# Maternal and Child Health Services Title V Block Grant

## North Carolina

## FY 2025 Application/ FY 2023 Annual Report

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# I. General Requirements

## I.A. Letter of Transmittal

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**ROY COOPER** • Governor
**KODY H. KINSLEY** • Secretary
**MARK BENTON** • Deputy Secretary for Health
**KELLY KIMPLE** • Acting Assistant Secretary for Public Health
Division of Public Health

July 15, 2024

Michael Warren, MD, MPH, FAAP
Associate Administrator
ATTN: MCH Block Grant
Division of State and Community Health
5600 Fishers Lane, Room 18-31
Rockville, MD 20857
MWarren@hrsa.gov

Dear Dr. Warren:

Enclosed is North Carolina's application for the Maternal and Child Health Services Title V Block Grant Fiscal Year 2025. 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 Kelly Kimple, NC Title V Program Director/Senior Medical Director for Health Promotion, at (919)614-9301.

Sincerely,

DocuSigned by:
Mark T. Benton
65A1EF320AD6419...

Kody Kinsley, Secretary

Enclosure: *Maternal and Child Health Services Title V Block Grant FY25 Application/FY23 Annual Report*

cc: Kelly Kimple, Acting Assistant Secretary for Public Health

**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 2021 Title V application/Annual Report guidance.

## 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, community-based organizations as well as other stakeholders to improve maternal and child health in NC. The NC Title V Director serves as Senior Medical Director for Health Promotion in DPH. The NC CYSHCN Director is positioned in the newly created Division of Child and Family Well-Being (DCFW) as the Assistant Director supervising the Whole Child Health Section (DCFW/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, driven by equity and committed to whole-person care. In addition to the Title V Office staff members, the NC Title V Director supervises the Women, Infant, and Community Wellness Section (WICWS) which is made up of three branches – Maternal Health, Reproductive Health, and Infant and Community Health; the Chronic Disease and Injury Section (CDIS), and the Oral Health Section (OHS). Additionally, in 2023, the Office of Child Fatality Prevention was established by statute to oversee the coordination of State-level support functions for the NC Child Fatality Prevention System, and this Office will also fall under the Title V Director. The DCFW/WCHS is made up of six units – Child Behavioral Health; School, Adolescent and Health; Best Practices; Child and Family Wellness; Genetics and Newborn Screening; and Operations. Also located in the DCFW are the Early Intervention Section and Community Nutrition Services Section which also serve the maternal and child health population.

The COVID-19 pandemic highlighted health inequities across the country and we took this as a call to action for NCDHHS to better support North Carolinians. As part of the realignment to bolster whole person health, encourage transparency and accountability, and promote health equity work across the department to create a healthier NC, the DCFW was established 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. In addition, the Immunization Branch moved to the NC DPH Epidemiology Section to allow better coordination with other branches in that Section. The Immunization, Communicable Disease, and Public Health Preparedness and Response Branches already work closely together on a range of issues like COVID-19, hepatitis, measles, and other vaccine-preventable illnesses. Bringing them together allowed greater coordination and collaboration.

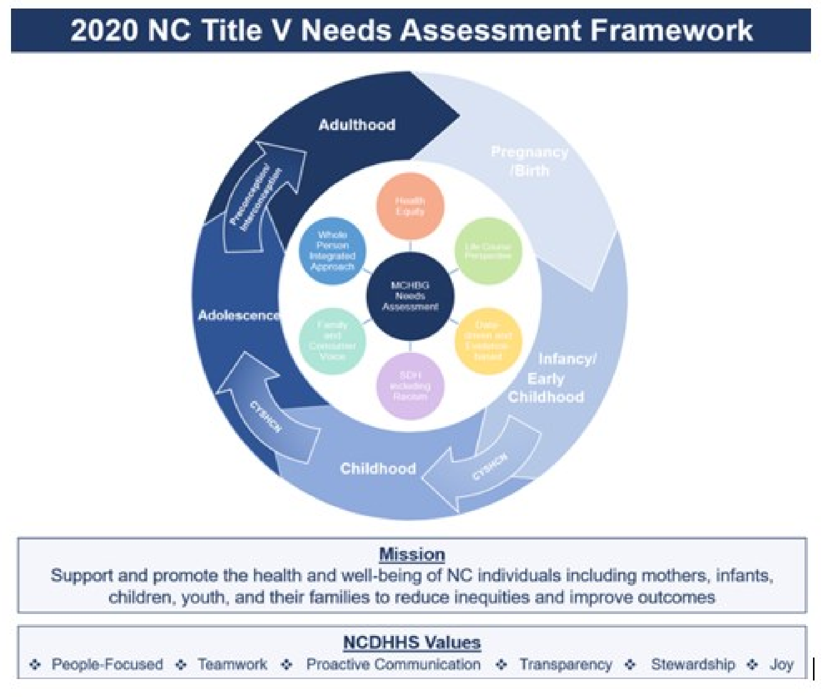
The NC Title V Program works across the NCDHHS to advance the Title V priorities and improve health, health equity and wellbeing of individuals of reproductive age, mothers, fathers, infants, children, and adolescents in the context of NCDHHS priority goals:

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.

NCDHHS is focusing particularly on priorities 2, 3, and 4 through 2024 as these are grounded in whole-person health

and equity which are cross-cutting principles of the NCDHHS 2024-26 Strategic Plan.

One overarching goal of the 2020 NC Title V Needs Assessment was to ensure that the process worked in alignment with Section, Division, and Department strategic planning efforts so that Title V resources could be leveraged as much as possible. These plans include, but are not limited to, the NC Perinatal Health Strategic Plan (PHSP), the CYSCHN Strategic Plan, the NC Early Childhood Action Plan, the NCDHHS Strategic Plan and Priorities, and the NC DPH Strategic Plan. The framework for the 2020 NC Title V Needs Assessment focused on a life-course approach driven by whole person integrated approach, health equity, social determinants of health inclusive of racism, family and consumer voice, and ensuring data-driven and evidence-based approach, as shown below:




The following table lists the eight selected priority needs that emerged from the 2020 Needs Assessment with the accompanying National and State Performance Measures (NPMs & SPMs) by population domain. The data and participant feedback supported continued use of most of the previous NPMs, but the Title V Office has chosen new SPMs which align more directly with the objectives and strategies in the State Action Plan as well as the other current strategic plans. While there has been incremental progress in most of the previously used indicators, there is still much room for improvement, particularly in decreasing racial/ethnic disparities and inequities.

| MCH Priority Needs Linked to Performance Measures | |
|---|---|
| **NC Priority Needs** | **NPM/SPM** |
| Women/Maternal Health | |
| 1. Improve access to high quality integrated health care services | NPM1 % of women, ages 18 through 44, with a preventive medical visit in the past year |
| 2. Increase pregnancy intendedness within reproductive justice framework | SPM1 % of PRAMS respondents who reported that their pregnancy was intended (wanted to be pregnant then or sooner) |
| Perinatal/Infant Health | |
| 1. Improve access to high quality integrated health care services | NPM3 % of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) |
| 3. Prevent infant/fetal deaths and premature births | NPM4A) % of infants who are ever breastfed and 4B) % of infants breastfed exclusively through 6 months |
| | SPM2 % of women who smoke during pregnancy |
| Child Health | |
| 4. Promote safe, stable, and nurturing relationships | NPM6 % of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year |
| | SPM3 % of children with two or more Adverse Childhood Experiences (ACEs) (NCHS) |
| 5. Improve immunization rates to prevent vaccine-preventable diseases | SPM4 % of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) |
| Adolescent Health | |
| 6. Improve access to mental/behavioral health services | NPM10 % of adolescents, ages 12 through 17, with a preventive medical visit in the past year |
| CYSHCN | |
| 7. Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN | NPM11 % of children with and without special health care needs, ages 0 through 17, who have a medical home |
| Cross-Cutting/Systems Building | |
| 8. Increase health equity, eliminate disparities, and address social determinants of health | SPM5 Ratio of black infant deaths to white infant deaths |

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 inequities 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 and health equity in 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.

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. Once complete, NCDHHS will be working through an Interagency Memorandum of Agreement between DPH and DCFW to ensure compliance of Title V requirements, ensure alignment of Title V goals, and promote sustainability of the new structure.

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 DCFW/WCHS, but also include staff members in the NC State Center for Health Statistics (SCHS), 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 local health department (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 Hospital 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 Advisory Network, 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 DCFW/WCHS who is a parent of a CSHCN to train and support family engagement in DCFW/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 PHSP

strategies, publications, and services. Participants are compensated for time, travel, meals, and lodging according to NC state government reimbursement guidelines.

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. 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 social determinants of health and systemic racism to achieve health and health equity, this work will take time. 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 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 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 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 Essentials for Childhood, 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), 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 NC Title V Program is a leader in efforts related to addressing social determinants and health equity within the DPH. The work across the life course is also be strengthened in 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. 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 health equity, 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 and that the lifelong effects of toxic stress and ACEs are considered. The Title V Office, WICWS, 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 along with equity is vital to the NC Title V Program. As NC continues to address challenges, such as infant mortality and its disparities, 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 community and family partner collaborations.

Perinatal Health Equity Collective Town Hall Meetings

The NC Perinatal Health Equity Collective (PHEC) provides leadership and guidance in implementing the NC Perinatal Health Strategic Plan (PHSP). In 2023, the PHEC's Village to Village (V2V) Work Group took the lead in planning six Community Town Hall meetings throughout the state, one in each Perinatal Care Region. Overall, there were an estimated 248 people who attended the town halls, 150 in person and 98 virtually through Zoom. This estimate excludes facilitators and staff. V2V is comprised primarily of NC residents of reproductive age who give feedback on the Collective's activities and work based on their lived experiences. Of the 369 people who registered for the town halls, 45% of registrants stated that they were not aware of the PHSP prior to learning about the town halls. Registrants were also asked the population(s) served by their organizations and to state their self-identified role(s). Registrants could choose multiple populations served and roles. The top two populations served by registrants were Pregnant/Birthing People and Families with Young Children. Additionally, 40% of registrants were parents, and 33% of registrants were of reproductive age. Participants who completed the evaluation survey reported feeling heard and that they walked away more knowledgeable about the work of the PHEC and the PHSP. Since the Town Halls, the PHEC listserv has grown by over 200 people, with additional organizations, partners, and people with lived experience engaging in the work of the PHSP.

NC CYSHCN Blueprint Learning Collaborative Team

NC is one the five states selected to participate in the CYSHCN Blueprint Learning Collaborative led by the National Center for a System of Services for CYSHCN (Consortium). The DCFW/WCHS assembled the state learning collaborative team co-led by the Title V CYSHCN Director and the Family Liaison Specialist and including Unit managers and a family partner (rotating schedule) which meets monthly to receive technical assistance from two national coaches. The team agreed that CYSHCN are part of the populations served by all WCHS Units, but not all CYSHCN are children with complex needs. To increase a shared understanding of the Blueprint, the team requested and received training from the national coaches. Additionally, they completed the *Aligning your work with the Blueprint for Change for CYSHCN Worksheet* which included a review of NSCH data for medical home and transition to identify unmet needs as well as a review of the NC CYSHCN Help Line data. This work led the team to choose its first two areas of focus: developing a medical home training (access to services) and informing partners about Medicaid expansion (accessing services, financing, and health equity). A workgroup of family partners from minoritized communities who are part of the DCFW/WCHS Family Partner Engagement and Leadership Committee is reviewing medical home trainings that other states have shared. The Senior Medical Director developed a required training for DCFW staff to explain the importance of Medicaid expansion to child and family well-being. The team is also revising an RFA to improve community systems to better meet the emerging needs of families of CYSHCN while still developing and maintaining system changes.

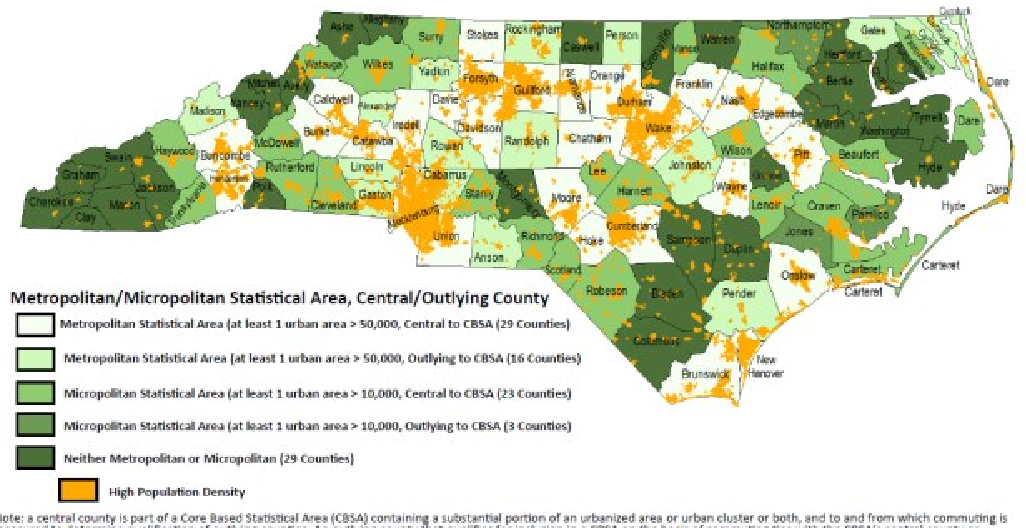
### III.B. Overview of the State

**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 diverse 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 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. NC's rural population is the 2nd largest rural population in the country (with Texas having the largest) according to the NC State Demographer's analysis of the 2020 Demographic Profile and Demographic Housing Characteristics datasets.

**Figure 1**

**County Designations of Core Based Statistical Areas**




According to the US 2020 Census, NC's official population was 10,439,388 which is an increase of 903,905 or 9.5% since 2010. This was the sixth largest increase among the states and the fifteenth fastest-growing state. (Carolina Demography Blog, April 26, 2021). According to the US Census Bureau's Population Estimates Program (PEP), the 2023 population estimate was10,835,491.

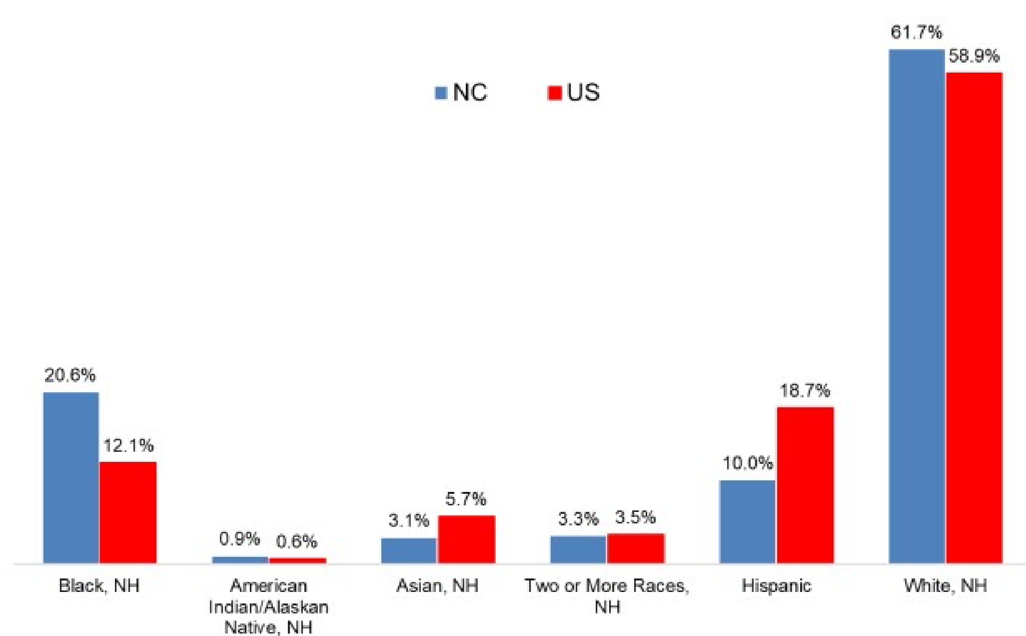
Per the 2018-2022 ACS, the age distribution of the female population of NC mirrors that of the nation. Females in

NC and in the US are also aging at approximately the same rate. The median age in NC is 39.1 years; for women, it is 40.4 years. The number of women in NC in their reproductive years (ages 15-44) compose 38.5% of the total female population, and the population projections for 2025 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. However, the number of resident births increased to 121,557 in 2022, and the birth rate of 11.4 was higher than the 2020 rate of 11.0 which was the lowest birth rate ever recorded in the state. 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, with it being 57.4 in 2022. Based on 2018-2022 ACS population estimates, children under five years make up 5.6% of NC's population, while children under 18 years comprise 21.8%. These percentages are similar to those for the US (5.7% and 22.1% respectively).

2018-2022 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 20.6% of the population. The combined other minority groups – Hispanic (10%), American Indian and Alaska Native, NH (0.9%), Asian, NH (3.1%) and those reporting two or more races, NH (3.3%) – represent a smaller proportion of the total population, but their numbers have increased significantly over the past decade. Data from the 2020 Census show that NC's Hispanic population is now greater than one million people, which is an increase of 320,000 new residents since 2010 for a percent change of 40 which is higher than that of the US at 23. (UNC Carolina Population Center Carolina Demography's blog *North Carolina's Hispanic Community: 2021 Snapshot* posted October 18, 2021). See Figure 2 for a comparison of racial/ethnic distribution in NC and the US.

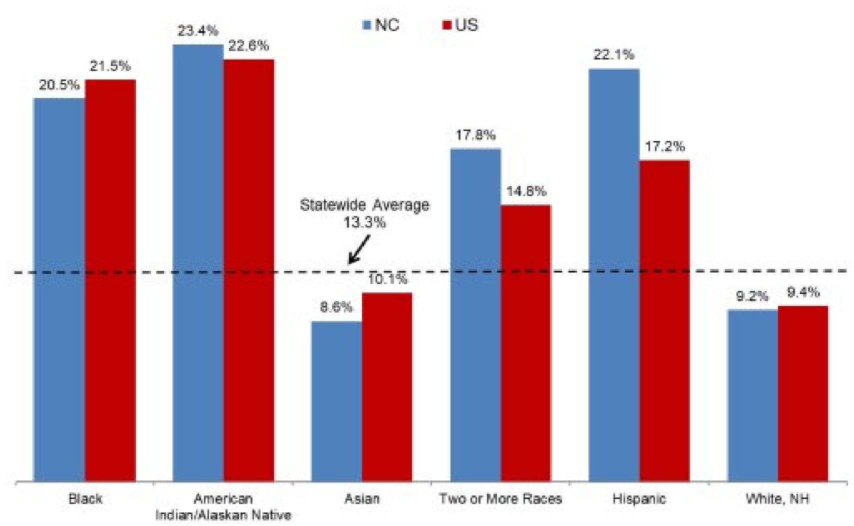
**Figure 2**




According to single-year ACS data, 1.3 million North Carolinians (12.8%) lived in poverty in 2022, making NC the

state with the 17th highest poverty rate (tied with Ohio). Poverty rates by race and ethnicity in NC from ACS 2018-2022 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, 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 (14.6%) than men (12%), and children under 18 in NC are at a higher rate of poverty (18.5%) than for the nation as a whole (16.7%).

**Figure 3**




Source: U.S. Census Bureau: 2018-2022 American Community Survey 5-Year Estimates

The state's poverty rate has declined slightly over the past ten years (2008-2012 ACS data for NC showed a rate of 16.8%) and income levels have increased slightly. Per 2018-2022 ACS data, the median household income level for North Carolinians was $67,481 as compared to $74,755 for the US. 2007-2011 ACS data shows the NC level at $46,291 and the US level at $52,762. Men continue to have higher median income with 2018-2022 ACS data showing that median earnings for men with a bachelor's degree (not including people who also have a graduate degree) were $74,400 compared to $50,200 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 3.5% for the last quarter of 2023, but this rose to 5.4% for Black people and 3.7% for Hispanic people, while the rate for white people was 2.8% and 2.9% for Asian Americans and Pacific Islanders. Since the first quarter of 2020 (before COVID-19), NC has seen a decrease of .4 percentage points in unemployment. (State Unemployment by Race and Ethnicity updated February 2024 and accessed May 2024).

