818,077

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Firearm - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	112.8	3.0	1,377	1,220,273
2021	122.2	3.2	1,485	1,215,687
2020	119.9	3.1	1,485	1,238,934
2019	126.7	3.2	1,569	1,238,636
2018	128.0	3.2	1,585	1,238,222
2017	119.4	3.1	1,484	1,242,763
2016	124.8	3.2	1,556	1,246,479
2015	130.8	3.7	1,224	935,852
2014	133.0	3.3	1,666	1,252,371
2013	139.2	3.3	1,751	1,257,688
2012	142.8	3.4	1,802	1,262,290
2011	149.6	3.4	1,895	1,266,781
2010	144.6	3.4	1,834	1,267,985
2009	153.0	3.5	1,934	1,264,363
2008	150.8	3.5	1,885	1,250,241

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Child - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	191.1	3.7	2,610	1,365,486
2021	200.6	3.8	2,756	1,373,885
2020	194.1	3.8	2,632	1,355,997
2019	177.9	3.6	2,408	1,353,801
2018	166.8	3.5	2,249	1,348,386
2017	176.7	3.6	2,359	1,335,106
2016	179.3	3.7	2,371	1,322,412
2015	187.0	4.4	1,839	983,603
2014	174.7	3.7	2,280	1,304,805
2013	181.4	3.7	2,361	1,301,668
2012	198.5	3.9	2,579	1,299,173
2011	215.2	4.1	2,789	1,296,193
2010	220.8	4.1	2,850	1,290,695
2009	259.4	4.5	3,341	1,288,104
2008	264.7	4.6	3,371	1,273,683

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	55.5 %	2.5 %	1,051,819	1,896,213
2022	54.9 %	2.2 %	1,027,586	1,870,431
2021	64.7 %	2.0 %	1,202,055	1,858,298
2020	61.3 %	1.8 %	1,143,566	1,866,219
2019	53.7 %	2.1 %	991,228	1,844,609
2018	52.5 %	2.1 %	959,974	1,830,152
2017	52.6 %	2.2 %	954,263	1,815,377
2017	52.6 %	2.2 %	954,263	1,815,377
2016	54.4 %	1.8 %	978,271	1,799,690
2015	55.3 %	1.7 %	987,512	1,784,875
2014	56.6 %	1.6 %	1,006,769	1,778,022
2013	55.1 %	1.7 %	975,241	1,770,658
2012	56.2 %	1.3 %	989,769	1,761,783

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM WHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	90.6 %	1.1 %	2,075,508	2,291,801
2021_2022	91.5 %	1.1 %	2,094,062	2,288,311
2020_2021	88.7 %	1.4 %	2,025,414	2,283,123
2019_2020	89.9 %	1.4 %	2,052,631	2,283,205
2018_2019	91.0 %	1.0 %	2,082,930	2,289,524
2017_2018	89.2 %	1.6 %	2,046,142	2,293,973
2016_2017	89.2 %	1.6 %	2,036,416	2,283,376

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 6 through 17, who are obese (BMI at or above the 95th percentile) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	14.1 %	0.2 %	8,070	57,101
2018	15.0 %	0.1 %	13,368	88,963
2016	14.2 %	0.1 %	13,849	97,286
2014	15.0 %	0.1 %	13,827	92,407
2012	13.5 %	0.1 %	12,575	92,859
2010	13.9 %	0.1 %	12,459	89,798
2008	14.2 %	0.1 %	10,440	73,574

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	15.6 %	1.8 %	226,725	1,451,145
2021_2022	19.0 %	1.9 %	284,329	1,495,124
2020_2021	22.5 %	2.0 %	322,496	1,430,725
2019_2020	21.2 %	2.2 %	304,254	1,433,832
2018_2019	17.8 %	2.1 %	260,877	1,466,724
2017_2018	13.8 %	1.9 %	200,382	1,454,503
2016_2017	14.4 %	1.8 %	203,870	1,415,473

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	11.4 %	1.4 %	12,689	111,496
2019	10.7 %	1.2 %	12,002	112,361
2018	11.8 %	1.3 %	13,392	113,697
2017	11.7 %	1.2 %	13,359	114,509

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum anxiety symptoms - PPA

Federally available Data (FAD) for this measure is not available/reportable.

NOM PPA - Notes:

The SCHS rolled out a pilot state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which included questions identical to the 2020 NC PRAMS survey and began data collection in 2024 using PRAMS Phase 9 questions. During the first year of data collection under PAS (2024), the response rates were insufficient for meaningful analyses of the data. However, 2025 data collection is currently underway, and SCHS has initiated data collection and monitoring improvements that should result in increased response rates.

Data Alerts:

1.	Data has not been entered for NOM PPA. This outcome measure is linked to the selected NPM(s): PPV. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	6.2 %	1.3 %	47,442	768,169
2021_2022	8.5 %	1.7 %	65,414	766,498
2020_2021	10.5 %	2.0 %	79,907	758,893
2019_2020	9.2 %	1.8 %	70,490	766,795
2018_2019	9.1 %	1.8 %	70,742	774,977
2017_2018	10.2 %	2.0 %	80,420	788,951
2016_2017	8.4 %	1.8 %	65,924	785,851

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM BCD - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	16.9 %	2.1 %	138,763	818,835
2021_2022	19.6 %	2.3 %	159,565	815,569
2020_2021	18.2 %	2.4 %	147,917	810,547
2019_2020	15.9 %	2.4 %	127,707	801,587
2018_2019	15.1 %	2.1 %	119,897	792,014
2017_2018	10.3 %	1.7 %	80,859	785,083
2016_2017	7.4 %	1.4 %	57,687	782,632

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ADA - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system - SOC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	14.5 %	2.1 %	96,108	663,667
2021_2022	10.9 %	1.6 %	67,252	614,788
2020_2021	11.3 %	1.8 %	66,724	591,344
2019_2020	18.5 %	2.9 %	118,896	644,363
2018_2019	18.4 %	2.7 %	122,564	667,607
2017_2018	12.2 %	2.0 %	71,832	590,037
2016_2017	17.0 %	2.7 %	102,244	602,690

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 5, who are flourishing - FL-YC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	80.9 %	2.6 %	515,795	637,571
2021_2022	79.9 %	2.8 %	507,467	635,228
2020_2021	76.8 %	3.2 %	503,907	656,368
2019_2020	79.7 %	3.3 %	525,394	659,411
2018_2019	86.1 %	2.7 %	564,661	655,821

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-YC - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA

Data Source: National Survey of Children's Health (NSCH)-CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	38.9 %	3.6 %	211,981	544,957
2021_2022	37.1 %	3.4 %	188,180	507,871
2020_2021	32.3 %	3.5 %	153,666	475,349
2019_2020	38.9 %	3.7 %	196,942	505,775
2018_2019	45.1 %	3.5 %	236,964	525,638

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-CA - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent

Data Source: National Survey of Children's Health (NSCH)-All Children

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	61.2 %	2.2 %	971,426	1,586,574
2021_2022	58.2 %	2.2 %	916,992	1,574,412
2020_2021	58.0 %	2.2 %	894,996	1,543,436
2019_2020	62.8 %	2.3 %	974,854	1,551,164
2018_2019	67.8 %	2.2 %	1,065,878	1,572,386