## 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, but it is too soon to know exactly the full impact of that transformation. The NC DPH and DCFW have been working with NC Medicaid and the LHDs to maintain continuity for the Medicaid beneficiaries through the roll out of NC Medicaid Managed Care. Most recently, 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 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 2025-2026. In addition, NCDHHS has been looking at the structure of CMARC and CMHRP in the context of workforce development initiatives and, in collaboration with two LHD regions, implemented a care management shared services pilot model with the support of ARPA Workforce funding.

The COVID-19 pandemic highlighted health inequities across the country, and we took this 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 health equity work 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. We hired a new Chief Health Equity Officer, Deputy Secretary for Operational Excellence and a Deputy Secretary for Policy and Communications. Additionally, the DCFW was established as a new departmental agency. 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, equity, and well-being.

**Delivery of Title V Services within NCDHHS**

With the launch of the NCDHHS' DCFW in February 2022, several organizational changes were made within the NC DPH and to the Title V Program. Dr. Kelly Kimple, a pediatrician and preventive medicine physician, was named Title V Director in August 2016. She still serves as the NC Title V Director but has also been named the Senior Medical Director for Health Promotion for the NC DPH. In this new role, she supervises the WICWS, the CDIS, the Oral Health Section, the NC Title V Office, and the new Office on Child Fatality Prevention. She also works closely

with the Assistant Secretary for Public Health and others across the NCDHHS on broader initiatives. The NC CYSHCN Director is now positioned in the DCFW as the Assistant Director supervising the Whole Child Health Section (DCFW/WCHS). Dr. Anne Odusanya started in that position in March 2022.

The mission of NCDHHS, in collaboration with its partners, is to protect the health and safety of all North Carolinians and provide essential human services. The Department's vision is that all North Carolinians will enjoy optimal health and well-being. Governor Roy Cooper was sworn into his second term of office on January 9, 2021. Prior to being elected Governor, Cooper served as the NC Attorney General from 2001 to 2017 and was previously a member of the NC House of Representatives (1987-1991) and NC Senate (1991-2001). In November 2021, Governor Cooper announced that Kody Kinsley, former NCDHHS Chief Deputy Secretary for Health and Operations Lead for NC's COVID-19 response, would succeed Secretary Mandy K. Cohen beginning January 1, 2022. Secretary Kinsley has identified three priority areas of focus for NCDHHS: 1) Investing in behavioral health and resilience; 2) Supporting child and family well-being; and 3) Building a strong and inclusive workforce. In May 2022, Secretary Kinsley announced that Mark Benton, who had served as the Assistant Secretary for Health and State Health Official and led NC DPH since June 2019 would resume his former role as the Deputy Secretary for Health and then he was recently named Chief Deputy Secretary. Susan Kansagra, who most recently served as Deputy Director of NC DPH, has been appointed to serve as the Assistant Secretary for Public Health and State Health Official. She is planning to step down in summer 2024, and an interim has yet to be named. The Title V Director is directly supervised by Assistant Secretary Kansagra. The State Health Director position, which previously was part of the NC DPH, is now the State Health Director/Chief Medical Officer of NCDHHS, who coordinates efforts across NCDHHS, which reflects the Division's and Department's value of collaboration and teamwork. Dr. Betsey Tilson, a pediatrician and preventive medicine physician, was appointed to serve as NCDHHS Chief Medical Officer and State Health Director in August 2017.

The NC DPH is composed of the Director's Office and the following offices and sections: Administrative, Local, and Community Support; Chronic Disease and Injury; Epidemiology; Environmental Health; Oral Health; Office of the Chief Medical Examiner; SCHS; State Laboratory; WICWS, the Title V Office, and the new Office on 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, Reach Out and Read, 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 Director co-chairs the MCH Steering Committee as a dedicated time for coordination across Divisions.

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 to: 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) advance equity; 6) earn trust; 7) strengthen partnerships; and 8) drive data-informed decision making and evidence-based policy. During 2023-2025, the NC DPH will focus on the following three main strategic priorities: 1) support the recruitment, development, retention, and diversity 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.

The NC Title V Program used to manage and administer an annual budget of over $627 million, which now has been allocated between the DPH ($78 million) and the new DCFW ($549 million) and employs 987 people (DCFW 790 and DPH 197). This MCH program represents 48% of the DPH and DCFW staff (2063 total positions), along with 57% of the total budget of $1,091,645,456. This reorganization has transitioned in several phases with the final phase being the passage of the 2023-2024 budget by the NC General Assembly.

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.

**NC's Systems of Care for Meeting the Needs of Underserved and Vulnerable Populations, Including CYSHCN**

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. Title V funding is provided to LHDs through the Consolidated Agreement, which is a contract between the LHD, DPH and DCFW that outlines requirements of DPH, DCFW and the LHD including funding stipulations, personnel policies, disbursement of funds, etc. State, federal, or special project funds cannot be used to reduce locally appropriated funds. The Consolidated Agreement is revised and renewed annually. Program specific requirements for each state funded activity are provided in Agreement Addenda (AA) which are also revised annually. The AA provide a scope of work and deliverables which provide guidelines for the provision of services and outcomes. LHDs bill Medicaid and private insurance companies and have a sliding fee scale for uninsured patients. LHDs are free to allocate portions of the Title V funds to provide services to patients who are ineligible for Medicaid with no other payment source. The Title V Program also administers a limited amount of state appropriations for these services.

Services and resources for CYSHCN are included within all programs and initiatives under the NC Title V Program. This intra-agency approach is inclusive, 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 and major medical facilities. In addition, DCFW/WCHS staff are supported by Title V to provide training and technical assistance to providers. To the greatest extent possible, services are offered within family-centered, community-based systems of care.

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. 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.

In 2015, the DCFW/WCHS developed a strategic plan for the years 2015-2020 for child health and children and youth with special health care needs. While progress has been made and many of the recommendations completed (Americans with Disabilities Act [ADA] assessments for many LHDs, integration of CYSHCN support in all programs in the DCFW/WCHS, development of an oral health checklist for parents and dentists, training to LHDs as medical home for CYSHCN, and increased internal and external partnerships to support the system of care for CYSHCN), long range goals of increasing access to care, integration of mental and behavioral health, improving the quality of care, and improving the system of care are incorporated in the Title V State Action Plan and will continue to be part of the DCFW/WCHS Strategic Plan which is being extended to 2025.

In 2017, it was determined that a more specific strategic plan needed to be developed for CYSHCN. The Standards for Systems of Care for CYSHCN was selected as the framework for the strategic plan, and a Summit was held in October 2017 that included all DCFW/WCHS staff as well as parents of CYSHCN and other internal and external partners.

The following activities have occurred, are ongoing, or are planned for FY22-25 that support the DCFW/WCHS and CYSHCN Strategic Plans and the Title V State Action Plan:

- Title V is partnering with the NC Integrated Care for Kids (InCK) project, a demonstration project of integrating and coordinating systems of care for children. In addition, Title V is working with DPI to address mental and behavioral health services in schools using K12 COVID testing expansion funds. Thirteen mental health initiatives were developed along with expanded COVID testing which included at-home tests.
- Title V will continue with behavioral health consultation, education, workforce capacity building, and outreach for pediatric primary care providers across the state and is expanding to DSS case workers, infant and early childhood mental health professionals, and schools. This is building upon the HRSA Pediatric Mental Health Care Access grant with additional support from the DMH/DD/SAS and DHB.
- Title V will continue working with Duke, University of NC at Chapel Hill (UNC-CH), family and community partnerships (including Medical Legal Partnership) to address access to care, medical home, and community-based services and supports for children with complex needs with the advisory committee for the Path4CNC.
- The nine-member Commission on CYSHCN is charged with monitoring and evaluating the availability and provision of health services for CSHCN in NC and to monitor and evaluate the services for special needs children through NC Health Choice. The Commission makes recommendations to key leaders to improve services to these children and make service delivery more efficient and effective. DCFW/WCHS provides staffing support for the Commission and its behavioral health and oral health work groups and other work groups as needed.
- The DCFW/WCHS, in partnership with the Commission on CSHCN, has developed and will continue to use various strategies to promote and distribute a dental home for CSHCN checklist for parents of CYSHCN and dentists to improve oral health access and care.
- The DCFW/WCHS will continue to conduct ADA assessments for LHDs to increase access for CYSHCN and ensure compliance related to accessibility as part of LHD accreditation.
- The DCFW/WCHS will highlight the *Blueprint for Change: Guiding Principles for a System of Services for CYSHCN and their Families* during webinars, trainings, meetings, and conference presentations.
- The DCFW/WCHS will participate in the CYSHCN Blueprint Learning Collaborative to develop a Blueprint Implementation Roadmap that identifies actionable steps at research, practice, and policy levels for sectors serving CYSHCN and their families.

The NC Early Childhood Action Plan (ECAP) was launched at the NC Early Childhood Summit on February 27,

2019. The ECAP was developed with input from over 350 stakeholders from across the state, including many from the NC Title V Program, and more than 1,500 people provided feedback on the draft plan before it was finalized and released. Work on the plan started in August 2018 when Governor Cooper issued an executive order directing NCDHHS to develop an early childhood plan devoted to the health, safety, development, and academic readiness of young children in NC. The ECAP's vision statement is: "All North Carolina children will get a healthy start and develop to their full potential in safe and nurturing families, schools and communities." The ECAP provides a framework to help NC create change for its young children by 2025. The overall goal of the plan is:

By 2025, all NC young children from birth to age eight will be:

1. Healthy: children are healthy at birth and thrive in environments that support their optimal health and well-being.
2. Safe and Nurtured: Children grow confident, resilient, and independent in safe, stable, and nurturing families, schools, and communities.
3. Learning and Ready to Succeed: Children experience the conditions they need to build strong brain architecture and skills that support their success in school and life.

NCDHHS continues to advance the ECAP now with a focus on four of the ECAP goals in alignment with the NCDHHS strategic goals and Secretary priorities, especially those that have an urgent need for families and young children as we emerge from the COVID-19 pandemic and work to recover stronger. These goals include Healthy Babies, Food Security, Permanent Families for Children in Foster Care, and High-Quality Early Learning and are highlighted in the Early Childhood Action Plan 2024 Update. NC Title V continues to support implementation of these goals as part of the NCDHHS priority areas.

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 PHEC and PHSP. Bi-monthly Perinatal Health Equity Collective (PHEC) meetings are held as well as routine meetings of the PHEC Leadership Team which is composed of the chairs of the five work groups: Communications; Data and Evaluation; Maternal Health (which currently has three action teams – Neonatal Levels of Care; Equity in Practice and Maternal Levels of Care); 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.

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, needed 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 DCFW/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 2022, for NC as a whole, there was an average of 7.4 physicians with a primary care practice per 10,000 individuals. However, 32 counties have relatively few primary care physicians (less than 4 per 10,000 people) and two counties did not have any primary care physicians. NC also has an increasing shortage of health care professionals performing deliveries, and there have been seven rural hospital closures since 2010 in NC. Also in 2022, there was an average of 1.56 physicians whose specialty was general pediatrics per 10,000 population, but 20 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 NC Child Fatality Task Force supported legislation (Session Law 2018-93) requiring a NCDHHS study of risk-appropriate neonatal and maternal care which corresponds to NPM3 and PSHP Strategy 3E - Ensure that pregnant women and high-risk infants have access to the appropriate level of care though a well-established regional perinatal system. The NCDHHS study occurred through a partnership between the NC Institute of Medicine (NCIOM) and the NC DPH, with NCIOM convening the Task Force on Developing a Perinatal Systems of Care (PSOC Task Force) during January-October 2019 and releasing a final report in April 2020 (*Healthy Moms, Healthy Babies: Building a Risk-Appropriate Perinatal System of Care for North Carolina*). The report “called on the state government, health care providers, health professional and trade organizations, health care payors, and other stakeholders to support the development of a regionalized and risk-appropriate perinatal system of care that addresses both clinical and

non-clinical health needs of mothers and their babies and work toward a healthier future for all North Carolinians." NC continues to work to align neonatal and maternal levels of care with national standards in partnership with NCIOM and the PHEC Maternal Health Action Teams.

In FY20, the WICWS received a 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. As reported earlier, a decision was made in March 2022 to merge the work of the MHTF into the PHEC to avoid duplication of efforts. The NCIOM will continue to play a vital role in promoting the recommendations identified by the MHTF. An application for continued Maternal Health Innovation funding was submitted in April 2024.

2020 marked the 50th anniversary of NC's Medicaid program, which provides health coverage for low-income adults, children, pregnant women, seniors, and people with disabilities. In 2021, Medicaid paid for 62,387 deliveries, or 51.8% of all births in NC. In NC, as of December 1, 2023, income eligibility standards for selected coverage groups that use Modified Adjusted Gross Income (MAGI) rules in Medicaid are as follows:

| **NC Medicaid Income Eligibility Standards – 12/1/2023** | |
|---|---|
| **Coverage Group** | **Percentage of the Federal Poverty Level** |
| Children Medicaid Ages 0-1 | 211 |
| Children Medicaid Ages 1-5 | 211 |
| Children Medicaid Ages 6-18 | 211 |
| Children Separate CHIP | N/A |
| Pregnant Women Medicaid | 196 |
| Pregnant Women CHIP | N/A |

The NC budget law for FY23 directed NCDHHS to submit any necessary State Plan amendments to the Centers for Medicare and Medicaid Services (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.

As documented more fully elsewhere in this document (III.C. Needs Assessment Summary and III.E.2.b.iv. Health Care Delivery Systems), NC was in the middle of implementing Medicaid transformation in FY19, but this implementation was suspended due to the lack of a state budget in November 2019. NC Medicaid Managed Care officially launched on July 1, 2021. Health Check (Medicaid for Children) is NC's preventive health and wellness program for NC Medicaid beneficiaries under age 21, and services provided under Health Check are part of the federal Early Periodic Screening, Diagnostic and Treatment benefit required by the CMS. The WICWS and DCFW/WCHS have partnered with NC Medicaid and Community Care of North Carolina (CCNC) to provide Care Management for High-Risk Pregnancy (CMHRP) and Care Management for At-Risk Children (CMARC), a population management program for high-risk pregnant women and children ages 0 to 5 years who meet certain criteria (children with special health care needs or those exposed to toxic stress in early childhood). With Medicaid transformation, these programs have continued with some modifications but with an ongoing focus on public health and community-based care management.

NCDHHS launched Medicaid Expansion on December 1, 2023. Medicaid Expansion 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. As of May 3, 2024, there were 447,498 people enrolled.  NCDHHS projects that the state's enrollment under expansion will reach 600,000 within two years.

The Behavioral Health and Intellectual/Developmental Disability 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 started July 1, 2024. There are approximately 210,000 beneficiaries with a serious mental illness, a severe substance use disorder, an I/DD, or atraumatic brain injury. Tailored Plans will be managed by the Local Management Entities Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health.

NC Medicaid partnered with Duke University and UNC-CH to apply for and received a $16 million federal funding grant from the Centers for Medicare and Medicaid Innovation to implement the Integrated Care for Kids (InCK) Model in five counties (Alamance, Granville, Vance, Durham, and Orange). The funding runs from January 2020 to December 2026. NC InCK is designed to build and support the infrastructure needed to integrate health and human services for Medicaid enrolled beneficiaries from birth to age 20. One goal of service integration is to identify and address social drivers of health in addition to physical and behavioral health issues.

**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.C. Needs Assessment**
**FY 2025 Application/FY 2023 Annual Report Update**

The NC Title V Program approaches the needs assessment as a continuous process, in which useful data, both quantitative and qualitative, relevant to the broad mission of the Program are continuously being gathered and analyzed with an eye to adjusting the Program priorities and activities as appropriate. The data capacity of the NC Title V Program is strong. There is a Perinatal Epidemiologist and SSDI Project Coordinator in the Title V Office, and the WICWS and DCFW/WCHS have 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 at the NC SCHS who provide further analyses, as necessary. In addition, most of the programs and initiatives provided under the Title V Program require local community action teams or advisory councils comprised of community members who provide input throughout the course of the project regarding emerging and ongoing needs. Often programs conduct focus groups and key informant interviews to gain more information from consumers, providers, and partners. Descriptions of how input from community groups, focus groups and other stakeholders was obtained and was used during FY23 can be found in the state action plan narrative domain reports.

The priority needs chosen during the 2020 Needs Assessment Process by Population Domain are:

| **NC Priority Needs by Population Domain** |
|---|
| Women/Maternal Health |
| 1. Improve access to high quality integrated health care services |
| 2. Increase pregnancy intendedness within reproductive justice framework |
| Perinatal/Infant Health |
| 1. Improve access to high quality integrated health care services |
| 3. Prevent infant/fetal deaths and premature births |
| Child Health Domain |
| 4. Promote safe, stable, and nurturing relationships |
| 5. Improve immunization rates to prevent vaccine-preventable diseases |
| Adolescent Health |
| 6. Improve access to mental/behavioral health services |
| CYSHCN |
| 7. Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN |
| Cross-Cutting/Systems Building |
| 8. Increase health equity, eliminate disparities, and address social determinants of health |

**Changes in the Health Status and Needs of NC's MCH Population**

There were no specific major changes in the overall health status and needs of NC's MCH population over the past four years other than the ongoing effects of the COVID-19 pandemic (including potential increases in maternal morbidity/mortality that are still being investigated) and the mental health crisis.

Women/Maternal Health

Per data from the 2022 Behavioral Risk Factor Surveillance System (BRFSS) in the FAD, 73.4% of women ages 18 to 44 surveyed had received a preventive medical visit in the past year which is higher than the national rate (72.5%)

and is a bit lower than the 2018 NC rate of 77.6% (although confidence intervals overlap for the two years). Pregnancy intendedness data from the 2020 Pregnancy Risk Assessment Monitoring System show that 59% of survey respondents either wanted to be pregnant then or sooner which is similar to the survey results for the past five years. Unfortunately, this is the most recent PRAMS data available at this time. As shown in the table below, there were no major changes over the past four years in most of the other Core State Preconception Health Indicators available from BRFSS, and inequities between racial and ethnic population groups persist. The increase in the number of women who currently have some type of health care coverage does seem to have increased significantly (confidence intervals don't overlap) between 2018 and 2022 and for total respondents and for white and Black respondents. There does seem to be an increase in those women who were overweight or obese except for Hispanic women where there was a decrease, although the confidence intervals are overlapping probably due to a small sample size.

**Characteristics of Women of Childbearing Age by Race/Ethnicity**
**North Carolina, 2018 & 2022**

| *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 | 2018 | 77.0 | 73.3-80.2 | 75.2 | 70.2-79.7 | 83.4 | 76.3-88.7 | 75.3 | 64.7-83.5 |
| | 2022 | 73.0 | 68.8-76.7 | 71.5 | 66.2-76.2 | 79.3 | 70.7-85.8 | 75.2 | 65.9-82.6 |
| Currently have some type of health care coverage | 2018 | 79.9 | 76.4-83.0 | 87.9 | 83.9-91.0 | 83.9 | 76.6-89.3 | 35.8 | 26.4-46.5 |
| | 2022 | 87.8 | 84.7-90.3 | 92.7 | 88.7-95.3 | 97.8 | 94.7-99.1 | 53.1 | 42.7-63.3 |
| Are overweight or obese based on body mass index (BMI) | 2018 | 58.5 | 54.2-62.8 | 53.6 | 48.0-59.2 | 70.5 | 61.4-78.3 | 64.4 | 50.7-76.1 |
| | 2022 | 63.5 | 58.7-68.0 | 59.4 | 53.3-65.4 | 78.3 | 69.7-85.0 | 59.0 | 45.7-71.1 |
| Have been told by provider that they had hypertension (including during pregnancy)* | 2017 | 17.9 | 14.9-21.3 | 15.4 | 11.8-20.0 | 22.8 | 16.3-31.0 | 15.4 | 8.5-26.3 |
| | 2021 | 13.5 | 11.0-16.3 | 13.0 | 9.9-17.0 | 16.3 | 11.3-23.1 | 7.8 | 4.3-13.6 |
| Currently smoke every day or some days | 2018 | 15.0 | 12.4-18.1 | 19.2 | 15.4-23.6 | 10.6 | 6.4-17.1 | 4.9 | 1.9-12.2 |
| | 2022 | 14.9 | 11.4-19.1 | 14.5 | 10.3-20.2 | 18.1 | 11.9-26.4 | N/A | N/A |
| Participated in binge drinking on at least one occasion in the past month | 2018 | 15.6 | 12.9-18.8 | 20.5 | 16.5-25.1 | 10.9 | 6.7-17.4 | 6.4 | 2.9-13.6 |
| | 2022 | 17.4 | 14.4-20.9 | 20.4 | 16.2-25.3 | 18.0 | 11.9-26.1 | 12.3 | 7.1-20.4 |

Source: NC Behavioral Risk Factor Surveillance System/NC SCHS
*Only asked in survey every other odd year.