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-Child Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	17.2 %	1.5 %	387,506	2,251,834
2021_2022	18.4 %	1.4 %	413,940	2,245,776
2020_2021	17.2 %	1.4 %	388,485	2,254,445
2019_2020	15.8 %	1.5 %	356,099	2,252,006
2018_2019	15.4 %	1.4 %	344,963	2,239,478
2017_2018	19.2 %	1.9 %	435,266	2,262,073
2016_2017	23.5 %	2.0 %	532,144	2,267,672

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ACE - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: North Carolina

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	88.6
Numerator	98,465
Denominator	111,078
Data Source	PRAMS
Data Source Year	2020

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	90.0	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
The SCHS rolled out a pilot state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which included questions identical to the 2020 NC PRAMS survey and began data collection in 2024 using PRAMS Phase 9 questions. During the first year of data collection under PAS (2024), the response rates were insufficient for meaningful analyses of the data. However, 2025 data collection is currently underway, and SCHS has initiated data collection and monitoring improvements that should result in increased response rates.

Provisional Annual Objectives are based on the 2020 data.

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2024
Annual Objective	
Annual Indicator	60.7
Numerator	
Denominator	
Data Source	NC Medicaid
Data Source Year	2023
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	61.5	62.0	62.5	63.0	63.7

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2024**

Column Name: **State Provided Data**

Field Note:
The SCHS rolled out a pilot state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which included questions identical to the 2020 NC PRAMS survey and began data collection in 2024 using PRAMS Phase 9 questions. During the first year of data collection under PAS (2024), the response rates were insufficient for meaningful analyses of the data. However, 2025 data collection is currently underway, and SCHS has initiated data collection and monitoring improvements that should result in increased response rates.

Provisional Annual Objectives are based on NC Medicaid data. In 2023, 60.7% of Medicaid deliveries had a comprehensive postpartum visit (which should include contraceptive counseling and depression screening) on or between seven and 84 days after delivery.

NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	85	85
Annual Indicator	82.1	81.5
Numerator	98,631	96,717
Denominator	120,143	118,618
Data Source	NVSS	NVSS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	82.0	82.5	83.0	83.5	83.5

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants breastfed exclusively through 6 months - BF

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	27.5	28
Annual Indicator	30.8	33.5
Numerator	84,259	97,041
Denominator	273,537	289,343
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	33.6	33.8	34.0	34.1	34.3

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	50	50	50	50	50
Annual Indicator	48.1	39.5	39.5	37.1	47.0
Numerator	119,658	94,883	94,883	92,922	120,834
Denominator	249,001	240,161	240,161	250,771	257,130
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2020_2021	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	83	83	83	83	85
Annual Indicator	87.3	72.4	72.4	76.3	81.5
Numerator	786,182	588,143	588,143	619,903	660,192
Denominator	900,582	812,116	812,116	812,165	810,229
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2020_2021	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	85.0	85.0	85.0	85.0	85.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	45	48.5	48.5	49	49
Annual Indicator	48.4	36.3	36.3	41.2	46.4
Numerator	241,421	184,239	184,239	211,221	308,004
Denominator	498,468	507,316	507,316	512,437	663,667
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2020_2021	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	47.0	47.5	48.0	48.5	48.7

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	48.9	53.0
Numerator	1,120,042	1,215,395
Denominator	2,292,452	2,291,102
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	53.5	54.0	54.5	55.0	55.7

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

State: North Carolina

2021-2025: NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		90	90	90	90
Annual Indicator	80.1	75.1	73.9	74.1	75.4
Numerator	1,375	1,253	1,266	1,210	1,250
Denominator	1,717	1,668	1,714	1,632	1,658
Data Source	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The state data for NPM#3 are based on the current self-designated levels of care which do not align with the AAP/ACOG/SMFM guidelines, thus are marked provisional.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The state data for NPM#3 are based on the current self-designated levels of care which do not align with the AAP/ACOG/SMFM guidelines, thus are marked provisional.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The state data for NPM#3 are based on the current self-designated levels of care which do not align with the AAP/ACOG/SMFM guidelines, thus are marked provisional.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The state data for NPM#3 are based on the current self-designated levels of care which do not align with the AAP/ACOG/SMFM guidelines, thus are marked provisional.	
5.	**Field Name:**	**2024**

Column Name:	State Provided Data

Field Note:
The state data for NPM#3 are based on the current self-designated levels of care which do not align with the AAP/ACOG/SMFM guidelines, thus are marked provisional.

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	78	78	78	79	79
Annual Indicator	76.1	75.9	75.9	73.4	75.5
Numerator	1,386,809	1,383,829	1,383,829	1,360,288	1,419,381
Denominator	1,823,266	1,822,669	1,822,669	1,853,350	1,879,778
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2021	2021	2022	2023

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: North Carolina

SPM 1 - Adult Mentor

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	86.6
Numerator	
Denominator	
Data Source	NSCH
Data Source Year	2022-23
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	87.0	88.0	89.0	90.0	90.9

Field Level Notes for Form 10 SPMs:

None

SPM 2 - CYSHCN Receiving Care in Well-Functioning System

Measure Status:	Active
State Provided Data	
	2024
Annual Objective	
Annual Indicator	15.6
Numerator	
Denominator	
Data Source	NSCH
Data Source Year	2022-23
Provisional or Final ?	Final

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	15.8	15.9	16.0	16.2	16.4

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Compensated Family Engagement and Leadership Opportunities

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	55.0	60.0	65.0	70.0	75.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Baseline data to be collected in FY26, so objectives will be adjusted for future years based on that baseline data.

SPM 4 - Counties who Have Utilized NC-PAL or NC MATTERS

Measure Status:	Active
State Provided Data	
	2024
Annual Objective	
Annual Indicator	74
Numerator	
Denominator	
Data Source	NC PAL and NC Matters internal program reports
Data Source Year	2024
Provisional or Final ?	Final

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	80.0	85.0	90.0	95.0	100.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 1 - Percent of PRAMS respondents who reported that their pregnancy was intended

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		59.7	60	60.3	60.6
Annual Indicator		58.6	58.6	58.6	58.6
Numerator					
Denominator					
Data Source		NC Pregnancy Risk Assessment Monitoring System	NC Pregnancy Risk Assessment Monitoring System	NC Pregnancy Risk Assessment Monitoring System	NC Pregnancy Risk Assessment Monitoring System
Data Source Year		2020	2020	2020	2020
Provisional or Final ?		Final	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The NC State Center for Health Statistics did not conduct PRAMS in 2021 or 2022, thus data are not available for this indicator for 2021 and 2020 data are repeated here. A state survey, NC Pregnancy Assessment Survey, with questions identical to the 2020 PRAMS was rolled out in May 2023.

2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
A state survey, NC Pregnancy Assessment Survey, with questions identical to the 2020 PRAMS was piloted by the NC State Center for Health Statistics in 2023, but data are not available from that survey, thus 2020 data are repeated here.

3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
The SCHS rolled out a pilot state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which included questions identical to the 2020 NC PRAMS survey and began data collection in 2024 using PRAMS Phase 9 questions. During the first year of data collection under PAS (2024), the response rates were insufficient for meaningful analyses of the data. However, 2025 data collection is currently underway, and SCHS has initiated data collection and monitoring improvements that should result in increased response rates.

2021-2025: SPM 2 - Percent of women who smoke during pregnancy

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		8.1	7	6.8	5
Annual Indicator		6.8	5.6	4.5	3.6
Numerator		7,923	6,756	5,425	4,293
Denominator		116,755	120,501	121,557	120,065
Data Source		NC Vital Statistics/SCHS	NC Vital Statistics/SCHS	NC Vital Statistics/SCHS	NC Vital Statistics/SCHS
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2021-2025: SPM 3 - Percent of children with two or more Adverse Childhood Experiences (ACEs)

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		15	15	15	14
Annual Indicator		16.6	17.8	18.5	17.3
Numerator					
Denominator					
Data Source		2019-20 NSCH	2020-21 NSCH	2021-22 NSCH	2022-23 NSCH
Data Source Year		2019-20	2020-21	2021-22	2022-23
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2021-2025: SPM 4 - Percent of NC children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		90	90	90	90
Annual Indicator		75.9	76.5	72.3	69.7
Numerator					
Denominator					
Data Source		2018-20 National Immunization Survey	2019-2021 National Immunization Survey	2020-2022 National Immunization Survey	2021-23 National Immunization Survey
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2021-2025: SPM 5 - Ratio of black infant deaths to white infant deaths

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		2.3	2.5	2.3	2.1
Annual Indicator		2.7	2.4	2.7	3
Numerator		12.8	12.1	12.9	13.6
Denominator		4.8	5.1	4.7	4.5
Data Source		NC Vital Statistics/SCHS	NC Vital Statistics/SCHS	NC Vital Statistics/SCHS	NC Vital Statistics/SCHS
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: North Carolina

ESM PPV.1 - Comprehensive postpartum visits in local health departments

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Baseline data will be collected in FY26 with new 0503F code, so objectives will be adjusted for future years based on that baseline data.	
2.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Baseline data will be collected in FY26 with new 0503F code, so objectives will be adjusted for future years based on that baseline data.	

ESM BF.1 - First Time Breastfeeding Hotline Callers

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10,000.0	10,000.0	10,000.0	10,000.0	10,000.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2024**

   Column Name: **State Provided Data**

   Field Note:
   Baseline data will become available in FY25 once hotline is implemented, so objectives will be adjusted in future years.

ESM BF.2 - Number of eligible WIC participants who receive breastfeeding peer counselor services

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		28,350	29,120	29,900	30,660
Annual Indicator	25,020	22,263	22,599	22,987	21,869
Numerator					
Denominator					
Data Source	NC Crossroads WIC System	NC Crossroads WIC System	NC Crossroads WIC System	NC Crossroads WIC System	NC Crossroads WIC System
Data Source Year	SFY19-20	SFY20-21	SFY21-22	SFY22-23	SFY23-24
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM DS.1 - Developmental Screening in Local Health Department During Well-Child Visits

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Baseline data will be collected in FY26, so objectives will be adjusted for future years based on that baseline data.

ESM DS.2 - Medicaid-Enrolled Children Receiving Developmental Screening

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	74.7
Numerator	
Denominator	
Data Source	Medicaid Claims Data
Data Source Year	2023
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	76.0	77.0	78.0	79.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM DS.3 - Percent of LHDs whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children during state fiscal year

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		80	85	90	95
Annual Indicator	75	80.9	75.4	80	80.3
Numerator	51	55	49	52	53
Denominator	68	68	65	65	66
Data Source	DCFW/WCHS staff internal log	DCFW/WCHS staff internal log	DCFW/WCHS staff internal log	DCFW/WCHS staff internal log	DCFW/WCHS staff internal log
Data Source Year	FY19-20	FY20-21	FY21-22	FY22-23	FY23-24
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM AWV.1 - Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		24,225	8,000	17,000	20,000
Annual Indicator	16,676	7,656	16,169	18,265	18,379
Numerator					
Denominator					
Data Source	LHD/HSA and NC SHC Annual Report	LHD/HSA and NC SHC Annual Report	LHD/HSA and NC SHC Annual Report	LHD/HSA and NC SHC Annual Report	LHD/HSA and NC SHC Annual Report
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	20,000.0	20,000.0	20,000.0	20,000.0	20,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The data from the SHC Annual Report included more than just preventive visit CPT codes, but it's not possible to subset just the ones needed from the data source for 2020, thus this is an overestimate and marked provisional for this reason.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: These data are for State Fiscal Year for the LHD/HSA data (July 1, 2020-June 30, 2021) and School Year 20-21 data for the NC SHC Annual Report.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: These data are for State Fiscal Year for the LHD/HSA data (July 1, 2021-June 30, 2022) and School Year 21-22 data for the NC SHC Annual Report.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: These data are for State Fiscal Year for the LHD/HSA data (July 1, 2022-June 30, 2023) and School Year 22-23 data for the NC SHC Annual Report.	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: These data are for State Fiscal Year for the LHD/HSA data (July 1, 2023-June 30, 2024) and School Year 23-24 data for the NC SHC Annual Report.	

ESM AWV.2 - Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		66.3	75	77	80
Annual Indicator		71.6	71.2	51.8	85.9
Numerator		4,334	5,073	5,207	7,476
Denominator		6,054	7,122	10,045	8,706
Data Source		LHD/HSA	LHD/HSA	LHD/HSA	LHD/HSA
Data Source Year		SFY20-21	SFY21-22	SFY22-23	SFY23-24
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	90.0	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM MH.1 - Parents who Report That They Understand the Available Tools and Resources Necessary to Access and Maintain Having a Health Care Provider/Team That Uses a Medical Home Approach to Care

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Baseline data will be collected in FY26, so objectives will be modified for future years based on that data.

ESM MH.2 - Percent of children with special health care needs who received family-centered care

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		88.7	85	87	90
Annual Indicator		80.8	80.3	84.3	83.4
Numerator					
Denominator					
Data Source		2019-20 NSCH	2020-21 NSCH	2021-22 NSCH	2022-23 NSCH
Data Source Year		2019-20	2020-21	2021-22	2022-23
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM MH.3 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	12	18	15
Annual Indicator	8	9	17	13	14
Numerator					
Denominator					
Data Source	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data are for State Fiscal Year (July 1 - June 30).	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data are for State Fiscal Year (July 1 - June 30).	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data are for State Fiscal Year (July 1 - June 30).	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data are for State Fiscal Year (July 1 - June 30).	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Data are for State Fiscal Year (July 1 - June 30).	

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM RAC.1 - Percent of birth facilities with level of care documented using the CDC LOCATe tool.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		50	75	100	100
Annual Indicator	37.2	70.9	78.8	80.2	80.2
Numerator	32	61	67	65	65
Denominator	86	86	85	81	81
Data Source	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year	FY19-20	FY20-21	FY21-22	FY22-23	FY23-24
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: WNC Birth Center closed in 2022, so denominator decreased.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Additional birth centers closed, decreasing the denominator.	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: During FY24, no facilities were asked to complete the LOCATe tool as the WICWS was waiting on an updated version, thus the percent stayed the same as in FY22-23.	