Perinatal/Infant Health

While the state is still working to update to the American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologist/Society for Maternal-Fetal Medicine (ACOG/SMFM) designations of birthing hospitals' levels of care, 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 very low birthweight infants received care at currently designated Level III+ neonatal intensive care units (NICUs), which is lower than the 2019 percentage of 80.1%.

In 2022, North Carolina's infant mortality rate remained stagnant at a rate of 6.8 infant deaths per 1,000 live births, which means that 828 infants (a figure equal to about 44 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, reprehensible 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 non-Hispanic Black and non-Hispanic white infant death rates rose from 2.51 in 2014 to 2.73 in 2022, up from 2.37 in 2021.

The most recent data available from the National Immunization Survey (NIS) data for NC births occurring in 2020 reported that 81.4% of infants were ever breastfed, yet by 6 months of age only 23.1% of infants were exclusively breastfed, below the national average of 25.4%. Additionally, breastfeeding initiation data obtained from birth certificates for infants born in 2022 indicate that 81.5% of all infants were breastfed at hospital discharge. However, this data reflects national trends of breastfeeding racial/ethnic disparities, with Hispanic infants (86.1%), non-Hispanic white (83.8%), and NH Asian/PI (87.6%) more likely to initiate breastfeeding than non-Hispanic Black (72.2%) or non-Hispanic American Indian (58.7%) infants. While birth certificate data on mothers who reported smoking during pregnancy continues to trend down (4.5% of all live births in 2022 as opposed to 10.9% of all births in 2011), this is probably underreported, and there is still room for improvement.

Child Health

According to data from the 2021-22 National Survey of Children's Health (NSCH), 91.5% of NC parents surveyed responded that their child was in excellent or very good health which is comparable to the 91% baseline from the 2018-19 NSCH. Results from the 2021-22 NSCH also showed that younger children (<6 years) and children whose parents had more education and higher income were more likely to be considered in very good or excellent health. Percentages were higher for non-Hispanic white (92.5%) and Hispanic (92.4%) children than non-Hispanic Black (86.5%) children. The percentage of children ages two through four receiving WIC services in NC who were overweight or obese (had a body mass index [BMI] ≥ $85^{th}$ percentile) remained at just over 30% in 2019, which is similar to the past four years. Data for the BMI-for-age in children will not be available for 2020 thru 2023 due to insufficient data. Additional data from the 2021-22 NSCH show that 37.1% of children in NC between 9-35 months had received appropriate developmental screening which is slightly higher than the national average of 33.7%. However, this is a decline from the NC baseline of 48.2% from the 2018-19 NSCH and from the 2019-20 NSCH result of 56%. The immunization coverage rate for the combined 7-series for infants from the 2017-19 National Immunization Survey (NIS) report was 80.1%, but this rate decreased to 72.3% per the 2020-2022 NIS. NCDHHS will continue to track the impact of the COVID-19 pandemic on childhood immunization rates and work with partners on catch-up opportunities even as the IB has moved into the Epidemiology Section.

Adolescent Health

Per 2021-22 NSCH data, the percentage of adolescents (ages 12 through 17) with a preventive visit was 76.3%.

While the NC rate has remained higher than the national rate, over time the rate has fluctuated from a high of 81.7% in the 2019-20 NSCH down to 73.3% in the 2020-21 NSCH. Teen immunization rates from the 2022 NIS – Teen showed continued an increase over 2019 reports for teens receiving the human papillomavirus series but a decrease from 2021 (43% in 2019; 65.6% in 2021; 52.3% in 2022). The 2022 rates for teens receiving meningococcal conjugate vaccine (90.9% %) and one or more doses of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (93.2%) remained about the same as the 2019 rates, but were down from the 2020 and 2022 rates. According to 2021-22 NSCH data, 19% of parents in NC responded that their child (age 6 to 17) was obese with a BMI ≥95$^{th}$ percentile (BMI is based on parents' recollection of the selected child's height and weight), with 21% of parents of children with children age 6 to 11 responding yes compared to 17.1% of parents of children age 12 to 17. Children and youth whose parents reported that they had experienced two or more adverse childhood experiences, were low-income (<200% of the federal poverty level), had special health care needs, or were on Medicaid were more likely to be reported as being obese.

CYSHCN

Through the use of a five item, parent-reported screening tool, there were an estimated 22.3% of CYSHCN in NC per the 2021-22 NSCH, which is slightly higher than the national total of 20.0% and comparable to the 2018-19 NSCH baseline of 22.5% for NC. The 2021-22 NSCH shows that CYSHCN were in NC were less likely to be in very good or excellent health as children without special health care needs (76.9% for CYSHCN v. 95.7% for non-CYSHCN), and this difference appears to be statistically significant. CYSHCN in NC age 6-17 years were more likely to be obese (24.1%) than children and youth without special health care needs (17.0%) according to the same survey. The percentage of CYSHCN in NC receiving care in a medical home was 41.2% in the 2021-22 NSCH which is a decrease from the 2018-19 NSCH baseline of 49.5% but a slight increase from the NSCH 2020-21 rate of 37.4%.

**Changes in NC's Title V Program Capacity and MCH Systems of Care**

Two significant changes in the MCH systems of care in NC, the transformation to NC Medicaid Managed Care and the creation of the new NCDHHS Division of Child & Family Well-Being, are still somewhat early in implementation, and it is too soon to tell exactly what the impact of those changes will be on the delivery of MCH services.

NC Medicaid Managed Care was officially launched on July 1, 2021, after being originally legislated in 2015, with nearly 1.6 million Medicaid beneficiaries now receiving Medicaid services through NC Medicaid Managed Care health plans. NC Medicaid Managed Care establishes a payment structure that rewards better health outcomes, integrating physical and behavioral health, and investing in non-medical interventions aimed at reducing costs and improving the health of Medicaid beneficiaries. All beneficiaries moving to NC Medicaid Managed Care were enrolled in one of five health plans or the Eastern Band of Cherokee Indians Tribal option by either selection of a health plan during the open enrollment period which ran from March 15 to May 14, 2021, or through the auto-enrollment process. Under managed care, Medicaid providers enroll with one or more health plan networks. NCDHHS launched Medicaid Expansion on December 1, 2023. Medicaid Expansion increased the eligible population to adults aged 19-64 who have incomes up to 138% of the federal poverty level. The Behavioral Health and Intellectual/Developmental Disability Tailored Plan which covers doctor visits, prescription drugs, and services for mental health, substance use, I/DD, and traumatic brain injury in one plan started July 1, 2024.

All pregnant women enrolled in managed care through pre-paid health plans (PHPs) continue to receive a coordinated set of high-quality maternity services through the Pregnancy Medical Program (PMP), which is administered as a partnership between PHPs and local perinatal service providers. Birthing people continue to be screened using a standardized screening tool to identify and refer those 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 coordinated and provided mostly by LHDs. In addition, the Care Management for At-Risk Children (CMARC) program which serves children ages zero-to-five, continues as PHPs will contract with LHDs for the provision of local care management services at least for the first four years now with a recent extension.

Medicaid postpartum health coverage had been extended in North Carolina from 60 days to 12 months as of November 2021 as the extension was approved in the state budget based on a provision of the American Rescue Plan Act of 2021. Effective April 1, 2022, the new benefit provides 12 months of continuous postpartum coverage to eligible NC Medicaid beneficiaries, giving them access to full Medicaid benefits instead of the maternity-focused benefits previously included in the Medicaid for Pregnant Women program. This extended coverage is currently authorized through March 2027.

In April 2021, the Secretary of NCDHHS announced the following major changes to the Department's organizational structure which stemmed from lessons learned during the COVID-19 pandemic:

1. Creation of a new leadership position of a Chief Health Equity Officer who will lead cross department work on equity and manage an expanded Office of Health Equity (formerly the Office of Minority Health and Health Disparities) and the Office of Rural Health to help embed equity in every aspect of the Department's work.
2. Alignment of NCDHHS divisions and programs to focus on whole-person health with the Chief Deputy Secretary for Opportunity and Well-Being (managing programs and policies that promote the economic and social well-being of families, children, individuals, and communities across North Carolina) and the Chief Deputy Secretary for Health (managing programs and policies that foster the whole-person health of North Carolinians).
3. Establishment of a new Division of Child and Family Well-Being to elevate and coordinate the critical work of supporting children and families in North Carolina.
4. Creation of the Deputy Secretary for Operational Excellence to better integrate accountability, performance management, and quality improvement in all aspects of how we do business and the Deputy Secretary for Policy, Strategy, and External Engagement positions to promote transparent communication with and authentic engagement of stakeholders.

The change that has impacted the NC Title V Program most directly was the establishment of the DCFW. The DCFW brings together complementary programs from within NCDHHS that primarily serve children and youth to improve outcomes for children and their families. The programs include:

- Nutrition programs for children, families, and seniors, including WIC, CACFP, FNS/SNAP, and the special metabolic formula program
- Health-related programs and services for children that enable them to be healthy in their schools and communities, such as school health promotion, home visiting services, and children and youth with special health care needs programs
- School and community mental health services for children and youth, including supporting children with complex needs, coordination with schools, and systems of care work to meet needs of families who are involved in multiple child service agencies
- Early Intervention/ Infant-Toddler Program, which providers supports and services to young children with developmental delays or established conditions

The Nutrition Services Branch (WIC, CACFP), the Early Intervention Branch, and the Children and Youth Branch were all moved into the new DCFW. No positions were lost, but job roles and responsibilities may change as a result of the reorganization. NCDHHS understands the critical importance of Title V being administered by the state's health agency and strong collaborations and structures to maintain a coordinated, life course approach to maternal and

child health.

With the additional changes to the structure of DPH made in June 2022 putting the CDIS under the supervision of the NC Title V Director/Senior Medical Director for Health Promotion, collaborations already in place regarding life course, substance use, and injury and violence prevention will be strengthened. In June 2023, the Oral Health Section was also moved under the supervision of the NC Title V Director, which will further enhance collaboration across these programs. In 2024, the NC Title V Director was also engaged in designing and implementing the new Office of Child Fatality Prevention, working with OCME, DSS, SCHS, local teams, and partners to streamline the new structure while maintaining the focus on prevention of future child deaths.

**Title V Partnerships and Collaborations with Other Federal, Tribal, State, and Local Entities that Serve the MCH Population**

The broad-reaching partnerships and collaborations of NC's Title V program described in other sections of this application have continued in the past year and will continue moving forward. Work by the Title V Director and staff members to help promote COVID-19 prevention efforts and testing were immense and strengthened relationships both with other state agencies and non-governmental partners. As mentioned above, the transformation to NC Medicaid Managed Care, the expansion of Medicaid, and the creation of the new DCFW will also strengthen existing partnerships and create opportunities for new collaborations.

**Efforts to Operationalize the Five-Year Needs Assessment Process**

As stated earlier, the NC Title V Program conceives of needs assessment as a continuous process. Given that, the biggest effort to operationalize the Five-Year Needs Assessment process over the past year has been to align Title V Program staff members around the State Action Plan to better understand how the state priority needs, strategies, objectives, and performance and outcome measures are aligned with the work that they are doing. The DCFW/WCHS and WICWS Chiefs and their staff members spent time during FY24 making minor revisions to the State Action Plan to better reflect the work of their staff members and the Title V partners. In developing the population narratives, relevant portions of the State Action Plan are shared with program staff for input on the annual report and annual plan. While work on the COVID-19 pandemic shifted some priorities, the NC Title V Program's mission to support and promote the health and well-being of NC individuals including mothers, infants, children, youth, and their families to reduce inequities and improve outcomes continued to drive the work of staff members.

**Changes in Organization Structure and Leadership**

Other than the changes that came with the Title V Director's expanded role and creation of the DCFW which have been described earlier, there were no major leadership changes in FY23.

**Emerging Public Health Issues**

In addition to Medicaid Transformation and Expansion, there continue to be a number of emerging public health issues which impact the NC Title V Program and its priority populations. One is the continued opioid crisis which seems to have become even more exacerbated during the COVID-19 pandemic as the rate of overdose deaths rose from 22.4 deaths per 100,000 residents in 2019 to 41.4 deaths per 100,000 residents in 2022. This burden of overdose has disproportionately worsened in some historically marginalized communities. The percentage of children who are in foster care due to parental substance use in NC has risen from 42.5% in 2018 to 45.7% in 2021. In addition to substance use, the stress related to the COVID-19 pandemic, job loss, social isolation, school

closures, lack of usual supports, among other situations have highlighted the worsening mental health crisis among children and adults that will have to be addressed with COVID-19 recover and long-term. NCDHHS is working to offer services further upstream to build resiliency, invest in coordinated systems of care that make mental health services easy to access when and where they are needed and reduce the stigma around accessing these services.

While health inequity due to systemic racism and structural disadvantage is not an emerging public health issue but a longstanding one, the COVID-19 pandemic has exposed the disproportionate impact of crisis in a profound way, not only on physical health outcomes, but on access to mental health support, food security, and employment, among others. In May 2022, NCDHHS published *Governmental Public Health: Workforce and Infrastructure Improvement in Action* which provides a high-level overview of efforts to reform the public health architecture in NC in the following three areas: Systems Capacity & Strong and Inclusive Workforce; State-Local Efficiency and Effectiveness; and Data Modernization & Transparency. Other initiatives included in this work were the NC Institute of Medicaid Task Force on the Future of Public Health, ongoing initiatives by the NC Association of Local Health Directors, and North Carolina's participation in the cross-state 21st Century Learning Collaborative on public health system change. In addition, the DPH Director continues to focus on these three main strategic priorities from the NCDPH 2023-2025 Strategic Plan:

1. Supporting the recruitment, development, retention, and diversity of our public health workforce
2. Building a durable statewide infrastructure that supports foundational public health capabilities – particularly community partnership development, advancing health equity, and data infrastructure
3. Earning trust by listening and lifting up the voices of our public health experts and combatting misinformation

On March 14, 2023, Governor Cooper announced the creation of a statewide Office of Violence Prevention which is located in the NC Department of Public Safety. The focus of the Office is to reduce violence and firearm misuse by coordinating efforts across the state, including those by the NC Title V Program and along with other NC DPH partners, particularly those in the CDIS.

**Click on the links below to view the previous years' needs assessment narrative content:**

2024 Application/2022 Annual Report – Needs Assessment Update

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

### III.D. Financial Narrative

| | 2021 | | 2022 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| **Federal Allocation** | $18,806,308 | $16,804,521 | $18,806,308 | $16,451,537 |
| **State Funds** | $34,195,972 | $35,228,731 | $37,169,426 | $45,802,293 |
| **Local Funds** | $0 | $0 | $0 | $0 |
| **Other Funds** | $66,371,749 | $57,078,391 | $65,371,749 | $57,707,314 |
| **Program Funds** | $69,967,790 | $67,155,895 | $73,859,576 | $70,327,753 |
| **SubTotal** | $189,341,819 | $176,267,538 | $195,207,059 | $190,288,897 |
| **Other Federal Funds** | $393,826,669 | $291,783,688 | $456,342,218 | $390,961,113 |
| **Total** | $583,168,488 | $468,051,226 | $651,549,277 | $581,250,010 |

| | 2023 | | 2024 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| **Federal Allocation** | $18,871,732 | $16,711,237 | $18,871,732 | |
| **State Funds** | $45,189,526 | $49,684,655 | $46,722,582 | |
| **Local Funds** | $0 | $0 | $0 | |
| **Other Funds** | $65,311,808 | $186,253,574 | $65,322,845 | |
| **Program Funds** | $67,155,895 | $75,179,067 | $70,327,754 | |
| **SubTotal** | $196,528,961 | $327,828,533 | $201,244,913 | |
| **Other Federal Funds** | $413,861,107 | $337,108,529 | $435,531,229 | |
| **Total** | $610,390,068 | $664,937,062 | $636,776,142 | |

| | 2025 | |
|---|---|---|
| | Budgeted | Expended |
| **Federal Allocation** | $18,871,732 | |
| **State Funds** | $54,811,949 | |
| **Local Funds** | $0 | |
| **Other Funds** | $0 | |
| **Program Funds** | $75,179,067 | |
| **SubTotal** | $148,862,748 | |
| **Other Federal Funds** | $69,890,335 | |
| **Total** | $218,753,083 | |

**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 the Title V funds occur within the approved state plan as determined by the NC General Assembly. 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 FY23, federal Maternal and Child Health Block Grant expenditures were $16,711,236 which is a slight increase of $259,700 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. 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. We have noted one significant variation of more than 10% in Title V Administrative Costs. This was due to the General Assembly increasing pay and benefits for consecutive years. Four more significant variations were noted and documented in the Field Notes section of Form 2 in the application.

- Federal Allocation FY23 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 the Title V funds occur within the approved state plan. 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, we rarely leave funds unexpended.
- The amount spent for Children with Special Healthcare Needs was approximately $789,000 less than budgeted for FY23. With the creation of DCFW, there was a significant reorganization of staffing, resulting in some positions being condensed. Additionally, there were lengthy position vacancies which resulted in less money being expended. These vacancies also led to a delay in contract finalization for several CSHCN programs.
- Per the Office of State Budget and Management, programs are encouraged to budget based on a three-year average of receipts; therefore, since rebates are based on participation rates, differences between budget and expenditures can fluctuate greater than 10%. Specific for the WIC program, additional funding associated with the COVID-19 pandemic resulted in an increase in expenditures. (Other Funds Expended).
- When calculating the Program Income budget for FY23, we utilized a DPH report. As this report wasn't used by DPH in FY23, to track the expenditures, we were able to request specific numbers and amounts from the local health departments which led to the variance.

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. 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 RCCs. These centers are used to group dollars intended for certain types of programs and services. The RCCs 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 FY25 Application Budget for the MCHBG is $18,871,732, 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.

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 stated 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 cost centers. 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.

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 RCCs. These centers are used to group dollars intended for certain types of programs and services. The RCCs 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.

For example, the RCC 5745 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 RCC 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.2. State Action Plan Narrative Overview

#### III.E.2.a. State Title V Program 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 inequities 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 and health equity in 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 Early Childhood Action Plan, 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 social determinants of health and racism to achieve health and health equity, as described in the PHSP, 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 wellbeing, 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.

### III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

#### III.E.2.b.i. MCH Workforce Development

The NC 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 and encourage diverse representation at all levels of the workforce. 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.

The NC 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 got 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 equitable, modern, and aligned with the State's objectives, and updates salary ranges to align with the labor market. Benefits for state employees 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 in 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.

In May 2022, the NCDHHS published *Governmental Public Health: Workforce and Infrastructure Improvement in Action* which outlines select programs and opportunities within DPH that could help strengthen the public health infrastructure and support workforce development while reducing disparities and advancing equity. Per the report, in North Carolina, 60% of public health employees are over the age of 45. In addition, in 2018, NC ranked 45th in the nation on public health spending. The report provides a high-level overview of select activities and initiatives in the following three inter-related areas, with equity woven throughout as a key theme:

- Systems Capacity & Strong and Inclusive Workforce
- State-Local Efficiency and Effectiveness
- Data Modernization & Transparency

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 also required to attend in person 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 September 2022, the NC DPH approved and adopted the NC DPH Workforce Development Plan 2022-2025 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, describes training needs and workforce development goals. In 2021, NC DPH secured a $63 million Public Health Workforce Development grant under the American Rescue Plan Act. This funding has been extended through June 30, 2024. In December 2022, NC DPH received five-year funding after submitting a successful application for CDC's Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems grant which will enable NC DPH to continue this work.

The NC 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, 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 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, systems development and integration, how to implement and sustain evidence-based programs with model fidelity, data analysis, quality improvement assessments, implicit bias, and trauma-informed services. As possible, staff members are sent to 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.

As other federal grant opportunities have expanded, training collaboration has been enhanced. The Building Bridges Conference is held every few years to include local staff from multiple programs serving families, i.e., Baby Love Plus, Healthy Beginnings, Sickle Cell, and Teen Pregnancy Prevention Initiative. Due to the pandemics, this conference had been delayed the last two years, but the WICWS was able to hold what it branded the Re-Building Bridges Conference in February 2023. Using a combination of several funding sources, topics were selected based on the needs and/or interest of the funded sites. Similar trainings are provided statewide utilizing web-based platforms.