2021-2025: ESM RAC.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL)

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25	25	40	60
Annual Indicator	1.2	2.4	16.5	15.3	4.7
Numerator	1	2	14	13	4
Denominator	85	85	85	85	85
Data Source	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2021-2025: ESM WWV.2 - Percent of WICWS programs that utilize the PCH Outreach and Education Toolkit

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		0	0	10	15
Annual Indicator		0	0	0	0
Numerator					
Denominator					
Data Source		WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The development of the PCH Outreach and Education Toolkit was delayed and and won't be implemented until FY23.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The review/approval of the PCH Outreach and Education Toolkit was delayed and and won't be implemented until Fall 2023..	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The review/approval of the PCH Outreach and Education Toolkit was delayed and won't be implemented until Spring 2025.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Internal review of the toolkit was extended through FY24, and submission to the NCDHHS Office for Public Affairs is in process.	

2021-2025: ESM WWV.3 - Percent of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and reproductive life planning (RLP).

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		30	40	75	95
Annual Indicator		32.9	82.1	95.2	97.6
Numerator		28	69	80	82
Denominator		85	84	84	84
Data Source		WICWS Internal Log	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year		FY20-21	FY21-22	FY22-23	FY23-24
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2021-2025: ESM WWV.4 - Percent of LHDs offering same day insertion of both contraceptive implants and intrauterine devices (IUDs)

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		74	85	86	86
Annual Indicator		84.5	73.7	59.2	56.1
Numerator		82	73	58	55
Denominator		97	99	98	98
Data Source		NC FP LHD Clinical Practice Survey	NC FP LHD Clinical Practice Survey	NC FP LHD Clinical Practice Survey	NC FP LHD Clinical Practice Survey
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2021-2025: ESM WWV.5 - Percent of LHDs that offer extended hours for Family Planning services.

Measure Status:		Active
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	28.6	33.3
Numerator	24	28
Denominator	84	84
Data Source	NC Family Planning Program Service Site Info.	NC Family Planning Program Service Site Info.
Data Source Year	2023	2024
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: North Carolina

SPM 1 - Adult Mentor
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	By 2030, increase the percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance by 5% from 86.6% (2022-23 Baseline) to 90.9%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents, ages 12 through 17, who are reported by a parent to have at least one other adult in their school, neighborhood, or community who knows them well and who they can rely on for advice or guidance **Denominator:** Number of adolescents, ages 12 through 17
Healthy People 2030 Objective:	Adolescent Health (AH) 03: Increase the proportion of adolescents who have an adult they can talk to about serious problems
Data Sources and Data Issues:	National Survey of Children's Health (parent-reported)
Significance:	As cited in Adult Mentor NPM Detail Sheet in MCHBG Technical Assistance Resources: Having a connection to a caring adult is one of several Positive Youth Experiences and is a protective factor that has been associated with several measures of child well-being, including markers of flourishing, physical activity, participation in activities, talking with parents as well as decreased likelihood of bullying and depression. Furthermore, a growing evidence base demonstrates the effectiveness of programs to foster youth-adult partnerships in wide variety of settings (ex. after school programming).

SPM 2 - CYSHCN Receiving Care in Well-Functioning System
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	By 2030, increase percent of CSHCN who receive care in a well-functioning system by 5% from 15.6% (2022-23 Baseline) to 16.4%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CSHCN, ages 0 through 17, who are reported by a parent to receive all components of a well-functioning system of care **Denominator:** Number of CSHCN, ages 0 through 17
Healthy People 2030 Objective:	Identical to Maternal, Infant, and Child Health (MICH) Objective 20: Increase the proportion of children and adolescents with special health care needs who receive care in a family-centered, comprehensive, and coordinated system.
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)
Significance:	As cited in CSHCN Systems of Care NOM Detail Sheet in MCHBG Technical Assistance Resources but with state NSCH data inserted: According to the 2022-23 NSCH, only 15.6% of CSHCN in North Carolina received services in a well-functioning system of services. The Omnibus Budget Reconciliation Act of 1989 requires Title V to provide and promote family-centered, community-based, coordinated care and facilitate the development of community-based systems of services for children with special health care needs and their families. To address this requirement a minimum of 30 percent of the Title V Block Grant funding is allocated for this purpose, and HP 2030 Objective MICH-20 establishes the goal to increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems.

SPM 3 - Compensated Family Engagement and Leadership Opportunities
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	By 2030, increase by X% from baseline (TBD) the percent of Title V programs that offer compensated family engagement and leadership opportunities
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of Title V programs that offer compensated family engagement and leadership opportunities **Denominator:** # of Title V programs
Healthy People 2030 Objective:	None identified
Data Sources and Data Issues:	NC Title V Office Program Information
Significance:	Family engagement in the design and delivery of programs is crucial for improving outcomes. Effective engagement acknowledges that the expertise and lived experience that families bring to the partnership is as valuable as the time of the professional partners, and families should be compensated in meaningful ways. This SPM tracks the proportion of programs funded through the Title V federal-state partnership that offer compensated engagement and leadership opportunities for families, fathers, and youth.

SPM 4 - Counties who Have Utilized NC-PAL or NC MATTERS
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To increase the percent of counties who have providers who have utilized the NC-PAL or NC MATTERS psychiatry access lines
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of counties who have providers who have utilized the NC-PAL or NC MATTERS psychiatry access lines **Denominator:** Total number of counties (100)
Healthy People 2030 Objective:	Related to Pregnancy and Childbirth (MICH) Objective D01: Increase the proportion of women who get screened for postpartum depression (Developmental) Related to Mental Health and Mental Disorders (MHMD) Objective 03: Increase the proportion of children with mental health problems who get treatment.
Data Sources and Data Issues:	NC MATTERS and NC-PAL internal program reports of calls received during fiscal year
Significance:	With up to 1 in 7 women experiencing perinatal depression, it is one of the most common complications of childbirth, but only 15% of women with perinatal depression ever receive professional treatment. Accortt & Wong (2017); Bonacquisti, Cohen, & Schiller (2017); Cox et al (2016) As cited in Mental Health Treatment NPM Detail Sheet in MCHBG Technical Assistance Resources, mental disorders among children are described as serious changes in the way children typically learn, behave, or handle their emotions, which cause distress and problems getting through the day. The prevalence of mental/behavioral health conditions has been increasing among children and has been found to vary by geographic and sociodemographic factors. However, a significant portion of children diagnosed with a mental health condition do not receive treatment. Further, the receipt of treatment is generally dependent on sociodemographic and health-related factors. Adequate insurance and access to a patient-centered medical home may improve mental health treatment. Centers for Disease Control and Prevention. Children's Mental Health. 2020 February 10. https://www.cdc.gov/childrensmentalhealth/index.html Ghandour RM, Sherman LJ, Vladutiu CJ, et al. Prevalence and Treatment of Depression, Anxiety, and Conduct Problems in US Children. J Pediatr. 2019;206:256-267.e3. doi:10.1016/ j.jpeds.2018.09.021. https://www.jpeds.com/article/S0022-3476(18)31292-7/fulltext

Form 10
State Performance Measure (SPM) Detail Sheets (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 1 - Percent of PRAMS respondents who reported that their pregnancy was intended
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	By 2025, increase the number of live births that were the result of an intended pregnancy to 61%
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of PRAMS respondents who reported that they wanted to be pregnant then or sooner **Denominator:** Number of PRAMS respondents
Healthy People 2030 Objective:	Family Planning (FP) Objective 1: Increase the proportion of pregnancies that are intended
Data Sources and Data Issues:	NC Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Unintended pregnancies directly correlate with poor birth outcomes. Couples may have risk factors or be engaging in behaviors that impact their own health and - unknowingly - the health of their unborn child at risk. Healthy timing and spacing of pregnancy provides couples the opportunity to prepare for the healthiest pregnancy possible.