For several years, the NC Home Visiting Consortium (NCHVC), a network of perinatal/early childhood home visiting programs and MCH organizations that work to support initiatives across NC, worked on developing a set of standard Core Competencies for home visitors and parent educators. At the 2019 and 2020 NC Home Visiting Summits, workshops were held to discuss the need for core competencies and a diverse group was recruited to participate in

a Core Competency Committee that drafted a set of competencies. The MIECHV Program Manager, Healthy Families America State Consultant, and Nurse-Family Partnership State Nurse Consultant were members of the Committee. In 2019, The North Carolina Partnership for Children (NCPC) launched the Home Visiting and Parenting Education (HVPE) Systems Building Initiative to build a network of support for home visiting and parenting education programs across NC. The Core Competency work shifted to the HVPE Programs Committee which met for some time to finalize the competencies and share them with the HVPE Collaborative Board to align with the NC HVPE System Action Plan. While HVPE stopped formal meetings in summer 2023 due to Board leadership changes and other challenges, currently a core group of HVPE members, many of whom are members of the NCHVC, are meeting and strategizing the next steps to reengage partners to resume the implementation of the initiative. In early 2024, the NC Positive Child Alliance (NCPCA) and NCPC began providing HVPE updates to revitalize the initiative during 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. In Summer 2024, PCANC, NCPC, and members of the NCHVC will prioritize completing the Core Competencies. Once finalized, the plan is to recommend home visiting and parenting education professionals adopt the Core Competencies to enhance the programs being implemented to at-risk families.

Both NC Baby Love Plus and the NC Sickle Cell Program provide consumer-driven trainings at least bi-annually, with patients or family members serving on the planning teams. The Adolescent Health Spring Summit presented by Fact Forward was held in April 2024 for current partners and other youth-serving agencies. In addition, the TPPI Annual Networking Meetings we held in May 2024.

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 diversity, equity, and inclusion topics and situations

Much state funding has been lost over the past several years, except that portion needed to meet Title V or Medicaid matching requirements. Some pockets of state funding remain such as that funding local school nurses and school health centers. Although this has allowed the NC Title V Program to maximize the reach of Title V, it also presents difficulties in extricating Title V funding and service impacts from the total effort. For instance, positions in the DCFW/WCHS are funded by Title V, Medicaid match, Medicaid receipts and various grants. The operational support for programs and contracts is also a mixture of funding sources. The Disability and Health Program Director is primarily supported through Title V. Home visiting programs are funded with a mixture of funds including state appropriations, private philanthropic organizations, MIECHV grant funds, Title V funds, and staff members are supported through either MIECHV or Title V funding. The NC Title V Program continually assesses staffing needs and other resources given the limited funding. The Title V Program has received additional federal grants to support and expand its work, including the Maternal Health Innovation Program grant and the CDC ERASE Maternal Mortality grant, and continues to work with its partners on stated goals and strengthened collaborations with agencies and organizations, such as universities, in order to best leverage resources.

### III.E.2.b.ii. Family Partnership

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 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 Advisory Network, the Care Coordination for Children Workgroup, Council on Developmental Disabilities, and the Governor's Council on Sickle Cell Syndrome. The DCFW/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 (FPs) 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. FPs 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 DCFW/WCHS Regional Consultants.

One of the priority needs highlighted by the Perinatal Health Equity Collective (PHEC) 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 chaired by a person with lived experience who also serves on the PHEC 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. Examples of this are their efforts to scope out the focus area for the new PHEC Equity in Practice Action Team and helping to host the PHEC Community Town Halls that were highlighted in the MCH Success Story earlier in this application.

The DCFW/WCHS experienced a vacancy in the full-time Family Liaison Specialist (FLS) position during 2022 while other staff members supported family engagement and training efforts in DCFW/WCHS programs and partner organizations. The Family Liaison position was reclassified, and a new person started in that position in April 2023. The DCFW/WCHS continues to employ a part-time Parent Consultant, and recently added a second part-time bilingual Parent Consultant, who serves the EHDI Program. These employees have CSHCN and are able to utilize their lived experience and acquired knowledge to support the family engagement efforts of the DCFW/WCHS. These staff have worked to institutionalize family engagement in all areas of the DCFW/WCHS and uphold the DCFW/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 DCFW/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 DCFW/WCHS FP Engagement and Leadership Committee meets quarterly and is comprised of ten diverse parents of CYSHCN with a full range of experience with systems of care, the Assistant Director for the DCFW/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 DCFW/WCHS and model family engagement on various state and regional groups. The DCFW/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. The Parent Leadership Trainers are trained to implement the Parents as Collaborative Leaders: Improving Outcomes for Children with Disabilities curriculum, which uses a peer-to-peer training model to support and build the leadership skills of parents of CYSHCN. When the FLS collaborated with parent trainers to convert the trainings to be deliverable virtually in FY21, the number of trainings and participants was triple that of the number in FY20. Thus, in FY24, trainings continued to be held virtually, reaching both English and Spanish speaking parents and caregivers across the state. FPs are included in educational opportunities alongside staff including attending national and state conferences, and in planning and participating in DCFW/WCHS meetings and other trainings hosted by the DCFW/WCHS. DCFC/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 DCFW/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 DCFW/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) Advisory Committee retains dedicated family partners attending the quarterly meetings and providing practical vision to the newborn hearing screening and EHDI programming. In August 2020, the EHDI Parent Support Team was formed which is entirely parent led. In the summer of 2022, the EHDI parent consultant led the launch of the DHHS Heroes (Deaf and Hard of Hearing adults/FPs to serve as role models) who continue to attend community events with t-shirts and trading cards. The EHDI program also worked with The Care Project and sponsored three in-person CARE Family Fun Day events providing opportunities for parents and professionals to support each other. 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 Crisis, and Oral Health. These groups provide feedback and recommendations on services or policies impacting Medicaid populations. One new parent/youth program engagement opportunity will include expanding strategies to embed the national CYSHCN Blueprint for Change framework into DCFW initiatives. Plans for developing a medical home training curriculum, including how to maintain a successful partnership with their child's health provider and empowering their child to be comfortable in eventual ownership of their health care, are underway based on feedback provided by FPs on training needs. In addition, plans are in place to explore the expansion of the training about dental home strategies for serving Hispanic populations. FY21 saw the development and piloting of a new sexual health curriculum for children with disabilities. This training curriculum was designed by FPs with a vision of developing a cadre of parent trainers and continuing the commitment of peer-to-peer training models by the DCFW/WCHS and will be launched in 2024.

Many FPs have expressed their gratitude and appreciation to be included in DCFW/WCHS activities. In a 2022 satisfaction survey regarding reimbursement, one parent said, "Thank you for honoring our value and supporting us financially. It is a great help and it speaks to your commitment to include family voice." Another parent echoed, "It is really progressive and appreciated to receive the stipends that we get for our participation. It allows parents to feel valued in the continuing improvement of services to children and family across the state." There is also gratitude and appreciation from the DCFW/WCHS staff as one described FP involvement "enriching our discussions, giving credibility to our work, and inspiring us for the task ahead."

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.

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.E.2.b.iii. MCH Data Capacity

### III.E.2.b.iii.a. MCH Epidemiology Workforce

The MCH epidemiology workforce of the NC Title V Program is strong. Within the Title V Office, WICWS, and DCFW/WCHS there are 11.5 positions whose primary 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. Each of the staff members have formal and on the job training and, based on their position responsibilities, fall along the spectrum of having the Competencies for Applied Epidemiologists in Governmental Public Health Agencies (Assessment and Analysis, Basic Public Health Sciences, Communications, Community Dimensions of Practice, Cultural Competency, and Financial and Operational Planning and Management) created by the CDC and the Council of State and Territorial Epidemiologists. Title V funding supports four of the positions in full (including the .5 FTE position) and one position partially. The remaining positions are covered by Title X, MIECHV, Healthy Start, SSDI, state funding, and other funding sources.

Another critical piece of the MCH epidemiology workforce in NC is the NC State Center for Health Statistics (SCHS) which is responsible for data collection, health-related surveillance and research, production of reports, and maintenance of a comprehensive collection of health statistics. According to their website (https://schs.dph.ncdhhs.gov/), the SCHS provides:

- A source of information to monitor the health conditions of North Carolinians
- Analyses of important health issues, such as birth defects and infant mortality statistics
- A central collection site for information about cancer, birth defects, births, deaths, marriages, and divorces
- Accurate and timely information for use in setting health policy, planning prevention programs, directing resources, and evaluating the effect of health programs and services
- A safe and secure environment for its confidential records

Title V funding provided to the SCHS is used to partially support several positions (SCHS Director, Statistical Services Unit Manager, and Birth Defects Monitoring Program staff, admin staff, and temps), as well as fully funding a statistician position in the Statistical Services Unit which supports the work of the Child Fatality Task Force preparing child death data reports and analyses. Title V funding is also used to support the Behavioral Risk Factor Surveillance System and the Pregnancy Assessment Survey.

Title V funding also supports the Injury and Violence Prevention Branch (IVPB) within the CDIS. Title V's collaboration with IVPB strengthens the MCH epidemiology workforce, particularly in the area of youth suicide and violence prevention. Title V funding fully supports the Youth Suicide Prevention Program Manager position and partially supports other epidemiologist and surveillance positions and provides some operating expenses to the Section.

The Perinatal Health Equity Collective's Data and Evaluation Work Group began meeting in 2014 with the inception of the strategic plan and 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, which was revised slightly in spring 2021 in anticipation of the release of the 2022-26 Perinatal Health Strategic Plan, is to provide guidance related to data and evaluation to the larger Planning Team, review individual, family, and community data across North Carolina, and identify strategies measuring the success of the Plan to inform policy and practice. The Work Group was instrumental in helping the Collective identify performance indicators for the new version of the plan and updates these indicators annually.

The DPH Epidemiology and Evaluation Team (EET) provides a monthly forum for epidemiology and evaluation staff members to share works in progress in a friendly, respectful atmosphere and to obtain constructive feedback and

assistance with project challenges. Anyone who self-identifies as having some job responsibilities in epidemiology or evaluation and/or anyone with a strong interest in epidemiology or evaluation is welcome. EET held its 23rd Annual EET Poster Day in May 2024, with participants able to share posters created for local, state, and national conferences with NCDHHS staff members.

All staff members that make up the MCH epidemiology workforce within DPH and DCFW are encouraged to participate in local, state, and national conferences and seek out professional development opportunities such as the DPH SAS Users Group, the AMCHP Conference, and the CityMatCH Leadership and MCH Epidemiology Conference.

**III.E.2.b.iii.b. 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 DCFW/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, and staff members of DPH and DCFW. She 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. She works with data coordinators, epidemiologists, and evaluators within DPH and DCFW to compile the necessary data for the Block Grant. The Federally Available Data (FAD) Excel workbook is extremely helpful in making comparisons from one year to the next and across demographic and other subgroups. In addition to uploading all the narrative to the Title V Information System, she 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 Operations Manager and the Budget Office 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 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 distribution, 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 which births were to families enrolled in Medicaid. This birth file with added health services data is referred to as the NC Composite Linked Birth File. 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 Risk Assessment Monitoring System (PRAMS) 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 DCFW/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 includes questions identical to the 2020 PRAMS survey and has begun data collection in 2024 using PRAMS Phase 9 questions.

The SSDI Project Coordinator and Perinatal Epidemiologist serve on the Maternal Health Innovation (MHI) Evaluation Team and have helped orient the new MHI Epidemiologist hired in February 2021. 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. During FY23, in addition to supporting the SCHS with onboarding new staff analyzing hospital discharge data, she devised a standardized approach to reporting population and vital statistics data using non-bridged race methodology.

*Goal 3 – Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming*

One of the NC Title V MCH Block Grant Priority Needs is to “increase health equity and eliminate disparities and address social determinants of health,” 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 promoting health equity and ensuring 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 PHEC Data and Evaluation Work Group (DEWG) since its inception in 2014 to help develop the initial strategic plan and serves on the PHEC 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 PHEC workgroups to move data to action. The Work Group was instrumental in helping the PHEC identify performance indicators for the updated version of the plan released in August 2022 which includes four overarching and thirty-five 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 health equity metrics for all MCH populations on race, ethnicity, culture, language, income, ability, health status, gender, sexual orientation, and geographic location, it provides a good basis from which to start.

The first annual update on the indicators took place at the April 2023 PHEC meeting, titled *Exploring the 2022-26 Perinatal Health Strategic Plan Indicators*. The overarching indicators were presented during a plenary session, and then the 115 participants (both in-person and hybrid) were transitioned into small groups where they discussed data indicators for particular points in the plan by reviewing a data packet of data placemats produced by the SSDI Project Coordinator with the help of the DEWG. The purpose of the meeting was to help the Collective members identify how the PHSP's data and strategies connect to the work of their organizations and prompt them to define action steps to ensure that their work aligns with that of the Collective. At the meeting, the new PHSP website was released, and information on the overarching indicators as well as the data packet can be found there. The 2024 update will be provided at the August PHEC meeting. Plans are to release results of the PHEC Impact Survey conducted in April 2024 as well as provide a handout with updated indicator data, but the majority of meeting time will be discussing qualitative data behind the indicators with a panel of diverse PHEC partners.

The SSDI Project Coordinator and Perinatal Epidemiologist have developed the NC Maternal & Infant Health Data Dashboard comprised of 19 indicators that was launched during summer 2024 along with an updated website providing additional MCH data resources. They also continue to update the Tracking Maternal and Child Health Data in North Carolina website annually.

The SSDI Project Coordinator continues to serve as chair of #impactEQUITYNC, a group made up of representatives from DPH, DCFW, NC Child, NC Office of Health Equity, and the NC Chapter of the March of Dimes. #impactEQUITYNC was initially started to create and promote the use of a Health Equity Impact Assessment (HEIA) tool, has also taken on some of the work initially begun with the SDoH Collaborative Improvement and Innovation Network (CoIIN) such as creating a foundational health equity training module. The SSDI Project Coordinator worked with a subgroup of #impactEQUITYNC members to revise and release an updated version of the HEIA in November 2021, and work to promote uptake of the tool continues. The HEIA consists of a series of action steps intended to focus discussions and document proposals for equitable 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 equitable, and developing a monitoring plan for measuring changes to the policy or program. Use of the HEIA tool is required by the Improving Community Outcomes for Maternal and Child Health (ICO4MCH) program managed by the WICWS. The SSDI Project Coordinator serves on the ICO4MCH Evaluation Team which evaluates the use of the HEIA, and that team continues to look for additional funding to help evaluate the effectiveness of the HEIA. In July 2022, the HEIA 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. #impactEQUITYNC is planning a HEIA facilitator training in September 2024. The SSDI Project Coordinator is also one of the co-chairs of the DPH Epidemiology and Evaluation Team which was described earlier.

One additional tool to help the Title V Program track social determinants of health is the North Carolina Data Portal which was released in 2024. Users can access data, maps, and tools to support community health assessments and should be especially helpful for local health departments. The NC Data Portal offers over 120 indicators in categories such as, but not limited to, economic stability, health outcomes, physical environment, and social support and pulls data from a variety of credible data sources.

*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 a lot of data capacity with numerous surveillance systems already in place which enable it to respond quickly to emergencies and emerging issues/threats to the MCH populations and populations as a whole. The SSDI Project Coordinator and Perinatal Epidemiologist will 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 PHEC Data and Evaluation Work Group instituted an Emerging Threats/Issues Discussion at the PHEC meetings in one effort to move data to action. The following topics have been covered thus far: 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; and Bridged vs. Non-Bridged Data. Topics covered in 2023 and thus far in 2024 include: NC Senate Bill 20 (Abortion Law Revisions); Congenital Syphilis in North Carolina; NC Family Engagement Report; and the NC Smart Start Data Dashboard.

#### III.E.2.b.iii.c. Other MCH Data Capacity Efforts

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 2020 State Health Improvement Plan, which is a companion report to HNC 2030 and the 2019 NC State Health Assessment. The 2023 State Health Improvement Plan which includes a HNC 2030 Data Indicator Table has also been released. The HNC 2030 Scorecard supports the 2020 State Health Improvement Plan 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. The NC Title V Director serves as the indicator lead for infant mortality, teen births, and early prenatal care for the NC State Health Improvement Plan and as the government representative on the Community Council.

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 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 oversees two other dashboards. The NC Opioid Action Plan Data Dashboard which provides integration and visualization of state, regional, and county-level metrics for stakeholder across the state to track progress toward reaching the goals outlined in the NC Opioid Action Plan. 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 DCFW/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 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.

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.

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.

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.E.2.b.iv. MCH Emergency Planning and Preparedness

According to the NC Emergency Operations Plan (NCEOP) 2023 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 December 2023. 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 2023 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 NCEM [NC Emergency Management] Director who is granted the responsibility and authority to respond to emergencies and disasters."

The Operations Section of the State Emergency Response Team (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.

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.

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.E.2.b.v. Health Care Delivery System

### III.E.2.b.v.a. Public and Private Partnerships

The NC Title V Program's relationship with other MCHB investments (e.g., SSDI, MIECHV, ECCS, etc.) and other federal investments (e.g., Title X, PREP, WIC, Immunizations, etc.) is very strong. In her expanded role as the Senior Medical Director for Health Promotion, the Title V Director has more direct involvement with additional federal investments regarding chronic disease and injury prevention across the life course and oral health. The weekly DMT meetings provide an avenue for the Title V Director to partner with administrators of other HRSA programs and other programs within DPH. In addition to monthly meetings with the NC Association of Local Health Directors (NCALHD) Executive Committee that include the Title V Director, the 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. 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.

As highlighted in the 2020 Five-Year Needs Assessment, the NC Title V Program strives to align its activities with strategic plans, programs, and projects that are already in place in NC to serve the MCH population across the life course. These include, but are not limited to, the following:

- NCDHHS Strategic Plan 2021-23 and 2023-25
- NC Early Childhood Action Plan
- NC Opioid Action Plan
- NCIOM Perinatal System of Care Task Force
- NCIOM Maternal Health Task Force
- NC Public Health Genomics Plan
- Home Visiting and Parenting Education Collaborative
- Healthy NC 2030 and the NC State Health Improvement Plan
- Integrated Care for Kids (InCK)
- Perinatal Health Strategic Plan
- NC Child Fatality Task Force
- Think Babies™ NC
- Children & Youth with Special Health Care Needs Strategic Plan
- NCIOM Essentials for Childhood Task Force

The NCDHHS houses the state's Medicaid, Social Services/Child Welfare programs, so within the management structure of the Department, interagency coordination is expected and facilitated between the Title V Program and those programs. A copy of the current Inter-Agency Agreement which expires on June 30, 2026, between DHB (Medicaid), DPH and DCFW is included in this application. As highlighted in other sections of this application, NC has transitioned from a predominantly fee-for-service Medicaid delivery system to managed care, and the NC Title V Program has been in partnership, and will continue to be in partnership, with NC Medicaid throughout that transition. DPH has regular meetings with NC Medicaid to discuss issues that arise as part of the Medicaid transformation.

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 nine 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 and NC Title V Program planning activities to provide review and critique from an academic and practice perspective. The Title V Director also serves on the Residency Advisory Committee for the UNC Preventive Medicine Residency at the UNC School of Medicine, facilitating networking and is the DPH Site Director for public health rotations.

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.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)**

The NC Title V Program has a long history of partnering with NC Medicaid (NC Division of Health Benefits [DHB]) to ensure quality services and programs. NC Title V Program staff members serve on different interagency NC Medicaid committees and work teams 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 2023, in SFY23, NC Medicaid provided access to care and services to more than 2.9. million people in the state, with many served through outreach and enrollment efforts of Title V programs and partners. According to the 2021 NC Composite Linked Birth File, 52% of all resident births were to women receiving Medicaid. NCDHHS launched Medicaid Expansion on December 1, 2023. Medicaid Expansion 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. As of May 3, 2024, there were 447,498 people enrolled. NCDHHS projects that the state's enrollment under expansion will reach 600,000 within two years.

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 DCFW/WCHS has an outreach team consisting of the Minority Outreach Coordinator, CYSHCN Help Line Coordinator, and CYSHCN Access to Care Coordinator who are committed to increasing the number of children who have health insurance and to enroll eligible children into NC Medicaid. A description of their work is found in the CYSHCN Domain Annual Report. With the transition to managed care, the NC 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.

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. NCDHHS was on track to go live with Medicaid transformation on February 1, 2020; however, in November 2019, the NC General Assembly adjourned without providing the required new funding and program authority for the transition to managed care. In June 2020, the NC General Assembly passed legislation that was signed into law by Governor Cooper in July 2020 that mandated 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. The five plans are AmeriHealth Caritas, Carolina Complete Health, Healthy Blue, UnitedHealthcare Community Plan, and WellCare. Beneficiaries had the option of selecting a health plan during open enrollment which ran from March 15 to May 18, 2021. They could enroll 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 by May 21 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 are 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) to federally recognized tribal members and others eligible for services through Indian Health Service.

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. Together, these two programs work to improve the overall health of women and young children across the state. 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 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 started July 1, 2024. There are approximately 210,000 beneficiaries with a serious mental illness, a severe substance use disorder, an I/DD, or atraumatic brain injury. Tailored Plans will be managed by the Local Management Entities Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health.

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 April 2024, NCDHHS celebrated the two year anniversary of HOP. Since the program began, more than 288,000 services were efficiently delivered, and more than 20,000 NC Medicaid beneficiaries were enrolled. Preliminary research suggests that the state is spending about $85 less in medical costs per HOP beneficiary per month, and that participants avoided a significant number of emergency department visits and had a reduced risk of food

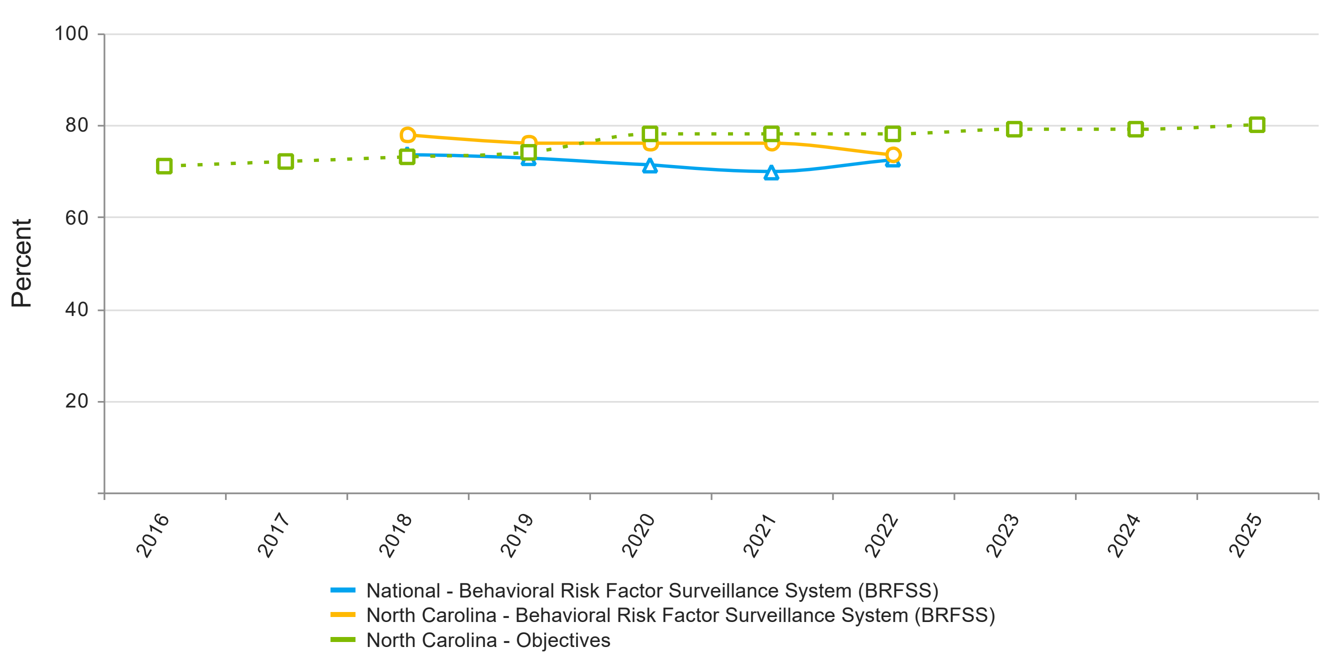
insecurity, housing instability, and lack of access to transportation. Because of the success of the program, NCDHHS renewed the federal 1115 waiver in October 2023 which included a request to allow expansion of Healthy Opportunities statewide.

## III.E.2.c State Action Plan Narrative by Domain

### Women/Maternal Health

### National Performance Measures

**NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV**
**Indicators and Annual Objectives**




National - Behavioral Risk Factor Surveillance System (BRFSS)
North Carolina - Behavioral Risk Factor Surveillance System (BRFSS)
North Carolina - Objectives

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Behavioral Risk Factor Surveillance System (BRFSS)** | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** |
| Annual Objective | | 78 | 78 | 78 | 79 |
| Annual Indicator | 77.6 | 76.1 | 75.9 | 75.9 | 73.4 |
| Numerator | 1,412,575 | 1,386,809 | 1,383,829 | 1,383,829 | 1,360,288 |
| Denominator | 1,820,993 | 1,823,266 | 1,822,669 | 1,822,669 | 1,853,350 |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2018 | 2019 | 2021 | 2021 | 2022 |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 79.0 | 80.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM WWV.1 - Number of LHDs that offer extended hours for FP services.**

| **Measure Status:** | **Inactive - Replaced** |
|---|---|

| **State Provided Data** | | | | | |
|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** |
| Annual Objective | | | 15 | 15.5 | 16 |
| Annual Indicator | 15 | | 10 | 11 | 24 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | NC FP Program Service Site Information | | NC FP Program Service Site Information | NC FP Program Service Site Information | NC FP Program Service Site Information |
| Data Source Year | 2020 | | 2021 | 2022 | 2023 |
| Provisional or Final ? | Final | | Final | Final | Final |

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 0 | 0 | 10 |
| Annual Indicator | | | 0 | 0 | 0 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log |
| Data Source Year | | | 2021 | 2022 | 2023 |
| Provisional or Final ? | | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 15.0 | 20.0 |

**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 | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 30 | 40 | 75 |
| Annual Indicator | | | 32.9 | 82.1 | 95.2 |
| Numerator | | | 28 | 69 | 80 |
| Denominator | | | 85 | 84 | 84 |
| Data Source | | | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log |
| Data Source Year | | | FY20-21 | FY21-22 | FY22-23 |
| Provisional or Final ? | | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 95.0 | 95.0 |

 Created on 7/12/2024 at 2:15 PM

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 74 | 85 | 86 |
| Annual Indicator | | | 84.5 | 73.7 | 59.2 |
| Numerator | | | 82 | 73 | 58 |
| Denominator | | | 97 | 99 | 98 |
| Data Source | | | NC FP LHD Clinical Practice Survey | NC FP LHD Clinical Practice Survey | NC FP LHD Clinical Practice Survey |
| Data Source Year | | | 2021 | 2022 | 2023 |
| Provisional or Final ? | | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 86.0 | 87.0 |

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

| Measure Status: | Active |
| --- | --- |

| State Provided Data | |
| --- | --- |
| | 2023 |
| Annual Objective | |
| Annual Indicator | 28.6 |
| Numerator | 24 |
| Denominator | 84 |
| Data Source | NC Family Planning Program Service Site Informatio |
| Data Source Year | 2023 |
| Provisional or Final ? | Final |

| Annual Objectives | |
| --- | --- |
| | 2025 |
| Annual Objective | 31.5 |

## NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV
## Indicators and Annual Objectives

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

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

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

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

**Evidence-Based or –Informed Strategy Measures**

None

**State Performance Measures**

**SPM 1 - Percent of PRAMS respondents who reported that their pregnancy was intended**

| Measure Status: | Active |
|---|---|

**State Provided Data**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 59.7 | 60 | 60.3 |
| Annual Indicator | 55.9 | | 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 | 2019 | | 2020 | 2020 | 2020 |
| Provisional or Final ? | Final | | Final | Provisional | Provisional |

**Annual Objectives**

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 60.6 | 61.0 |

**State Action Plan Table**

## State Action Plan Table (North Carolina) - Women/Maternal Health - Entry 1

### Priority Need

Improve access to high quality integrated health care services

### NPM

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

### Five-Year Objectives

WMH 1A. By 2025, increase the percentage of LHDS that offer extended hours for FP services by 10% (from 28.6% in 2023 to 31.5% by 2025).

WMH 1B.1 Create the PCH Outreach and Education Toolkit by June 30, 2023.

WMH 1B.2. By 2025, increase by 2% the number of individuals who receive preconception health services through LHDs.

### Strategies

WMH 1A.1 Provide guidance and support to LHDs to offer family friendly clinical services in a manner that meets the varying needs of their community.

WMH 1A.2. Work with LHDs to increase awareness of their extended hours within their community.

WMH 1A.3. Develop a lesson learned document/compendium from existing LHDs that offer extended hours to share with potential new sites.

WMH 1B.1 Develop outreach and education toolkit for LHDs and other partners related to preconception health services.

WMH 1B.2. Increase awareness of LHDs PCH services and provider type through social media and other outreach efforts.

| ESMs | Status |
|---|---|
| ESM WWV.1 - Number of LHDs that offer extended hours for FP services. | Inactive |
| ESM WWV.2 - Percent of WICWS programs that utilize the PCH Outreach and Education Toolkit | Active |
| ESM WWV.3 - Percent of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and reproductive life planning (RLP). | Active |
| ESM WWV.4 - Percent of LHDs offering same day insertion of both contraceptive implants and intrauterine devices (IUDs) | Active |
| ESM WWV.5 - Percent of LHDs that offer extended hours for Family Planning services. | Active |

NOMs

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

## State Action Plan Table (North Carolina) - Women/Maternal Health - Entry 2

### Priority Need

Improve access to high quality integrated health care services

### NPM

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

### Five-Year Objectives

WMH Objective 3A. By 2025, increase by 10% from 25 (Baseline February 2024) to 28 the number of LHDs who provide home visit for postnatal assessment and follow up care

### Strategies

WMH 3A.1. Provide training to LHD nurses related to postpartum visits.

WMH 3A.2. Provide technical assistance and support for LHDs providing the services.

| ESMs | Status |
| --- | --- |

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

### NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

## State Action Plan Table (North Carolina) - Women/Maternal Health - Entry 3

### Priority Need

Increase pregnancy intendedness within reproductive justice framework

### SPM

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

### Five-Year Objectives

WMH 2A. By 2025, increase by 2.3% from 88% (Baseline May 2020) to 90% the percent of LHDs that provide access to highly effective comprehensive (all methods) contraceptive methods for women.

WMH 2B. By 2025, at least 76% of LHDs will have polices to implement same day insertion of contraceptive implants and intrauterine devices (IUDs) (Baseline December 2019 – 74% offer same day insertion).

WMH 2C. By 2025, reduce the rate of births to girls aged 15-19 per 1,000 population to 14 (Baseline 2018 N.C. teen birth rate 18.7/1,000).

### Strategies

WMH 2A.1. Provide training for LHDs including the importance of offering all methods of contraceptives, reproductive justice framework, reproductive life planning (RLP).

WMH 2A.2. Partner with public health professional societies/organizations to provide information on latest evidence related to all contraceptive methods, i.e., UNC School of Pharmacy, NC Medical Society, NC Office of Rural Health, NC Community Health Center Association, etc.

WMH 2A.3 Develop peer mentoring program between LHDs on the importance of offering all methods of contraceptives.

WMH 2B.1. Partner with Upstream to promote same-day access to the full range of contraceptive methods at low or no cost.

WMH 2B.2. Develop sample policies and clinic flows for LHDs related to same day insertion.

WMH 2B.3. Provide consultation and technical support in addressing identified barriers for same day insertion.

WMH 2C.1. Provide training for Teen Pregnancy Prevention Initiatives (TPPI) agencies on applying a racial equity/reproductive justice/inclusivity lens to teen pregnancy prevention.

WMH 2C.2. Develop at least 4 workgroups across the TPPI network addressing topics including inclusivity, consent, virtual program implementation and reproductive justice/equity.

WMH 2C.3.Provide opportunities for youth to raise their voice in reducing teen pregnancy prevention through a statewide youth leadership council.

**Women/Maternal Health - Annual Report**

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

The NC Title V Office 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 before, during and after delivery of their baby, and for the 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 worked asked if they were feeling down or depressed. Per FAD data from the 2022 BRFSS, 73.4%% of women ages 18 to 44 surveyed had received such a service which is similar to the national rate (72.5%) and is slightly lower than the 2019 NC rate of 76.1%. Of the women who responded to the 2022 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 (79.3%) were more likely to have had a visit than Hispanic women (75.2%) or non-Hispanic white women (71.5%). 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. A core indicator for Point 12 (Provide interconception care) of the NC 2022-26 Perinatal Health Strategic Plan is the following: Percentage of women enrolled in Medicaid who deliver and receive a primary care visit within 12 months of delivery. With Medicaid paying for 54% of deliveries in 2020, an increase in this indicator will definitely affect the Postpartum Visit NPM as well as the Well-Woman Visit Standardized Measure. For women giving birth in 2014, 21.6% of women continuously enrolled in Medicaid for twelve months after delivery received a primary care visit within twelve months of delivery; however, this percentage dropped to 16.8% for people giving birth in 2019 and remained at 16.7% for 2020 births. 2020 data indicate that Black non-Hispanic women (18.2%), American Indian/Alaskan Native non-Hispanic women (21.9%), Asian/Pacific Islander, non-Hispanic women (17.6%), multiracial non-Hispanic women (15.8%), and Hispanic women (17.1%) were more likely to receive a primary care visit within 12 months than non-Hispanic White women (15%).

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 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 FY23. According to the 2023 Family Planning Annual Report, 58,606 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 DCFW/WCHS used Title V funds to support adolescent reproductive health services as part of their increased emphasis on adolescent health. LHDs can choose to implement approved evidence-based strategies (EBS) to improve health outcomes of adolescents. One sample EBS template that LHDs can choose to implement is Improving Adolescent Health through Preventative Care which focuses on establishing teen friendly clinics by implementing Association of Maternal and Child Health Programs (AMCHP) identified strategies to improve access and quality of adolescent services, improve state/systems-level policies and practices and promote positive youth development. LHDs can also choose to submit an EBS for review and approval. One LHD has implemented the Youth Development Program which is a comprehensive program that includes a school, parent, and community component. The activities of the program are aimed at providing students with meaningful alternatives to pregnancy while simultaneously increasing knowledge and skills for pregnancy prevention and sexually transmitted infections. It is designed to provide young adolescents with social support and guidance, life-skills training, positive and constructive alternatives to risky behaviors, and opportunities for meaningful contributions to the community. This program utilizes Advocates for Youth's Sexuality Education Curriculum which is an evidence-informed curriculum.

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 four local adolescent parenting programs. 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 networked to find a youth serving agency to fill the work that SHIFT NC did in NC. SHIFT NC closed their doors in June 2022, and the WICWS created a RFA process during FY23 to find a new agency to continue the work of building up youth-serving professionals and creating a platform for young voices to provide input into the work. The RFA was released in February 2023, and reviewers selected Fact Forward to receive a contract beginning in October 2023 for this work. Fact Forward has led a South Carolina statewide effort to impact teen reproductive health since 1994. With this contract, they began to expand their work into NC providing professional development opportunities, technical assistance, and to build a new Youth Leadership Council for North Carolina. Fact Forward is not new to NC youth agencies as they have served as speakers for several conferences and hold a widely attended Summer Institute Conference every year attracting agencies from across the U.S.

During this timeframe, a social media campaign was developed with the NC DHHS Communications office to reach adolescents (ages 13-25) to increase awareness about reproductive health services. Focusing on adolescents stemmed from learning during our Title X program review that the percent of adolescents seen in NC Title X clinics is lower than the average in other Title X networks in the U.S. The development of the campaign included collecting feedback from adolescents on the ads, slogans, and social media placement. The ads ran March-April 2023, receiving 155,947 clicks. This campaign was strong at driving site traffic to the landing page. The Snapchat platform ads received the most traffic, and the Spanish-speaking audiences had the highest engagement rates. The ads were made available for LHDs to utilize within their communities, outside of the statewide release, as well.

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

Throughout FY23, 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 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.

Inspired by significant staff turnover at the local level in FY23, the RNCs extensively revised the LHD staff orientation process. 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 enabled the RNCs to focus time during orientation discussing the individual staff person's role in assuring the clinic is assessing and addressing the reproductive health needs of their community.

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. In May 2018, there were 15 agencies that offered extended hours. This number dropped during the pandemic with 11 LHDs reported offering in 2022. In 2023, 24 LHDs reported offering different hours. 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 11.9% in FY21 to 13.1% in FY22, and up to 28.6% in FY23.

During the Regional Family Planning Meetings in February 2023, thirteen agencies expressed interest in offering extended hours. A one-page document was created for agencies and LHD's to highlight the benefits, lessons learned, and effective tips for extending clinic hours. The document serves as a resource for agencies thinking about offering different hours. The Reproductive Health Program Consultant continued to offer technical assistance to LHDs around extended hours. Guidance on clinic advertising, staff scheduling, and program sustainability were common topics of discussion.

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 continued through FY23, and submission to the NCDHHS Office for Public Affairs for approval will follow.

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. The ICHB implements the Preconception Peer Educator (PPE) program in collaboration with Historically Black Colleges and Universities and other colleges, community colleges and universities around the state. College 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 Department of Public Health, in collaboration with North Carolina Agricultural and Technical State and Johnson C. Smith Universities and the ICHB, hosted a hybrid (Zoom/in-person) PPE training on November 11- 12, 2022. More than thirty students attended the training along with volunteers from Guilford County Health Department'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 FY23, 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. Guilford County and the Mecklenburg-Union and Sandhills Collaboratives conducted outreach events focused on preconception and interconception health, reaching 1394 women of reproductive age (Sandhills: 445; Mecklenburg-Union: 687; and Guilford: 262). Twenty-six staff members from two grantee sites were trained to facilitate the Mothers & Babies (MB) Program (12 from Sandhills and 14 from the Mecklenburg-Union Collaborative). They delivered 40 group and 293 individual sessions of the program to 77 women (16 from Sandhills and 61 from the Mecklenburg-Union Collaborative). Attendees received 14 referrals and eight of those were completed (57% connection rate). Sandhills Collaborative provided journals as an incentive and helped patients journal their thoughts and feelings throughout their experience. The Mecklenburg-Union Collaborative hosted two peer support groups for facilitators to share experiences implementing the MB program and how impactful it was with their clients.

During FY23, 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. Over 91 virtual education and support sessions were provided to NC BLP clients on topics ranging from mental wellness, reproductive life planning, to self-esteem. As communities relaxed restrictions, many sites started incorporating some in-person components safely. 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. In addition, CHWs, FCCs and the Fatherhood Coordinator participated in 31 outreach events during the report period. 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 FY23, 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.

Priority 2 – Increase Pregnancy Intendedness Within a Reproductive Justice Framework

Another NC Title V priority is to increase pregnancy intendedness within a reproductive justice framework. This would be inclusive of 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 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.

Providing Services Within a Reproductive Justice Framework

In order for local partners, including LHDs, to provide services within a reproductive justice 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 reproductive justice 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 FY23, 73% of LHDs had staff complete a training during FY23 and 95% of LHDs have completed a training over the last three years.

During FY23, the WICWS sponsored several trainings for LHD staff. In fall 2022, the WICWS partnered with Provide to offer six virtual trainings on pregnancy options counseling. Over 175 people attended the trainings from 32 different LHDs. The training included knowledge and skill-building around all-options counseling and referrals. In December 2022, the WICWS held a webinar on expanding community access to family planning services. This webinar showcased three different health departments sharing their work around telehealth, offering extended clinic hours, and collaborating with a local university to expand their family planning reach within their local communities. The webinar had 194 attendees from over 60 different LHDs. Also in December 2022, the WICWS held a webinar on infertility services, led by the WICWS Medical Consultant Dr. Rachel Urrutia. The webinar discussed infertility causes, identified medical history questions and labs to assist in diagnosis, looked at preconception health education and lifestyle changes to maximize fertility, and defined polycystic ovary syndrome and understand causes and lifestyle factors. The webinar offered nursing continuing education hours and had 125 attendees during the live webinar from 35 different agencies.