2021-2025: SPM 2 - Percent of women who smoke during pregnancy
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	By June 30, 2025, reduce the percent of women who smoke during pregnancy by 10.7% to 7.5%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women who report smoking during pregnancy **Denominator:** Number of live births
Healthy People 2030 Objective:	Related to Tobacco Use (TU) Objective 6: Increase smoking cessation during pregnancy (Target: 30.0%)
Data Sources and Data Issues:	Vital Statistics/NC State Center for Health Statistics
Significance:	Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Adverse effects of parental smoking on children have been a clinical and public health concern for decades. Children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections; and SIDS. The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. https://www.surgeongeneral.gov/library/reports/50-years-of-progress/index.html

2021-2025: SPM 3 - Percent of children with two or more Adverse Childhood Experiences (ACEs)
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	By 2030, reduce the percent of children with two or more ACEs to 18%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children with 2 or more adverse childhood experiences as reported by their parents **Denominator:** Number of children age 0-17 years
Healthy People 2030 Objective:	Related to Early and Middle Childhood Objective 2: Increase the proportion of parents who use positive parenting and communicate with their doctors or other health care professionals about positive parenting and Adolescent Health Objective 3: Increase the proportion of adolescents who are connected to a parent or other positive adult caregiver.
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	Children thrive in safe, stable, and nurturing environments. Adverse experiences, such as exposure to trauma, violence, or neglect during childhood, increase the likelihood of poor physical and mental health as a child grows up. The more Adverse Childhood Experiences (ACEs) an individual has, the greater the risk for health-related challenges in adulthood. This includes a higher risk for coronary heart disease, stroke, asthma, and chronic obstructive pulmonary disease, much higher risk of depression, higher rates of risky health behaviors like smoking and heavy drinking, and more socioeconomic challenges. Research has shown that exposure to these ACEs can impact children's neurobiological development, negatively affecting their learning, language, behavior, and physical and mental health. Decreasing childhood exposures to trauma, building resilience, strong relationships with caregivers, and providing safe, stable environments can help children overcome the impact of ACEs. While two-thirds of people have at least one ACE, the more ACEs a child accumulates the more at risk to chronic disease and risky health behaviors they become. (NCIOM. Healthy North Carolina 2030 A Path Toward Health. Morrisville, NC: NCIOM; 2020)

2021-2025: SPM 4 - Percent of NC children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4)
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	By 2025, increase the percent of all children 19 to 36 months of age who have completed recommended vaccines to 90%
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of NC children sampled, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) **Denominator:** Number of NC children sampled, ages 19 through 35 months
Healthy People 2030 Objective:	Identical to Immunization and Infectious Disease (IID) Objective 8.0: Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV)
Data Sources and Data Issues:	National Immunization Survey
Significance:	Vaccination is one of the greatest public health achievements of the 20th century, resulting in dramatic declines in morbidity and mortality for many infectious diseases. Childhood vaccination in particular is considered among the most cost-effective preventive services available, as it averts a potential lifetime lost to death and disability. Currently, there are 12 different vaccines recommended by the Centers for Disease Control and Prevention from birth through age 18, many of which require multiple doses for effectiveness as well as boosters to sustain immunity. (https://www.cdc.gov/vaccines/index.html)

2021-2025: SPM 5 - Ratio of black infant deaths to white infant deaths
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	By 2025, decrease the statewide black/white infant mortality ratio to 1.92.
Definition:	**Unit Type:** Ratio **Unit Number:** 1 **Numerator:** Black, non-Hispanic infant mortality rate **Denominator:** White, non-Hsipanic infant mortalit rate
Healthy People 2030 Objective:	Maternal, Infant, and Child Health (MICH) Objective 1.3 Reduce the rate of all infant deaths (within 1 year)
Data Sources and Data Issues:	Vital Statistics/NC State Center for Health Statistics
Significance:	The death of an infant in the first year of life is considered a sentinel public health event and an indicator of the overall health of a population. The 2018 infant mortality rate for North Carolina was 6.8 deaths per 1,000 live births, which represents a historic low for the state. While the state has experienced substantial declines in overall infant mortality over the last two decades, racial disparities in infant mortality persist and at times widen. Comparing infant mortality rates among babies born to non-Hispanic Black mothers with non-Hispanic white mothers, the disparity ratio remained virtually unchanged from 1999 to 2018,with non-Hispanic Black infants having mortality rates 2.4 to 2.5 times higher than non-Hispanic white infants throughout this time period. Disparity ratios are also high among non-Hispanic American Indians, with rates 1.6 to 2 times higher than non-Hispanic white infants over the same period.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: North Carolina

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: North Carolina

ESM PPV.1 - Comprehensive postpartum visits in local health departments
NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase number of women receiving services in local health departments who receive a comprehensive postpartum visit on or between seven and 84 days after delivery.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>Number of women who receive a comprehensive postpartum visit on or between seven and 84 days after delivery in local health departments</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>NC Local Health Department Health Services Analysis (LHD-HSA) reports

Number of patients with 0503F coded in their medical record.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The evidence-based/informed strategies that this ESM measures are Medicaid Expansion/Extension (moderate evidence) and Quality Improvement Initiatives (emerging evidence). Evidence on these strategies was accessed from the MCH Evidence Center’s MCHbest database. These strategies influence the percent of women receiving a timely and comprehensive postpartum checkup by providing better access to care, improving documentation of visits and components of the visit, and increasing provider knowledge about the importance of the postpartum visit.</td></tr>
<tr><td>Significance:</td><td>As cited in Postpartum Visit NPM Detail Sheet in MCHBG Technical Assistance Resources: The postpartum period is an important time for maternal health and well-being. Untreated chronic conditions and pregnancy-related complications increase the risk of adverse health outcomes in the weeks and months following delivery. Data from Maternal Mortality Review Committees in 36 states suggest that more than half of pregnancy-related deaths occur from 7 to 365 days postpartum. A comprehensive postpartum visit is an opportunity to improve maternal health by providing recommended clinical services, including screening, counseling, and management of health issues. Anticipatory guidance and screening for mental health conditions and contraceptive counseling are key components of postpartum care that are recommended by national quality standards and professional organizations. The American College of Obstetricians and Gynecologists (ACOG) recommends that all women have contact with their obstetrician-gynecologists or other obstetric providers within the first three weeks postpartum followed by a comprehensive postpartum visit within 12 weeks after birth.2

Trost SL, Beauregard J, Njie F, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019. Atlanta, GA: Centers for Disease</td></tr>
</table>

Control and Prevention, US Department of Health and Human Services; 2022.