The WICWS partnered with the National Clinical Training Center for Family Planning (NCTCFP) to offer LARC training in Greensboro in February 2023. The training was offered at no cost to LHDs funded under Title X. The training was opened to other providers in NC and in other states. Of NC LHDS, 24 attended the training with 33 participants. Lastly, in February 2023, the WICWS hosted five regional virtual meetings for family planning and

maternal health LHD staff. During these meetings family planning program updates were shared and local outreach and advertising ideas and successes were highlighted. Over 180 individuals attended the meetings from 76 different LHDs.

In 2020 TPPI convened four multi-disciplinary workgroups of local program coordinators, many of which participated in a reproductive justice workshop and/or other equity training, certified curriculum trainers, and TPPI Program Consultants to incorporate adaptations and develop interactive virtual curriculum activities and materials. Based on these groups, a handout was created titled *Supporting a Culturally Sensitive Approach to Sexuality Education*. The local program coordinators self-selected the groups in which they wanted to participate. Over the years, the local agency participants transitioned in and out of groups based on interest, curricula implemented at the local level, and availability. During FY23, TPPI hosted workgroups for the Adolescent Parenting Program local coordinators to provide feedback on program policies, curricula, program structure, and RFA changes. Local coordinators expressed concerns on topics covered, ensuring trauma-informed lens, and reducing barriers to services.

Another objective is to increase access to highly effective contraceptive methods. During FY23, 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 October 2022 (15 attendees); January 2023 (19 attendees); and May 2023 (17 attendees). The topics during these meetings included expanding access to contraceptives through pharmacies, Medicaid expansion, overall access to reproductive health services with changes to NC law, and updates on Upstream's work in NC. The group received regular updates on the progression of the Pharmacy Bill and getting pharmacists trained to offer oral and transdermal contraceptives. As reproductive health laws changed in NC, the group also discussed how to ensure individuals understand what services are available and how to obtain those. The group was part of the development of a webpage to house resources for individuals seeking information.

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 FY23, Upstream reported working with 15 different agencies, seven of those being LHDs. They successfully "graduated" four agencies, meaning they have adopted all or some of the Upstream work into their practices. Upstream also initiated a project integrating screening for NC Family Planning Medicaid into their training and technical assistance model. The materials Upstream created for the screening were shared with Title X agencies partnering with them.

During FY23, 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 long-acting reversible contraception (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. Additionally, staff continued to partner with Upstream to assist agencies in need of more intensive technical assistance around provision of same day LARC insertion. The percentage of LHDs offering same day insertion of both contraceptive implants and intrauterine devices (ESM WWV.4) according to results of the 2023 FPAR Survey was 59%. This was a decline from the almost 74% reported previously. The question was worded slightly differently, which may have created some change. Local agencies also continued to deal with staff

turnover, which may impact this data. The survey indicated that 94% of LHDs offer IUD insertions on site and 95% offer implant insertions on site.

The State Maternal Health Innovation program provided funds to Eastern AHEC to develop and offer reproductive justice training to medical, midwifery, and nursing students at ECU. Eastern AHEC has a long history partnering with the ECU Brody School of Medicine. The reproductive justice curriculum was designed by staff at both Eastern AHEC and the Brody School of Medicine. The two-day, voluntary training for students focused on the history of gynecology/obstetrics in the US, the history of reproductive oppression in the US and specifically in NC and provides students with standardized patient simulations centered on reproductive health topics such as unplanned pregnancy. In FY23, two reproductive justice training courses were held with a total of eight health professions students participating.

**Women/Maternal Health - Application Year**

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

As stated in the WMH Domain Annual Report, the NC Title V Office is committed to assuring that people in NC have access to high quality integrated health care services across the life course. The WICWS leads the work detailed in this domain partnering with local agencies to ensure equitable, quality services are available to North Carolinians. Priorities, strategies, and measures for this domain have been reviewed and updated, and details have been added regarding the planned work for FY25.

Provide Guidance and Support to Offer Family Friendly Clinical Services

The WICWS is committed to assisting LHDs offer family friendly clinical services. For the Family Planning clinics within the health departments, the Reproductive Health Branch (RHB) will be offering a youth friendly toolkit and a series of trainings to enhance understanding of mandatory reporting and topics included.

The RHB has developed a webpage housing a variety of topics and tools related to adolescent health services that will be available to local agencies in FY25 as the entire WICWS website moves to a new platform. This webpage will be helpful in providing a robust supply of resources in one area for agencies to ensure they are addressing adolescent health needs (e.g., how to include adolescents in planning and evaluation; what areas can be adapted to ensure addressing specific needs of youth; and creating inclusive environments where young people feel safe to seek services).

Additionally, the RHB is partnering with a lawyer from the University of North Carolina School of Government to provide an updated mandatory reporting webinar and a series of office hours on related topics such as human trafficking, minor's rights, foster care, etc. These webinars will all be held in FY25 to ensure LHD staff are aware of the requirements and their responsibilities. Mandatory reporting encompasses many facets, and it is critical for staff to know when and what they need to do to ensure young people are safe and have someone looking out for their best interest, in all circumstances.

Extended Hours for FP Services

Assisting LHDs to offer extended family planning clinic hours continues to be a goal to increase access for the community. With state funding, six LHDs and six federally qualified health centers (FQHCs) will be working to increase access to contraceptives by offering extended clinic hours under the Supporting Women's Health Services program. Nine of these 12 agencies started this work in FY24, and all will be implementing services in FY25. The RHB will connect with these agencies to identify what tips and lessons they have learned to share with other LHDs looking to expand. The goal is to specifically learn more about how to sustain the extended hours. Historically, many health departments have started offering extended hours at some point, but are not able to continue offering them long term. Resources will be shared to help agencies understand the importance of evaluating the changes with patients and ensuring they are still offering services that are necessary and accessible for when the community is available to access those services.

Improving Preconception Health and Creation of Outreach and Education Toolkit

The Preconception Health Outreach and Education Toolkit that will be used by LHDs, other providers, and community-based organizations to increase knowledge about preconception health is going through final approval for release. The toolkit includes a webinar on preconception health services; educational materials, including a

brochure and a webinar on birth spacing; and information on the *Ready, Set, Plan!* (RSP) training materials.

The Preconception Health Outreach and Education Toolkit will be posted on the WICWS website by December 31, 2024. Once it is posted, the PCH Team will engage and collaborate with other WICWS programs including NC BLP, ICO4MCH, Adolescent Pregnancy Prevention, Adolescent Parenting, Southeastern NC Healthy Start, and Healthy Beginnings to make them aware of it and provide at least one training on the purpose, contents, and use of the updated toolkit during FY25.

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

Additional FY25 efforts supporting this priority need include that three out of the five funded ICO4MCH sites will continue to implement a strategy focused on improving preconception and interconception health among individuals of reproductive age. Three ICO4MCH sites will continue their collaboration with local colleges and universities who have participated in and have active PPE programs on their campuses. PPE sites will implement on-campus and community-based health education and outreach program for individuals of reproductive age and/or individuals during the interconception period designed to build social support, learn health information, adopt healthy life skills, become knowledgeable of resources, and increase motivation to adopt health improving behaviors. They will continue to promote increased utilization of pre-pregnancy services by individuals of reproductive age, including under-served and uninsured, to reinforce the importance of pregnancy planning and preparedness among individuals in the LHD Family Planning clinic or within other primary care practices.

WICWS' two federally funded Healthy Start programs, NC BLP and Southeastern NC Healthy Start, will continue to provide case management services using evidence-based tools for risk assessment and screening, provide education on pregnancy intendedness using the Preconception Health Outreach and Education Toolkit, and facilitate access to health services for preconception women in FY25 as described in the WMH Domain Annual Report.

CMHRP Care Managers will continue to refer patients to the local DSS for Medicaid eligibility determination, and assist patients in applying for ongoing Medicaid coverage, including family planning coverage and family planning services, as applicable. CMHRP Care Managers are also critical in identifying and reducing barriers that may prohibit the patient from attending their post-partum 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. A specific statewide RSP training course for all CMHRP Care Managers is being planned with the WICWS Preconception Health and Wellness Program Manager for FY25.

NC LHDs will implement a new or enhance an existing Home Visit for Postnatal Assessment (HVPNA) and Follow-up Care service in FY25. HVPNA is provided to postpartum individuals within two to three weeks after giving birth. The LHDs will provide this service to Medicaid beneficiaries as well as to underinsured and uninsured postpartum women in the county. HVPNA is a key mechanism for reaching families early post-delivery with preventative and anticipatory services, providing opportunities for timely referral of problems, promoting spacing of subsequent pregnancies, and serving as the linkage to women's preventative health services. HVPNA services are provided by a registered nurse in the client's home. WICWS will collaborate with Northwest AHEC to coordinate annual training for LHD staff hired to provide the home visiting service. Training will include topics such as maternal warning signs, reproductive life planning, conducting postpartum depression assessments, supporting breastfeeding and newborn nutrition, and personal safety. The WICWS RNCs will provide technical assistance and support during monitoring visits. The RNCs will utilize a standardized audit tool that aligns with Medicaid clinical policy for HVPNA and Follow-up Care service.

Priority 2 – Increase Pregnancy Intendedness Within a Reproductive Justice Framework

The RHB continues to provide trainings to expand local agency staff's understanding and capacity to provide inclusive reproductive health services, utilizing the reproductive justice framework. For FY25, the RHB will host a webinar series about providing trauma-informed services. During this series, a total of four different webinars will be held, each building off a different domain of trauma-informed services. The series stems from the trauma-informed toolkit that the Reproductive Heath National Training Center released in the fall of 2023. The trainings in the series include Physical Environment, Inclusive Language, Gender Affirming Clinical Care (family planning services for LGBTQ community), and Workforce toolkit. These trainings will provide understanding, resources, and skill-building for local staff to address their physical space, how they are speaking with patients, inclusive services for all patients, and how agencies support their staff through this work.

The WICWS TPPI provides ongoing training and technical assistance to ensure local agencies are providing equitable reproductive health programs to young people. In FY25, TPPI plans to provide training and resources to locally funded projects around program sustainability. The training will include sharing inclusive terminology with local programs around how to talk about their work and programs with their community advisory councils and other stakeholders. This includes how to present data and the program in a way to ensure not alienating or victim-blaming any group for outcomes, disparities, etc. The hope is to increase knowledge of entire communities about teen pregnancy prevention work and importance of language, inclusiveness, and raising up teen's voices.

The RHB will continue to partner with Fact Forward as they broaden their reach into NC. Fact Forward is a South Carolina-based adolescent health serving agency that first partnered with us in FY24. They will continue to lead a youth council for NC and provide training and networking opportunities for professionals working with youth in reproductive health during FY25. At least twelve youth leaders will serve on the council with the opportunity to develop their leadership skills, deepen knowledge of pregnancy prevention, and strengthen teamwork. During FY25, Fact Forward will also be developing a State of Adolescent Pregnancy Prevention Report with recommendations for continued progress on reducing teen pregnancies in NC.

The RHB continues to move forward on the objective to increase access to highly effective contraceptive methods. The WICWS continues to collaborate with Upstream NC to increase access to contraceptive methods and same day access to method of choice. In FY25, the RHB plans to connect with LHDs who have expressed interest in receiving technical assistance around creating same-day contraceptive policies. Virtual "office hours" will also be held for agencies to encourage clinic flow to provide same day contraceptive access and maintain inventories of all highly effective methods. In addition, information will be shared with LHDs about the increased availability of contraceptive prescribing pharmacists throughout NC and how this can increase access for many communities. Partnerships between the contraceptive pharmacists and LHDs will be encouraged to ensure patients have access to full reproductive health care.

CMHRP Care Managers' work related to Reproductive Life Planning is ongoing into FY25. Care Managers provide reproductive life education and counseling to all patients who receive CMHRP services. They collaborate with medical providers to ensure pregnant and postpartum individuals 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. Care Managers 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.

CMHRP Care Managers emphasize and reinforce the information and education shared by medical providers which promote 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 increases patient understanding and compliance which in turn leads to improved contraceptive use, family planning, birth spacing, and pregnancy intendedness.

**Perinatal/Infant Health**

**National Performance Measures**

**NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC**
**Indicators and Annual Objectives**

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

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | 90 | 90 | 90 | 90 | 90 |
| Annual Indicator | 76.7 | 80.1 | 75.1 | 73.9 | 74.1 |
| Numerator | 1,269 | 1,375 | 1,253 | 1,266 | 1,210 |
| Denominator | 1,654 | 1,717 | 1,668 | 1,714 | 1,632 |
| Data Source | NC Vital Statistics | NC Vital Statistics | NC Vital Statistics | NC Vital Statistics | NC Vital Statistics |
| Data Source Year | 2018 | 2019 | 2020 | 2021 | 2022 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 90.0 | 90.0 |

**Evidence-Based or –Informed Strategy Measures**

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

| Measure Status: | Active |
|---|---|

**State Provided Data**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 50 | 75 | 100 |
| Annual Indicator | 33.7 | 37.2 | 70.9 | 78.8 | 80.2 |
| Numerator | 29 | 32 | 61 | 67 | 65 |
| Denominator | 86 | 86 | 86 | 85 | 81 |
| Data Source | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log |
| Data Source Year | FY18-19 | FY19-20 | FY20-21 | FY21-22 | FY22-23 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**Annual Objectives**

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 100.0 | 100.0 |

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

| Measure Status: | Active |
|---|---|

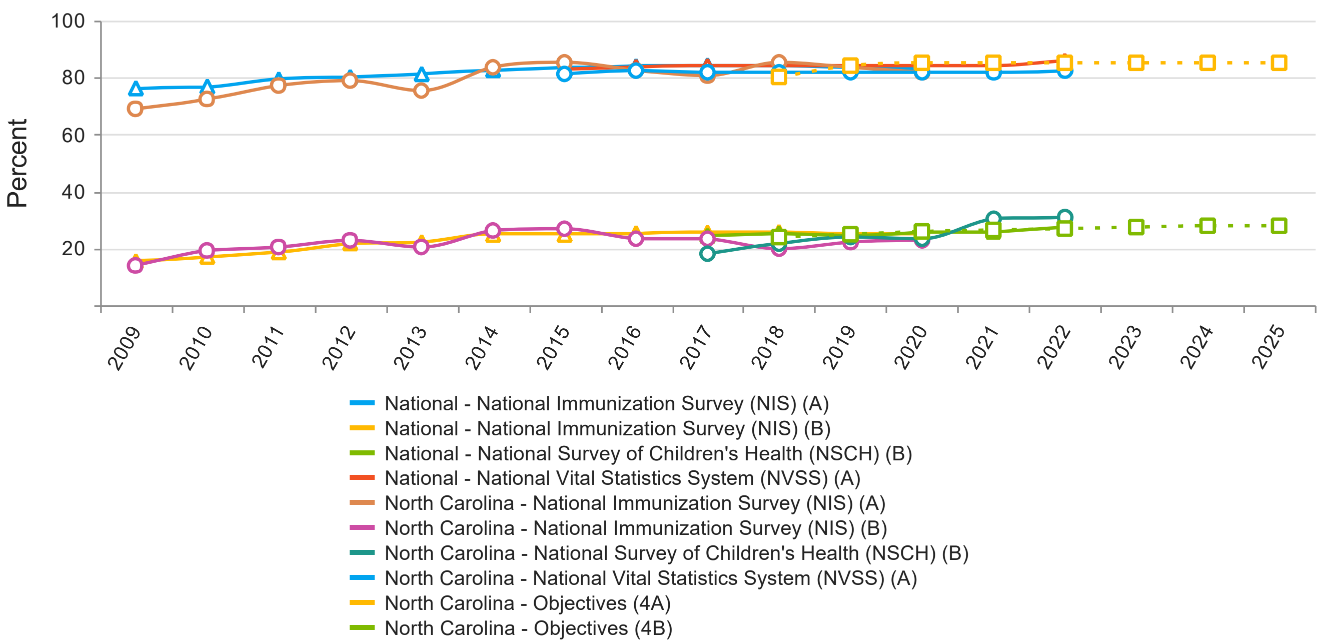
**State Provided Data**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 25 | 25 | 40 |
| Annual Indicator | | 1.2 | 2.4 | 16.5 | 15.3 |
| Numerator | | 1 | 2 | 14 | 13 |
| Denominator | | 85 | 85 | 85 | 85 |
| Data Source | | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log |
| Data Source Year | | 2020 | 2021 | 2022 | 2023 |
| Provisional or Final ? | | Final | Final | Final | Final |

**Annual Objectives**

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 60.0 | 75.0 |

**NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF Indicators and Annual Objectives**




**NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** |
| Annual Objective | 84 | 85 | 85 | 85 | 85 |
| Annual Indicator | 82.5 | 80.3 | 83.4 | 83.4 | 81.4 |
| Numerator | 88,249 | 90,222 | 92,086 | 92,086 | 92,139 |
| Denominator | 106,953 | 112,365 | 110,468 | 110,468 | 113,239 |
| Data Source | NIS | NIS | NIS | NIS | NIS |
| Data Source Year | 2016 | 2017 | 2019 | 2019 | 2020 |

| Federally Available Data | |
|---|---|
| **Data Source: National Vital Statistics System (NVSS)** | |
| | **2023** |
| Annual Objective | 85 |
| Annual Indicator | 82.1 |
| Numerator | 98,631 |
| Denominator | 120,143 |
| Data Source | NVSS |
| Data Source Year | 2022 |

| Annual Objectives | | |
|---|---|---|
| | **2024** | **2025** |
| Annual Objective | 85.0 | 85.0 |

**NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** |
| Annual Objective | 25 | 26 | 27 | 27 | 27.5 |
| Annual Indicator | 23.4 | 23.3 | 22.1 | 22.1 | 23.1 |
| Numerator | 24,051 | 25,865 | 24,009 | 24,009 | 25,017 |
| Denominator | 102,887 | 111,143 | 108,844 | 108,844 | 108,429 |
| Data Source | NIS | NIS | NIS | NIS | NIS |
| Data Source Year | 2016 | 2017 | 2019 | 2019 | 2020 |

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | |
| | **2023** |
| Annual Objective | 27.5 |
| Annual Indicator | 30.8 |
| Numerator | 84,259 |
| Denominator | 273,537 |
| Data Source | NSCH |
| Data Source Year | 2021_2022 |

| Annual Objectives | | |
|---|---|---|
| | **2024** | **2025** |
| Annual Objective | 28.0 | 28.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM BF.1 - Number of eligible WIC participants who receive breastfeeding peer counselor services**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 28,350 | 29,120 | 29,900 |
| Annual Indicator | 27,587 | 25,020 | 22,263 | 22,599 | 22,987 |
| 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 | SFY18-19 | SFY19-20 | SFY20-21 | SFY21-22 | SFY22-23 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 30,660.0 | 31,425.0 |

**State Performance Measures**

**SPM 2 - Percent of women who smoke during pregnancy**

| Measure Status: | Active |
|---|---|

**State Provided Data**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 8.1 | 7 | 6.8 |
| Annual Indicator | 7.6 | | 6.8 | 5.6 | 4.5 |
| Numerator | 8,991 | | 7,923 | 6,756 | 5,425 |
| Denominator | 118,725 | | 116,755 | 120,501 | 121,557 |
| Data Source | NC Vital Statistics/SCHS | | NC Vital Statistics/SCHS | NC Vital Statistics/SCHS | NC Vital Statistics/SCHS |
| Data Source Year | 2019 | | 2020 | 2021 | 2022 |
| Provisional or Final ? | Final | | Final | Final | Final |

**Annual Objectives**

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 5.0 | 5.0 |

**State Action Plan Table**

## State Action Plan Table (North Carolina) - Perinatal/Infant Health - Entry 1

### Priority Need

Improve access to high quality integrated health care services

### NPM

NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC

### Five-Year Objectives

PIH 1A. By June 30, 2023, all birth facilities will have a designation based on the national maternal and infant risk-appropriate level of care standards.

PIH 1B. Staff from 75% of LHDs will participate in the LHDs/LMEs annual trainings during FY21 to FY25.

PIH 1C. Each year, 99% of newborn infants in NC will be screened for metabolic and other hereditary and congenital disorders and will receive necessary follow-up.

### Strategies

PIH 1A.1. Partner with the Perinatal Health Equity Collective Maternal Health Action Team to prioritize levels of care within the state’s Maternal Health Strategic Plan.

PIH 1A.2. Partner with Division of Health Services Regulations to update existing neonatal rules and develop maternal health rules.

PIH 1A.3. Implement the LOCATe tool within all birthing facilities in collaboration with the MHI Provider Support Network inclusive of the Perinatal Nurse Champions.

PIH 1B.1. Provide two maternal mental health and behavioral health trainings for LHDs, LMEs, etc. annually.

PIH 1B.2. Conduct orientation on the NC-PAL for all LHDs/LMEs (hold 2-3 webinars).

PIH 1B.3. Expand the MATTERS Leadership Team to include local LMEs.

PIH 1B.4. WICWS RNC will provide orientation and TA for LHDs inclusive of behavioral health.

PIH 1B.5. WICWS RSWC will provide support for the CMHRP Care Managers inclusive of behavioral health.

PIH 1C.1. The Newborn Screening Follow-Up Team, EHDI Team and NC Birth Defects Registry 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 RAC.1 - Percent of birth facilities with level of care documented using the CDC LOCATe tool. | Active |
| ESM RAC.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL) | Active |

| NOMs |
|---|
| NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM |
| NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM |
| NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal |
| NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related |

## State Action Plan Table (North Carolina) - Perinatal/Infant Health - Entry 2

### Priority Need

Prevent infant/fetal deaths and premature births

### NPM

NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

### Five-Year Objectives

PIH 3A.1. By 2025, increase the percent of NC resident live births who are breastfed at hospital discharge as reported on birth certificate from 80.9% (Baseline 2018) by 2% to 82.5%.

PIH 3A.2. By 2025, increase the percent of women participating in WIC who initiate breastfeeding from 72.5% (SFY2019 baseline) by 2% to 74%.

PIH 3A.3. By 2025, increase by 14% from 44% (Baseline Fall 2019) to 50% of NC maternity centers that have implemented two or more steps of the World Health Organization's evidenced based Ten Steps to Successful Breastfeeding.

PIH 3A.4. By 2025, increase the number of eligible WIC participants who receive breastfeeding peer counselor support by 15% from 27,587 (FY19 baseline) to 31,725.

PIH 3A.5. By 2025, increase the number of NC Child Care Centers who are designated as Breastfeeding Friendly Child Care Center by 50% from 28 (Baseline May 2020) to 42.

PIH 3A.6. By 2025, increase the number of LHDs who are awarded the NC Breastfeeding Coalition's Mother-Baby Award for outpatient healthcare clinics by 100% from 5 (Baseline May 2019) to 10.

PIH 3A.7 By 2025, increase the percent of women participating in WIC, Healthy Beginnings and/or MIECHV who report any breastfeeding through 6 months by 1% (FY19 Baseline: WIC 26.6%; Healthy Beginnings 13.7%; and MIECHV 23%/Non-MIECHV funded 38.6%)

### Strategies

PIH 3A.1. Support activities in the following strategic plans/task force to reduce the infant mortality disparity ratio: NC Perinatal Health Strategic Plan; NC Early Childhood Action Plan; and NC Child Fatality Task Force.

PIH 3A.2. Support implementation of Healthy Beginnings, Healthy Start Baby Love Plus, Improving Community Outcomes for Maternal and Child Health, and the Infant Mortality Reduction Program/Reducing Infant Mortality in Communities.

PIH 3A.3. Support strategies in the following strategic plans to improve breastfeeding rates: NC Perinatal Health Strategic Plan; NC Early Childhood Action Plan; and North Carolina's Plan to Address Overweight and Obesity - Eat Smart, Move More North Carolina. 2020.

PIH 3A.4. Support work of maternity centers to obtain the North Carolina Maternity Center Breastfeeding Friendly Designation from the NCDivision of Child & Family Well-Being or full Baby-Friendly Designation from Baby-Friendly, USA.

PIH 3A.5. Support the work of child care providers to obtain the NC Breastfeeding Friendly Child Care Designation through application revisions, promotion, and training for external partners.

PIH 3A.6. Support the work of LHDs who are working toward or awarded the NC Breastfeeding Coalition's Mother-Baby Award for outpatient healthcare clinics.

PIH 3A.7. Optimize breastfeeding training for, but not limited to, Maternal and Child Health care managers, LHD employees, and home visitors through coordination with the Regional Lactation Training Centers through the State Breastfeeding Coordinator.

PIH 3A.8. NC Title V Program will work with the Office of Rural Health to ensure that breastfeeding information is included as part of the Knowledge Base Core Competency for NC Community Health Workers.

PIH 3A.9. The Pediatric Nutrition Consultant will provide breastfeeding training to Child Health Program staff at local health departments through virtual, regional, and statewide meetings.

PIH 3A.10. Support dissemination and use of the revised NC Making It Work Tool Kit to help breastfeeding mothers return to work.

PIH 3A.11. Promote the WIC Breastfeeding Peer Counseling Program to all women receiving services in LHD/WIC clinics and increase the number of women who sign the Breastfeeding Peer Counseling Program Letter of Agreement to begin services.

| ESMs | Status |
| --- | --- |
| ESM BF.1 - Number of eligible WIC participants who receive breastfeeding peer counselor services | Active |

### NOMs

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

## State Action Plan Table (North Carolina) - Perinatal/Infant Health - Entry 3

### Priority Need

Prevent infant/fetal deaths and premature births

### SPM

SPM 2 - Percent of women who smoke during pregnancy

### Five-Year Objectives

PIH 3B. By June 30, 2025, reduce the percent of women who smoke during pregnancy by 10.7% from 8.4% (Baseline 2019) to 7.5%.

### Strategies

PIH 3B.1. Revitalize the work of the Women and Tobacco Coalition for Health as a leader in women's health and tobacco use.

PIH 3B.2. Partner with WATCH to update the "Guide for Helping to Eliminate Tobacco Use and Exposure for Women."

PIH 3B.3. Smoking cessation counseling will be provided in all WICWS and DCFW/WCHS direct service programs.

PIH 3B.4. Provide annual training for at least two WICWS programs on women's health and tobacco use, inclusive of QuitlineNC and e-cigarettes.

**Perinatal/Infant Health - Annual Report**

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 people are receiving care in a risk-appropriate level of care facility. In FY23, Perinatal Health Equity Collective (PHEC) launched three action teams. The Action Teams are topic and time specific small groups focused on moving forward maternal health efforts identified in the Perinatal Health Strategic Plan (PHSP). The identified three Action Teams were: Neonatal Levels of Care, Maternal Levels of Care, and Equity in Practice. The Neonatal and Maternal Levels of Care Action Teams will be discussed further later in this document. The goal of the Equity into Practice action team was to increase accessibility of educational tools and resources specific to the Dignity for Women who are Incarcerated Women Act. This action team has successfully identified existing educational tools and resources related to perinatal incarceration in North Carolina; gaps in resources and tools related to perinatal incarceration in North Carolina; and strategies to increase accessibility of existing perinatal incarceration resources.

With funding from the CDC, the WICWS contracted with the Collaborative for Maternal and Infant Health (CMIH) at the University of North Carolina at Chapel Hill to support the project *Developing Models to Mitigate COVID-19 Disparities Among Incarcerated Pregnant/Postpartum Women.* CMIH work centered around the development and implementation of comprehensive training and technical assistance components aimed at supporting the provisions of the Dignity Act. The training programs addressed a spectrum of critical topics, including infectious disease prevention, risk mitigation strategies, and identification of and appropriate response to urgent maternal warning signs. In FY23, CMIH offered 4 trainings that reached 152 people. Two educational tools were developed, *Take Care of You and Baby*, which is a booklet for pregnant/postpartum incarcerated women, and *Guidelines Regarding Women in North Carolina Jails*, which is a handout for correctional staff. Other materials developed during the reporting period were podcasts and video clips to increase awareness via social media.

The State Maternal Health Innovation (MHI) Program supported trainings for health care providers across the six perinatal care regions (PCRs) to improve high quality care. In FY23, Perinatal Nurse Champions (PNCs) in each of the PCRs provided training to more than 3500 clinical providers, doulas, emergency service responders, and others. Training topics were chosen based on a gap analysis conducted in the region. Some examples of trainings include Obstetric Emergencies, Fetal Monitoring, Postpartum Hemorrhage Escape Room, Supporting Trans and Queer Clients, and Survivor Services.

The MHI program provided direct care services to pregnant and postpartum women through two Community Health Worker (CHW) Doula programs. These programs, located at Novant Health New Hanover Regional Medical Center and the Young Women's Christian Association of High Point, served at least 30 pregnant clients annually. The program provided free prenatal, labor, and postpartum support. Clients were enrolled in the program by the CHW, provided prenatal and labor support by the doula, and then given a warm handoff back to the CHW for up to one year postpartum. The programs aim to support pregnant people who are from historically marginalized communities and/or facing barriers to accessing care. By March 2023, 112 participants had been enrolled in the programs.

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 PHEC established Action Teams in FY23 to include a focus on updating NC's Neonatal Levels of Care and developing Maternal Levels of Care. The Neonatal Levels of Care Action Team met monthly from December 2022 until July 2023. The Action Team initially reviewed the state's current neonatal levels of care guidelines. Work began to develop a set of draft recommendations to align more closely with the American Academy of Pediatrics guidance. The Maternal Levels of Care Action Team started meeting in May 2023. This group's work focused on drafting recommendations to determine what was needed to implement the guidance provided by the American Academy of Obstetrics and Gynecology and the Society for Maternal and Fetal Medicine.

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℠) to determine risk appropriate levels of maternal and neonatal care. By the end of FY23, 65 birthing facilities had completed the LOCATe℠ 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).

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 FY23, NC MATTERS received 549 calls on the psychiatric access line and provided 22 one-time psychiatric assessments. NC MATTERS conducted outreach and provided training to 1290 health care providers during FY23. Training topics ranged from Depression, Anxiety, and Sleep in the Perinatal Period to Substance Use Disorders, Latino/a women and the perinatal period. ESM RAC.2 (Percent of LHDs who are utilizing NC-PAL) was created to help monitor this strategy. Thirteen LHDs (15.3%) were using NC-PAL in FY23 which is a slight decrease from 14 LHDs who used NC-PAL to address in FY22 to address behavioral health needs of pregnant and postpartum patients. In December 2022, NC MATTERS sent web-based surveys to all NC LHDs to gather information that would help NC MATTERS determine how to best meet their needs. Survey results from the 66 LHDs that responded (78%) indicated that LHD staff wanted additional training and support in the following areas: aid in connecting with resources (72%); additional staff training (68%), technical assistance with screening, monitoring, and brief treatment (28%), case consultation (17%), and site visits to support training (15%). The needs assessment helped inform NC MATTERS on how to further support and/or collaborate with LHDs.

The NC MATTERS team continues to enhance relationships with NC LHD staff. In FY23, NC MATTERS collaborated with two LHDs, Beaufort County Health Department and Yadkin County Health Department, in a QI project for their behavioral health services for pregnant and postpartum clients. The QI project included peer learning collaborative

calls and/or meetings, examining and augmenting current behavioral health screening policies and processes, monitoring patient records that screen positive for anxiety, depression, or substance use to support staff in connecting them to resources and providing referrals, as appropriate, and helping LHDs determine what new screening tools may be beneficial for the clinic.

In FY23, the WICWS continued to host a recorded webinar titled *Perinatal Mental Health for Local Health Departments: Awareness, Assessment, Action* for LHD Staff. During FY23, the webinar had 74 live views and 92 online enduring views. Those who completed the webinar and the evaluation received 1.25 nursing continuing professional development contact hours. The webinar was presented by the WICWS Licensed Clinical Social Worker and the Maternal Health Nurse Consultant. The intended audience for the webinar was nurses, social workers, and OB/Family Medicine providers that care for pregnant and postpartum clients in LHDs. The webinar addressed concerns from our local agencies related to screening and referral for mental health issues, such as how to distinguish between the typical hormonal and mood changes in pregnancy. The webinar also covered how to administer, and score validated screening tools to determine if further assessment is needed. This webinar was reviewed and determined to still contain relevant and up-to-date information; therefore, it remained as an archived resource on the WICWS website for repeat viewing throughout FY23.

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 FY23:

- Four New Hire Orientations (NHOs) were held with 66 new hires in attendance.
- Each new hire completed four trainings within the first year of being hired which included topics such as infant mortality equity, social determinants of health, 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 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 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 care managers 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 Care Managers in maintaining communication.

The CMHRP began emphasizing the importance of assessing members for behavioral health concerns with the CMHRP NHO process. Motivational Interviewing and Trauma Informed Care are trainings that CMHRP care managers 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 Care Managers 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 care manager then conducts a Patient Health Questionnaire-9 (PHQ-9) for additional insight. These questions allow care managers to identify members who may benefit from a referral for additional behavioral health services. During FY23, one of the CMHRP Regional Consultants participated in the Government Agency Maternal Mental Health Policy Fellows program conducted by the Policy Center for Maternal Mental Health (formerly 2020 Mom). During this timeframe, she began developing a Perinatal Mental Health Educational Pathway as an additional behavioral health resource for CMHRP Care Managers. The CMHRP Resource and References document contains Behavioral Health resources such as Postpartum Support International and the LME/MCO Directory.

The WICWS Regional Nurse Consultants (RNC) added a behavioral health component to their orientation guide in FY23. This orientation document is reviewed with new lead health department staff, including but not limited to the Directors of Nursing and Providers. Additionally, RNCs provide ongoing technical assistance related to behavioral health topics when requested or when deemed necessary.

The WICWS Nutrition Consultant made a presentation focused on providing client-centered nutrition and lifestyle counseling specifically engaging African American women to Healthy Beginnings Program staff, including community health workers, in FY23. As part of the 37th Annual School Nurse Conference, she presented a session titled *Reflect & Refocus: Weight Inclusive Approaches to Health in Schools* focused on providing school nurses the latest information about incorporating weight-inclusive strategies in the school setting. In November 2022, the WICWS Nutrition Consultant presented to the Statewide Eat Smart Move More Committee in a webinar titled *'Weighty' Matters: Inclusive & Compassionate Approaches to Whole Person, Whole Community Health* which highlighted weight-inclusive practices and shared evidence-based principles and resources on using a weight-inclusive and compassionate lens in public health settings.

Perinatal Oral Health

The Perinatal Oral Health Program continues to educate medical providers, dental providers and pregnancy support service professionals on the importance of oral health during pregnancy. Public Health Dental Hygienists delivered 151 perinatal oral health educational trainings to 785 participants in FY23.

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 of 2021. 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." of which Mucopolysaccharidosis Type II (MPS II) and Guanidinoacetate Methyltransferase Deficiency (GAMT) are upcoming.

The NBS Follow-Up Team, housed in the DCFW/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 FY23, the NBS Follow-Up Team provided services for 1,477 infants with abnormal NBS results for CH, CAH, galactosemia, biotinidase deficiency, SCID, SMA and CF, 119 of whom were confirmed to be affected and are receiving treatment as determined by the appropriate subspecialist. The number of abnormal NBS results increased by a large margin beginning in FY23 due to changes in early NICU collection procedures in one large hospital system, with the vast majority normalizing upon a repeat screen collected after 24 hours of age. The NBS Follow-Up Team completed follow-up protocols and educational materials to coincide with the launch of MPS II and Pompe February of 2023. Along with partners at RTI, UNC-Chapel Hill and SLPH, the DCFW/WCHS follow-up staff began a review to update galactosemia follow-up protocols. In addition, work began to create new parent and provider galactosemia educational materials. The DCFW/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 DCFW/WCHS maintains a contract with UNC-Chapel Hill for follow-up and management of infants identified by tandem mass spectrometry (MS/MS) and X-linked adrenoleukodystrophy (X-ALD). They also follow up on positive screens for SMA when the family is referred to UNC and follow up for MPS I began in February 2023. The team at UNC continued to provide clinical genetic services, genetic counseling services, and genetic testing for approximately 2,300 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 715 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 26 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 6,000 phone encounters with all their metabolic patients regarding ongoing management.

The SLPH NBS Program completed first-tier method verification of α-L-iduronidase (IDUA) and acid-α-glucosidase (GAA) enzyme activity measurement via NeoLSD*TM* MS/MS Kit assay for MPS I and Glycogen Storage Disorder II (Pompe), respectively. Additionally, second- and third-tier testing for both disorders were established with an outside vendor to perform biochemical testing followed by gene sequencing. The NBS Follow-Up Team at the UNC Division of Genetics and Metabolism began receiving notification of potential MPS I and Pompe cases and began providing timely interpretation, confirmation of suspected diagnoses, and coordination of care. Since the launch of MPS I and Pompe screening on February 13, 2023, one confirmed-positive MPS I case has been identified and six Late-Onset Pompe (LOPD) cases have been identified. The NBS MS/MS Lab has begun planning for the addition of MPS II and GAMT which were added to the RUSP in August 2022 and January 2023, respectively.

The DCFW/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 FY23. 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 the NC Healthcare Association and other partners to improve enrollment and reporting of CCHD data into the statewide WCSWeb database by birthing

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hospitals, free-standing birthing centers, and other health care providers attending deliveries of newborns. 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. DCFW/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 DCFW/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 2022, a total of 122,571 (99% of 123,772 occurrent live births) were screened for hearing, with 119,906 (96.9% 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 PHEC, 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 PHEC meetings now highlight speakers/organizations from various domains to increase awareness of organizations working on different social determinants, 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 North Carolina and identifies varying organizations' roles in that strategy. When working on proposals or thinking through our larger approach, PHEC 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 People of Childbearing Age

Work to reduce the infant mortality disparity ratio continued in FY23 through a variety of methods. The PHSP's adapted framework is designed to focus on equity and social determinants of health 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 equity. 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 493 minority pregnant and postpartum/ interconception women and their children in FY23. During FY23, there were 441 live births with one infant death (2.3 infant death rate). Among all pregnant program participants, 87% received prenatal care within the first trimester. Ninety-two percent of postpartum program participants received their postpartum care checkup. 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 NC Baby Love Plus (BLP) 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 FY23 BLP continued to focus its efforts in four counties with higher infant mortality rates within the state and enrolled 260 pregnant persons. 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.

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 equity lens. Under the new funding cycle, the ICO4MCH initiative renewed funding to five lead LHDs (totaling 9 health departments) in FY23. 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 North Carolina. Four ICO4MCH sites (Durham, Mecklenburg-Union, Sandhills Collaborative, and Wake) conducted reproductive justice training in FY23 reaching a combined total of 26 providers and staff. Durham and Wake conducted 51 education and community outreach events reaching 667 persons of reproductive age. Guilford, Mecklenburg-Union and Sandhills Collaborative reached approximately 1,400 people through outreach events focused on preconception and interconception health. Under the breastfeeding EBS, a total of 777 staff were trained in lactation education, peer counseling and related areas across all ICO4MCH sites in FY23.Under Triple P, 101 new practitioners were accredited representing Guilford (21), Mecklenburg-Union (58) and Sandhills 21) Collaboratives. In addition, a total

of 2,614 caregivers and 2,637 children ages 0-5 were served in Mecklenburg and Sandhills regions. ICO4MCH staff at Family Connect Durham site conducted 894 in-person and virtual visits in FY23.

Title V funding supported the Infant Mortality Reduction Program in FY23 by providing funding to 20 LHDs in counties that have experienced some of the highest infant mortality 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 FY23, one LHD implemented Centering Pregnancy and provided services to 79 clients; nine community members were trained as doulas and 19 clients received doula services;13 LHDs collectively provided infant safe sleep educational sessions to 1,631 clients; three LHDs served 188 clients and staff completed 1,219 home visits under Nurse Family Partnership; 33 staff representing 10 LHDs were trained in reproductive life planning and educated 9,525 clients; and three LHDs trained 30 staff on 5As (ask, advise, assess, assist, and 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 2020 reported that 81.4% of infants were ever breastfed, yet by 6 months of age only 23.1% of infants were exclusively breastfed. This rate falls below the national average of 25.4%. Further, breastfeeding initiation data obtained from birth certificates for infants born in 2022 reveal that 81.5% of all infants were breastfed at hospital discharge. However, these data mirror national trends of racial/ethnic disparities in breastfeeding, as Hispanic infants had an 86.1% initiation rate, NH white 83.8%, and NH Asian/PI 87.non-6%. In contrast, NH Black had a lower rate of 72.2%, and NH American Indian had the lowest rate at 58.7%. These disparities were also evident among women et for babies born in 2020 to women enrolled in the WIC program prenatally with initiation rates of 85.5% for Hispanic and 70.6% for NH white women, but only 65.1% for NH Black and 49.3% for NH American Indian women.