ACOG Committee Opinion No. 736: Optimizing Postpartum Care. Obstet Gynecol. 2018 Sept; 132(3): 784-785. doi: 10.1097/AOG.0000000000002849.

Interrante JD, Admon LK, Caroll C, et al. Association of health insurance, geography, and race and ethnicity with disparities in receipt of recommended postpartum care in the US. JAMA Health Forum. 2022; 3(10): e223292. doi:10.1001/jamahealthforum.2022.3292

Centers for Medicare & Medicaid Services. 2023 and 2024 Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP (Maternity Core Set). 2023.

ESM BF.1 - First Time Breastfeeding Hotline Callers
NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

Measure Status:	Active
Goal:	Increase the number of first time callers receiving telephonic and text-based lactation support provided by the breastfeeding hotline.
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** # of first time callers receiving telephonic and text-based lactation support provided by the breastfeeding hotline **Denominator:**
Data Sources and Data Issues:	Hotline vendor data reports
Evidence-based/informed strategy:	The evidence-based/informed strategy that this ESM measures is Text Message-Based Support. Evidence on this emerging evidence strategy was accessed from the MCH Evidence Center's MCHbest database. In addition, lactation consultants is another strategy found in the MCHbest database with moderate evidence which discusses telephone support. This strategy influences the percent of infants who are ever breastfed or breastfed exclusively for 6 months by increasing the confidence of participants to breastfeed through consistent support.
Significance:	As cited in Breastfeeding NPM Detail Sheet in MCHBG Technical Assistance Resources: The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months, followed by continued breastfeeding as complementary foods are introduced for 2 years or longer. However, significant differences in breastfeeding initiation and duration persist by socioeconomic status and race/ethnicity. Breastfeeding supports optimal growth and development, strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer, diabetes, hypertension, and heart disease. Meek JY, Noble L; Section on Breastfeeding. Policy Statement: Breastfeeding and the Use of Human Milk. Pediatrics. 2022;150(1):e2022057988. doi:10.1542/peds.2022-057988. https://publications.aap.org/pediatrics/article/150/1/e2022057988/188347/Policy-Statement-Breastfeeding-and-the-Use-of

ESM BF.2 - Number of eligible WIC participants who receive breastfeeding peer counselor services
NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

Measure Status:	Inactive - Replaced
Goal:	By 2025, the number of eligible WIC participants who receive breastfeeding peer counselor services will be 31,425 (15% increase from FY19 baseline of 27, 587).
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of eligible WIC participants who receive breastfeeding peer counselor services (determined by having a signed Breastfeeding Peer Counselor Program Letter of Agreement in the Crossroads WIC System) **Denominator:**
Data Sources and Data Issues:	NC Crossroads WIC System
Significance:	Systematic literature reviews have returned similar findings: “Dedicated lactation specialists may play a role in providing education and support to pregnant women and new mothers wishing to breastfeed and to continue breastfeeding (duration) to improve breastfeeding outcomes.”1 1 Patel, S., & Patel, S. (2016). The Effectiveness of Lactation Consultants and Lactation Counselors on Breastfeeding Outcomes. Journal of Human Lactation, 32(3), 530–541.

ESM DS.1 - Developmental Screening in Local Health Department During Well-Child Visits
NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Measure Status:	Active
Goal:	Increase the percent of children age birth to five receiving developmental screening at time of well-visit in LHD
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of well-child visits among children ages birth to five where there is documentation of a developmental screening **Denominator:** # of well-child visits among children ages birth to five
Data Sources and Data Issues:	NC Local Health Department Health Services Analysis (LHD-HSA) reports
Evidence-based/informed strategy:	The evidence-based/informed strategies that this ESM measures are Provider Training and Home Visiting Programs. Evidence on these moderate evidence strategies was accessed from the MCH Evidence Center's MCHbest database. These strategies influence the percent of children receiving developmental screening at time of well-visit in LHD as LHD clinic and home visiting program providers will be better informed on how best to conduct developmental screening.
Significance:	As cited in the Developmental Screening NPM Detail Sheet in MCHBG Technical Assistance Resources: Early identification of developmental delays and disabilities is critical to provide referrals to services that can promote health and educational success. It is an integral function of the primary care medical home. The American Academy of Pediatrics (AAP) recommends developmental screening at the 9, 18, and 24 or 30 month visit. Developmental screening is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. Systems-level quality improvement efforts that build on the medical home are needed to improve rates of developmental screening and surveillance. Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening [published correction appears in Pediatrics. 2006 Oct;118(4):1808-9]. Pediatrics. 2006;118(1):405-420. doi:10.1542/peds.2006-1231 https://publications.aap.org/pediatrics/article/118/1/405/69580/Identifying-Infants-and-Young-Children-With Hirai AH, Kogan MD, Kandasamy V, Reuland C, Bethell C. Prevalence and Variation of Developmental Screening and Surveillance in Early Childhood. JAMA Pediatr. 2018 Sep 1;172(9):857-866. doi: 10.1001/jamapediatrics.2018.1524. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2686728

ESM DS.2 - Medicaid-Enrolled Children Receiving Developmental Screening
NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Measure Status:	Active
Goal:	Increase the percent of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of children continuously enrolled in Medicaid screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday **Denominator:** # of children continuously enrolled in Medicaid
Data Sources and Data Issues:	Medicaid Claims Data
Evidence-based/informed strategy:	The evidence-based/informed strategies that this ESM measures are Provider Training and Home Visiting Programs. Evidence on these moderate evidence strategies was accessed from the MCH Evidence Center's MCHbest database. These strategies influence the percent of children continuously enrolled in Medicaid screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday as clinic and home visiting providers serving children enrolled in Medicaid will be better informed on how best to conduct developmental screening.
Significance:	As cited in the Developmental Screening NPM Detail Sheet in MCHBG Technical Assistance Resources: Early identification of developmental delays and disabilities is critical to provide referrals to services that can promote health and educational success.1 It is an integral function of the primary care medical home. The American Academy of Pediatrics (AAP) recommends developmental screening at the 9, 18, and 24 or 30 month visit.1 Developmental screening is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. Systems-level quality improvement efforts that build on the medical home are needed to improve rates of developmental screening and surveillance.2 Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening [published correction appears in Pediatrics. 2006 Oct;118(4):1808-9]. Pediatrics. 2006;118(1):405-420. doi:10.1542/peds.2006-1231 https://publications.aap.org/pediatrics/article/118/1/405/69580/Identifying-Infants-and-Young-Children-With Hirai AH, Kogan MD, Kandasamy V, Reuland C, Bethell C. Prevalence and Variation of Developmental Screening and Surveillance in Early Childhood. JAMA Pediatr. 2018 Sep 1;172(9):857-866. doi: 10.1001/jamapediatrics.2018.1524. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2686728

ESM DS.3 - Percent of LHDs whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children during state fiscal year
NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Measure Status:	Inactive - Replaced
Goal:	By 2025, 100% of LHDs providing direct child health services will have received training on the use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number LHDs whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children during state fiscal year **Denominator:** Number of LHDs providing child health services
Data Sources and Data Issues:	The Pediatric Medical Consultant in the Children & Youth Branch will collect this information annually as she provides the majority of these trainings.
Significance:	The risk for developmental delay is increased in the population of low income children seen in LHDs. The appropriate use of evidence-based tools in developmental, psychosocial, and behavioral health screening for children greatly improves the ability to elicit and identify developmental concerns from parents. Formal tools are much more effective than in informal interview. Screening examines the general population to identify those children at most risk. Children identified with concerns are at risk for developmental delay and are referred for further evaluation. Evaluation goes beyond screening to ascertain diagnosis and develop recommendations for intervention or treatment. This is generally not done by the primary care medical home, unless co-located or integrated professionals are in the practice. The evaluation determines the existence of developmental delay or disability which generates a decision regarding intervention. Ongoing periodic screening gives a longitudinal perspective of an infant or child's developmental progress. All concerns must be clarified and a need for a referral for further evaluation and intervention needs to be determined. Early referral for diagnosis and intervention helps to: - prevent or reduce the impact of developmental delays - identify, build and reinforce developmental strengths in the child and family - prevent fully developed developmental conditions or disorders; and - support school readiness.

ESM AWV.1 - Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Measure Status:	Active
Goal:	By 2030, at least 20,000 adolescents will have received a preventive medical visit in the past year at a local health department or school health center
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center **Denominator:**
Data Sources and Data Issues:	Local Health Department - Health Systems Analysis (LHD-HSA) and School Health Center Annual Report
Evidence-based/informed strategy:	The evidence-based/informed strategies that this ESM measures are Support Clinic Systems in Promoting Attendance of Well-Visits and School-Based Health Centers. Emerging evidence on these strategies was accessed from the MCH Evidence Center's MCHbest database. These strategies influence the number of adolescents receiving a preventive medical visit at a LHD or school health center by improving documentation of services provided and increasing access to healthcare services when needed.
Significance:	As cited in the Adolescent Well-Visit NPM Detail Sheet in MCHBG Technical Assistance Resources: Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors, such as unsafe sexual activity, unsafe driving, and substance use, is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. An annual preventive well visit may help adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. The Bright Futures guidelines recommends that adolescents have an annual checkup from age 11 through 21. The visit should cover a comprehensive set of preventive services, such as a physical examination, immunizations, and discussion of health-related behaviors including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety. The adolescent well-care visit measure for health plans is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP and the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set. Hagan JF, Shaw JS, Duncan PM, eds. Adolescence Visits 11 Through 21 Years. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_AdolescenceVisits.pdf h.

ESM AWV.2 - Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Measure Status:	Active
Goal:	By 2030, the percent of adolescents who had a behavioral health screening at time of preventive care visit will be 90%
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of adolescents who had a behavioral health screening at time of preventive care visit in local health department **Denominator:** # of adolescents with a preventive care visit at local health department
Data Sources and Data Issues:	Local Health Department - Health Systems Analysis (LHD-HSA)
Evidence-based/informed strategy:	The evidence-based/informed strategy that this ESM measures is Support Clinic Systems in Promoting Attendance of Well-Visits. Emerging evidence on this strategy was accessed from the MCH Evidence Center's MCHbest database. This strategy influences the number of adolescents who had a behavioral health screening at time of preventive care visit at a local health department by improving documentation of services provided and increasing access to healthcare services when needed.
Significance:	"Mental health and substance use disorders are the most significant threat to the lifelong health and well-being of youth. Approximately one in five adolescents has a diagnosable mental health or substance use disorder, that, if left untreated, will likely persist into adulthood and contribute to poor lifelong education, employment, and health outcomes. Youth with mental health and substance use disorders are often involved in more than one special service system, including mental health, special education, child welfare, juvenile justice, and health care. Prevention and early intervention are particularly important among adolescents, as are follow-up care and recovery supports after treatment. Ensuring a full continuum of care for adolescents can result in substantially shorter and less disabling experiences with mental health and substance use disorders and create a more positive health trajectory into adulthood." (Issue Brief: Transforming North Carolina's Mental Health and Substance Use Systems A Report from the NCIOM Task Force on Mental Health and Substance Use North Carolina Medical Journal November 2016, 77 (6) 437-440; DOI: https://doi.org/10.18043/ncm.77.6.437)

ESM MH.1 - Parents who Report That They Understand the Available Tools and Resources Necessary to Access and Maintain Having a Health Care Provider/Team That Uses a Medical Home Approach to Care
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of parents who report that they understand the available tools and resources necessary to access and maintain having a health care provider/team that uses a medical home approach to care</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of parents who report that they understand the available tools and resources necessary to access and maintain having a health care provider/team that uses a medical home approach to care</td></tr>
<tr><td>Denominator:</td><td># of parents who complete the Teaching Parents of Children and Youth with Disabilities About the Medical Home Approach Training Post Evaluation Survey</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Teaching Parents of Children and Youth with Disabilities About the Medical Home Approach Training Post Evaluation Survey</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The evidence-based/informed strategy that this ESM measures is Parent and Caregiver Partnership. Evidence on this moderate-evidence strategy was accessed from the MCH Evidence Center’s MCHbest database. This strategy influences the percent of parents who report that they understand the available tools and resources necessary to access and maintain having a health care provider/team that uses a medical home approach to care by strengthening their medical knowledge and advocacy skills.</td></tr>
<tr><td>Significance:</td><td>As cited in the Medical Home NPM Detail Sheet in MCHBG Technical Assistance Resources: The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

American Academy of Pediatrics. National Resource Center for Patient/Family-Centered Medical Home. (n.d.) https://medicalhomeinfo.aap.org</td></tr>
</table>

ESM MH.2 - Percent of children with special health care needs who received family-centered care
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Replaced
Goal:	By 2025, increase the percent of CSHCN who received family-centered care to 90%
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CSHCN ages 0 through 17 that received family-centered care **Denominator:** Number of CSHCN ages 0 through 17
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org In the NSCH, family-centered care is comprised of responses to five experience-of-care questions: [provider] spends enough time with child, listens carefully to you, is sensitive to family values/customs, gives needed information , and family feels like partner.

ESM MH.3 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Replaced
Goal:	By 2025, increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home to 45%.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by MCH staff with an agenda item related to medical home promotion **Denominator:**
Data Sources and Data Issues:	Internal log kept by C&Y Branch Staff
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org

Form 10

Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM RAC.1 - Percent of birth facilities with level of care documented using the CDC LOCATe tool.
2021-2025: NPM – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2025, 100% of birth facilities will have levels of neonatal and maternal care documented in an effort to ensure risk appropriate care is provided for infants and mothers.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of birthing facilities in NC which have completed the CDC Levels of Care Assessment Tool (CDC LOCATe) and been assigned appropriate maternal and neonatal levels of care within the past five years</td></tr>
<tr><td>Denominator:</td><td>Total Number of birthing facilities in NC</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The Women's Health Branch (WHB) will keep an internal log of birthing facilities that complete the LOCATe tool within each calendar year. The WHB is working with the Division of Health Services Regulations to update the existing neonatal rules and to develop maternal health rules.</td></tr>
<tr><td>Significance:</td><td>Ensuring that infants are born at facilities that are equipped to meet the need of both the infant and the mother is important to improve both maternal and neonatal outcomes. The LOCATe tool is a hospital survey on obstetric and neonatal practices and services which classifies maternal and neonatal levels of care based on responses to survey questions that are tied to criteria found in the 2015 ACOG/SMFM maternal levels of care and the 2012 AAP neonatal levels of care.</td></tr>
</table>

2021-2025: ESM RAC.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL)
2021-2025: NPM – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC

Measure Status:	Active
Goal:	By 2025, 75% of LHDs will use the NC-PAL in an effort to assist primary care providers in addressing the behavioral health needs of pregnant and post-partum patients.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of LHDs who are utilizing the NC-PAL **Denominator:** Number of LHDs providing maternal health services
Data Sources and Data Issues:	NC MATTERS Report
Significance:	Depression and anxiety during pregnancy and the postpartum period are common and have significant negative impacts on mother and child. Suicide is a leading cause of maternal mortality. Evidence-based efforts for screening, assessment, and treatment improve maternal and infant mental health, as well as overall family health, throughout the lives of women and children. NC-PAL or the NC Psychiatry Access Line, is a telephone consultation program designed to assist primary care providers in addressing the behavioral health needs of pediatric, pregnant, and post-partum patients. When primary care providers have a question about perinatal mental health, they can call the NC-PAL to be connected with the information they need. Care coordinators respond to questions within the scope of their expertise, provide resources and referrals, and can connect providers to psychiatric perinatal mental health specialists. Board-certified psychiatric perinatal mental health specialists can assist with diagnostic clarification and medication questions.

2021-2025: ESM WWV.2 - Percent of WICWS programs that utilize the PCH Outreach and Education Toolkit
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	By 2025, 20% of WHB programs will utilize the PCH Outreach and Education Toolkit in an effort to increase the percent of women who receive annual preventive medical visits.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of WHB programs that utilize the PCH Outreach and Education Toolkit **Denominator:** Number of WHB programs
Data Sources and Data Issues:	The WICWS Branch Managers will keep an internal log of programs using the Tool kit and will share this log with the WICWS Chief annually.
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit is recommended by the American College of Obstetrics and Gynecologists (ACOG). http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Well-Woman-Visit

2021-2025: ESM WWV.3 - Percent of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and reproductive life planning (RLP).
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	By 2025, 50% of LHDs will have staff who completed training on reproductive justice framework, contraceptive methods, and RLP in an effort to increase intended pregnancies.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and RLP **Denominator:** 85 LHDs
Data Sources and Data Issues:	LHDs will report annual to the Family Planning & Reproductive Health Unit Manager the number of staff members completing training on reproductive justice framework, contraceptive methods, and RLP. In addition, any training sponsored directly by the WHB will have rosters providing LHD site information.
Significance:	Unintended pregnancy is correlated with late or inadequate prenatal care, low birth weight, neonatal death, domestic violence, child abuse, and exposure of the fetus to harmful substances like tobacco, alcohol, and other drugs. It is associated with social and economic co-factors such as economic hardship, marital dissolution, failure to achieve educational goals, and spousal abuse. Reproductive life planning is also a critical component of pregnancy intendedness. Individuals should receive the support needed to make the best decision for themselves concerning their reproductive health, while ensuring this decision is free of coercion and the individual is aware of all their options.

2021-2025: ESM WWV.4 - Percent of LHDs offering same day insertion of both contraceptive implants and intrauterine devices (IUDs)
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	By 2025, at least 76% of LHDS will offer same day insertion of contraceptive implants and IUDs in an effort to increase intended pregnancies.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of LHDs that offer same day insertion of contraceptive methods. (IUDs & implants) **Denominator:** 99 counties
Data Sources and Data Issues:	NC Family Planning Local Health Department Clinical Practice Survey Note: Polk County does not provide FP services but assures services are available at Blue Ridge Health, the FQHC in their county.
Significance:	Unintended pregnancy is correlated with late or inadequate prenatal care, low birth weight, neonatal death, domestic violence, child abuse, and exposure of the fetus to harmful substances like tobacco, alcohol, and other drugs. It is associated with social and economic co-factors such as economic hardship, marital dissolution, failure to achieve educational goals, and spousal abuse. Reproductive life planning is also a critical component of pregnancy intendedness. Individuals should receive the support needed to make the best decision for themselves concerning their reproductive health, while ensuring this decision is free of coercion and the individual is aware of all their options.

2021-2025: ESM WWV.5 - Percent of LHDs that offer extended hours for Family Planning services.
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	To increase the percentage of LHDS that offer extended hours for FP services by 10% (from 28.6% in 2023 to 31.5% by 2025) in order to increase access to preventive medical visits.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of LHDs that offer extended hours for FP services. **Denominator:** Number of LHDs providing Family Planning services.
Data Sources and Data Issues:	NC Family Planning Program Service Site Information
Evidence-based/informed strategy:	Having designated clinic/extended hours was found to have moderate evidence of increasing receipt of preventive services by women. Information about the evidence for this strategy can be found in the NPM 1 Well-Woman Visit: Evidence Review Full Report produced in June 2017 by the Women's and Children's Health Policy Center at Johns Hopkins University and accessed through the National Center for Education in Maternal and Child Health's MCH Evidence website. This strategy influences the Well-Woman Visit NPM as extended hours help birthing people arrange their schedules to be able to obtain preventive care at more convenient times.
Significance:	There is moderate evidence that having extended hours can prevent missed opportunities in providing preventive services to women. As cited by both the American College of Obstetricians and Gynecologists and the Institute of Medicine, the well woman visit provides an opportunity for the provision of preventive services that can improve women’s health immediately and long term, address reproductive life planning/family planning, and ultimately improve birth outcomes.

Form 11
Other State Data

State: North Carolina

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: North Carolina

Annual Report Year 2024

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	0		
2) Vital Records Death	Yes	Yes	Quarterly	3	Yes	
3) Medicaid	Yes	Yes	Quarterly	3	Yes	
4) WIC	Yes	Yes	Quarterly	2	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	1	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	6	Yes	
8) PRAMS or PRAMS-like	No	No	Never	NA	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	8) PRAMS or PRAMS-like
	Field Note: While the Title V Office has had consistent access to PRAMS data for many years (and access to the electronic data source on an as needed basis), an application for CDC funding was not submitted by SCHS in 2020. The SCHS rolled out a pilot state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which included questions identical to the 2020 NC PRAMS survey and began data collection in 2024 using PRAMS Phase 9 questions. During the first year of data collection under PAS (2024), the response rates were insufficient for meaningful analyses of the data. However, 2025 data collection is currently underway, and SCHS has initiated data collection and monitoring improvements that should result in increased response rates.

Form 12
Part 2 – Products and Publications (Optional)

State: North Carolina

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Form 12 Products And Publications