North Carolina continued to build on the necessary changes to the breastfeeding support infrastructure prompted by the COVID-19 pandemic and the infant formula shortage. The ongoing emphasis on access to breastfeeding aids through the NC WIC Program and NC Medicaid has been facilitated by developing resources and receiving collaborative feedback on clinical coverage policies. These two entities serve as the primary sources of breastfeeding aids for Medicaid recipients.

In FY22, the NC WIC Program embarked on a strategic rollout of the US Department of Agriculture's WIC Breastfeeding Curriculum, a comprehensive educational framework designed to standardize breastfeeding support across all staff roles within the program. This curriculum is structured in four tiered levels of learning, tailored to the specific roles and responsibilities of WIC staff, ensuring that each member is equipped with the knowledge and skills necessary to promote and support breastfeeding effectively. The rollout began in FY22 with over 1,200 state and local WIC staff completing Level 1 of the curriculum, and 135 peer counselors advancing through Level 2. While continuing to offer Levels 1 and 2 to new staff, in FY23, the North Carolina WIC Program rolled out Level 3 aimed at WIC nutritionist and WIC Designated Breastfeeding Experts (DBEs) training over 300 nutritionists and DBEs in lactation support specific to their roles and implemented a plan for continuation of Level 3 training for new staff.

The implementation of a breastfeeding training program through the NC WIC Program and the Lactation Area Training Center for Health (LATCH) grant, which provides lactation education to the WIC Program and surrounding medical providers, has improved the continuity of care in lactation messaging for WIC Program participants. This initiative has led to increased breastfeeding rates. The focus on both the resources and the knowledge base of service providers has contributed to rising breastfeeding rates in North Carolina and the normalization of breastfeeding support.

The Division of Health Benefits began work in FY23 in developing a state plan amendment to support development of a statewide breastfeeding hotline, under the CHIP Authorization. As this work continued, DPH began discussions in developing an RFP in order to establish the breastfeeding hotline once funds were secured. As part of the State Action Plan for Nutrition Security, an advisory council of statewide stakeholders was created to help inform the work of the North Carolina Breastfeeding Hotline. The group has met twice to assist in providing feedback about the RFP.

In FY23, the CMHRP Care Managers 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 on the benefits of breastfeeding for the pregnant person and the infant. Care managers made referrals to breastfeeding classes and other breastfeeding supports. Moreover, CMHRP Care Managers 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/Chest and Human Milk Feeding

Multiple state strategic plans in NC have prioritized breastfeeding objectives, strategies, and action. These include the NC PHSP; NC ECAP; 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 DCFW/WCHS Pediatric Nutrition Consultant (PNC). NC's Title V MCH Block Grant continued to support 100% of the salary of the DCFW/WCHS PNC in FY23. 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; Diversity, Equity & Inclusion; 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/chest 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 FY23, the DPH/DCFW Breastfeeding Coordination Team continued to meet quarterly. The team consists of ~17 members in both leadership and programmatic positions. Each year, the team usually works on several projects together or in small workgroups. The PNC co-developed agendas and worked to identify facilitators, recorders and timekeepers for each meeting; served on sub workgroups which produced a webinar for August 2022 and planned DHHS breastfeeding promotions for August 2023.

The Coordination Team has increased training of community health workers in the Healthy Beginnings program through allowing participation in the WIC Program's 30-hour standardized breastfeeding training for WIC Peer Counselors. Additionally, this training requirement has been added to the RFA of the Infant Mortality Reduction program. In FY21, the WICWS hired a RDN to fill their Section's Nutrition Program Consultant position. The person in this position provides clinical nutrition consultation to the Section and establishes nutrition standards for the management of women's health before, during and after pregnancy. The person in this position also serves on the DPH/DCFW Breastfeeding Coordination Team.

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 the implementation activities that reduce the barriers of breast/chest and human milk feeding success.

WIC Breastfeeding Peer Counselor Program

In FY23, the NC WIC Program undertook significant changes to enhance breastfeeding support infrastructure, notably impacted by the COVID-19 pandemic. The program revised its approach by replacing the Regional Lactation Training Centers with the Lactation Area Training Center for Health (LATCH). This initiative is specifically designed to bridge the gap between local WIC agencies, often located within LHDs, and external partners, particularly healthcare providers. LATCH focuses on orientation, continuing education for public health agency staff and healthcare providers, and coordinating partnerships between public and private providers who deliver lactation services to the same population.

The NC WIC Program, operated through CNSS, continues its federally mandated role to provide comprehensive breastfeeding promotion and support. This includes anticipatory guidance, counseling, educational materials on breastfeeding, a greater variety and quantity of foods for breastfeeding dyads, extended program participation for breastfeeding mothers, access to breastfeeding aids like breast pumps, and comprehensive training for all staff in breastfeeding promotion and support. The program reported a notable increase in breastfeeding initiation among participants, with rates rising to 77.9%—a 4.4% increase from the previous year's rate of 74.6%.

To monitor the Breastfeeding National Performance Measure, ESM BF.1 (the number of eligible WIC participants who receive breastfeeding peer counselor services) was chosen. Since the availability of BFPC Program funds to

local agencies in 2005, the program has expanded from four local WIC agencies to 85 of 86 agencies accepting BFPC funds. In FY19, Peer Counselors served 27,587 pregnant and breastfeeding participants, although over 52,000 clients were eligible for these services. A goal was set in 2020 to increase this number by 15% by 2025. However, the onset of the COVID-19 pandemic led to a decline in BFPC program participation, with an 11% decrease in FY21 compared to FY19. FY22 marked a year of rebuilding, with 22,599 participants receiving BFPC services, indicating stabilization and a slight increase from SFY21. In FY23, Peer Counselors served 22,987 clients, thus holding steady.

The pandemic disrupted the referral process for WIC participants to enroll in the BFPC program. As the program relies heavily on referrals for initiating services, Peer Counselors had to adapt their recruitment practices without in-person services. In FY23, the NC WIC Program focused on technical assistance for the implementation of a standardized referral structure for each NC WIC Program through training and implementation within the WIC Program's State Program Manual. This facilitated the program's rebuilding and enabled more effective referral processes. The BFPC program remains one of the most effective interventions for promoting the initiation and continuation of breastfeeding.

Breastfeeding Friendly Designations

NCDHHS developed the first state designation to recognize incremental implementation of the World Health Organization’s Ten Steps to Successful Breastfeeding through the NC Maternity Center Breastfeeding Friendly Designation (NC MCBFD). This program, led DCFW, awards maternity centers one star for every two steps implemented. Since its inception, 75% of North Carolina’s hospitals providing obstetric services have been awarded the designation at various levels. Currently, 28 hospitals have been awarded one or more stars, and ten of these hospitals have achieved the Baby-Friendly designation by Baby-Friendly USA for the successful implementation of all *Ten Steps to Successful Breastfeeding*. The continued uptake and recognition of the program result from collaborative partnerships that elevate the program as an infant mortality initiative and provide technical assistance for quality improvement in breastfeeding support. However, the application has not been updated to align with the World Health Organization’s updated steps from 2018. While strides were made in FY23, and an original draft was created, the draft requires further review and support before it can be advanced for approval and implementation. A revised deadline for FY25 implementation appears more likely. The application update would greatly benefit from greater administrative support and awareness, which would help elevate its prioritization.

In FY22, NCDHHS released the updated NC Breastfeeding Friendly Child Care Designation application which was originally implemented in January 2015. The designation provides strategic actions for the implementation of the Ten Steps to a Breastfeeding Friendly Child Care developed by the Carolina Global Breastfeeding Institute. The emphasis on this designation is to increase the continuum of breastfeeding support when families reenter the workforce during the postpartum period. The application was revised to transition from an incremental designation to a requirement for the implementation of all Ten Steps to a Breastfeeding Friendly Child Care. DCFW/CNSS staff members collaborate with the NC Child Care Resource and Referral Council and Child Care Health Consultants (CCHCs) to provide resources, training, and technical assistance for implementing the five standards. Additionally, the PNC and CCHCs help promote the NC Breastfeeding Friendly Child Care Designation. During FY23, six new childcare centers were designated as NC Breastfeeding-Friendly Child Care center for the implementation of all Ten Steps to a Breastfeeding Friendly Child Care for a total of 10 childcare centers.

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, chestfeeding and human milk feeding support practices for pregnant and/or postpartum people, 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 FY23 a total of eight LHDs have received the award, and during 2023 one of the eight were awarded (Swain County Health Department).

Other Breastfeeding Activities

During FY23, the PNC, in partnership with the DPH/DCFW Breastfeeding Coordination Team members, contributed to efforts to enhance breastfeeding resources and practices statewide such as the following:

- In August 2022 the PNC in DCFW co-planned and presented with two other colleagues from DPH (WICSS Nutrition Consultant and WICWS Maternal Health Innovation Program Coordinator) a webinar titled *Inclusive Lactation Support for LGBTQ+ Families*. It was presented live and recorded. It is available here: https://wicws.dph.ncdhhs.gov/provpart/training.htm under the heading *Maternal Health Non-Required Trainings*. The objectives of the webinar (based on a successful implementation of a similar training for staff in WICWS) were to help participants 1) learn about providing more inclusive lactation support for LGBTQ+ families in NC; 2) to examine personal biases about breastfeeding; 3) to understand the importance of inclusive language in lactation care; 4) and to identify ways to use more inclusive language in culturally appropriate patient care and healthcare promotion. The team worked with the Public Health Nursing Institute for Continuing Excellence to secure 1.25 Nursing Continuing Professional Development (NCPD) contact hours and Recertification Credits upon completion. There were 104 people who attended the webinar which had a high evaluation completion rate (82%) with overall excellent evaluation results. Ninety-five percent of survey respondents strongly agreed or agreed that Objective 1 of the webinar was fulfilled. The two greatest competency areas that respondents felt improved as a result of this activity included: 1) Cultural Competency Skills (83%); and Communication Skills (77%). Over 90% strongly agreed or agreed that the activity was evidence-based and balanced; presented in an impartial and unbiased manner; content (including graphics, language, etc.) included voices and perspectives that were diverse and inclusive. All three speakers rated ~4.7 (strongly agree).
- In January 2023, these same three speakers were invited to provide this same training to MIECHV home visitors and for this presentation were able to identify a person who identified as lesbian who spoke of their

prenatal and breastfeeding experience. That live training (which also included a presentation on Medicaid Managed Care) was also generally well received. Twenty-two site staff attended the training, and 13 online meeting evaluations were completed. Because overall evaluations included both presentations, that data is not shared. Some general positive comments about the breast/chest feeding portion included "new perspective I had not considered during breastfeeding/LGBTQ+ presentation/having a firsthand account of a family who has had this experience was particularly engaging."

In FY23, the PNC also continued to integrate breastfeeding education, family engagement, and Life Course Nutrition into the Child Health program through trainings conducted as part of the Child Health Enhanced Role Registered Nurses (CHERRN) course and through other Child Health programs, including work with programs that specifically target CYSHCN. This included ensuring more inclusive breast, chest and human milk feeding language was used in trainings.

NC DPH uses CDC Preventive Health and Health Services (PHHS) Block Grant funding to administer the Healthy Communities Program through the CDIS. The aim of this program is to reduce the burden of chronic disease and injury in North Carolina. Funding goes out through the LHD AA process (886 Healthy Communities). As part of this AA, LHD's can choose from a variety of evidence-based and promising strategies focused on policy, systems, and environmental change. Many of these strategies are supportive of MCHBG priorities including breastfeeding-friendly facilities, opportunities for physical activity, policies and guidelines promoting healthier food options, promoting tobacco-free facilities and programs, and promoting evidence-based injury and violence prevention in communities. In FY23, the Healthy Communities program (in CDIS) reported that Amerihealth and Martin-Tyrell-Washington District Health Department received Breastfeeding-Friendly Employer Awards and Montgomery County Schools and North Asheville Famers Market were awarded Breastfeeding-Friendly Community Partner Awards.

In FY19, the CDIS's Community and Clinical Connections for Prevention and Health (CCCPH) Branch received a five-year competitive CDC State Physical Activity and Nutrition (SPAN) Grant. CCCPH's Physical Activity and Nutrition (PAN) Connections Initiative supports state and local efforts to address physical activity and nutrition, specifically focusing on the following strategies:

- Food Service Guidelines
- Interventions Supportive of Breastfeeding
- Activity-Friendly Routes to Connect Everyday Destinations
- Early Care and Education Nutrition and Physical Activity Standards

The PNC from the NC Title V Program and CDIS staff work together to coordinate and share information across programs to help focus TA and training, reduce duplication of effort, and increase outcomes. As part of their SPAN funding, CCCPH created a brand new, breastfeeding resources webpage (www.BreastfeedNC.com) and the PNC (plus staff from WIC and WICSS with breastfeeding expertise) provided TA and resources to CCCPH staff as they were building and launching the site and also helped promote the site.

Additional Breastfeeding Efforts by Infant Mortality Reduction Programs/Initiatives

In FY23, 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 FY23, and 69.8% of postpartum program participants initiated breastfeeding, while 27% were breastfeeding for 6 months or longer. All existing and newly hired Healthy Beginnings program staff received WIC Breastfeeding Peer Counselor Core training. In FY23, 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 FY23, the NC BLP program enrolled 81 women in the interconception period. Any eligible pregnant individual was also referred to WIC for services and for breastfeeding assistance if they were not enrolled in WIC services. During FY23, NC BLP participants were breastfeeding at a rate of 60.5 % at discharge (an increase from FY22); however, the rate plummeted to 18.5% (an increase from 11.1% in FY22) at 6 months. 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 FY23, 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 and the Sandhills Collaborative are implementing the Breastfeeding-Friendly City program, Mecklenburg-Union Collaborative is implementing the Patient Decision Aid program, and Wake County Human Services is establishing public lactation rooms.

In FY23, Durham County hosted 23 outreach and education events, reaching 590 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 created a survey sent to organizations to assess their interest in becoming a breastfeeding friendly business. By the end of FY23, twelve businesses have partnered to receive the designation.
Mecklenburg-Union Collaborative hosted 5 outreach events with 3 dedicated to creating a space for families to learn from peers, share their journeys, learn about human milk and consult with a lactation professional. In addition, Mecklenburg reached more than 20 businesses using the Making It Work toolkit and finalized a lactation renovation project with 25 locations, guiding by the work of the Community Health Worker.

Sandhills Collaborative collaborated with 13 new partners and held 189 outreach events reaching over 10,000 people in FY23. At the start of FY23, they had implemented 66 public lactation spaces and revisited those sites to monitor them for any resource needs with the help of their Community Health Worker. Sandhills Collaborative is pursuing new public lactation spaces in childcare centers, building relationships with federal buildings and partnering with a local Walmart to provide space.

Wake County created a new public lactation space at their new Departure Drive location. This space is solely dedicated to the public. Wake County ordered and secured all furniture and supplies for 5 rooms and will be opening them after the initial kick-off ribbon cutting event where they will work to re-energize the Community Action Team and other community partners.

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 FY22, 28.8% of MIECHV participants reported any breastfeeding at 6 months of age, while non-MIECHV NFP sites were at 32.3%. In FY23, 25.9% of MIECHV participants reported any breastfeeding at 6 months of age, while non-MIECHV NFP sites were at 39.7%.

Both NFP and HFA programs practiced numerous strategies to promote breastfeeding during FY23. 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.

Additional Strategies to Increase Breastfeeding Rates

The Office of Rural Health and the NC CHW Association play complementary roles in the NC CHW initiative. NC CHWs currently hold both formal and informal roles within the healthcare system. NC's program officially launched in 2018 after four years of stakeholder meetings, surveys, listening sessions, and a summit. In spring 2021, the NC CHW Initiative began offering coursework at educational institutions in the NC Community College System which provides individuals with the required knowledge, tools, and resources to become recognized as a certified CHW in NC. The curriculum was specifically designed to cover the nine core competencies recommended by the NC CHW Initiative stakeholders, including communication, capacity building, service coordination, interpersonal advocacy, outreach, and personal/professional skills.

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 2022, this percentage decreased to 4.5%. Hispanic women (.8%) and NH Asian women (.4%) were least likely to smoke during pregnancy, and NH American Indian women were most likely to smoke (14.6%) in 2022. NH Black women (4.4%) were less likely to smoke than NH White women (5.8%) and NH multi-race women (6.2%). 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 260 pregnant women during FY23. Of those pregnant, 81.54% reported abstaining from tobacco during pregnancy, with 94.66% 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. These approaches have been effective for not only the pregnant participants, but preconception and interconception participants as well, with an abstention rate of 812%.

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 FY23, 5.4% of program participants who enrolled pregnant reported smoking during pregnancy.

In FY23, the Infant Mortality Reduction program had three local health departments implement the tobacco cessation and prevention evidence-based strategy. A total of four local health department staff were trained as Certified Tobacco Treatment Specialists and provided tobacco cessation counseling services to a total of 94 clients (86% female). Sixty-five percent of the total clients served were of reproductive age, between 15 and 44 years of age.

Since tobacco use during pregnancy is a driving factor for preterm birth and low birth weight, CMHRP Care Managers continue to employ interventions to assist pregnant persons with tobacco cessation. All pregnant and postpartum individuals 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 care managers. This pathway is a resource developed in collaboration with UNC Collaborative for Maternal & Infant Health and the You Quit, Two Quit initiative and was updated during FY 22-23, 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 care managers and patients continued to be a resource for CMHRP Care Managers. Care managers 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 FY23.

During FY23, the WICWS and DCFW/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.

**Perinatal/Infant Health - Application Year**

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

Priorities, strategies, and measures for this domain have been reviewed, and there are minimal updates for FY25. One way of improving access to high quality integrated health care services is to ensure that infants and mothers are receiving care in a risk-appropriate level of care facility. In FY25, the Perinatal Nurse Champions will promote the development and implementation of collaborative systems within their respective perinatal care regions that promote the proactive integration of risk-appropriate antepartum, intrapartum, and postpartum care, which includes completing the CDC LOCATe℠ with birthing facilities in each region that have not been assessed within the last two years. The Perinatal Nurse Champions will utilize regional data to make recommended improvements to the system of risk-appropriate maternal and neonatal care.

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

One of the priority strategies of the PHSP is to adopt updated neonatal levels of care and develop maternal levels of care. Collaboration will continue within DHHS (DPH and DHSR) along with NC OB GYN Society, NC Pediatric Society, NC Healthcare Association, NCIOM, and individuals with lived experience will continue in order to finalize recommendations, draft language, and focus on fiscal impact related to levels of care.

Providing Behavioral Health Support to Maternal Health Providers

In FY25, the MATTERS program will launch the NC MATTERS Fellows program for 30 perinatal providers who care for pregnant, postpartum women, and new parent patients across the six perinatal care regions. The Fellows program is an intensive 6-month educational and technical assistance program and will introduce providers to topics related to screening, referral, and management of maternal mental health and substance use disorders through skills building, peer learning, and leadership development as well as how to incorporate the services of NC PAL into their practice. The Fellows will meet virtually once a month and attend an in-person one day workshop in August 2024. A second cohort of Fellows will be recruited in Spring 2025.

NC MATTERS will host at least three Stakeholders Group meetings in FY25. The NC MATTERS Stakeholders Group is representative of perinatal providers from across NC with an interest in advancing services addressing maternal mental health and substance use disorders. The Stakeholders Group will provide guidance and feedback to the NC MATTERS program to ensure that the program efforts are relevant and appropriate for what the perinatal providers need in their practice.

In FY25, the MHB LCSW will provide maternal mental health and substance use disorders education and support by convening a Community of Practice. The Community of Practice will provide opportunities for LHD staff to discuss ways to learn, improve, or address issues related to maternal mental health and substance use disorders.

The MHB LCSW will also aim to coordinate training with LME/MCOs on mental health treatment considerations for the perinatal population. To strengthen the relationship with LMEs related to WICWS programs, the MHB LCSW will work with LME/MCOs and LHDs to consider opportunities for LHDs to contract with LME/MCOs to provide behavioral health services, such as outpatient psychotherapy, as well as to facilitate opportunities for educating LHDs, as needed, on how to access resources through or make appropriate referrals to the LME/MCO.

The NC MATTERS program will collaborate with the NCDHHS Office of Communications to develop a media campaign for the National Maternal Mental Health Hotline. The purpose of the media campaign will be to increase

awareness of the national hotline among pregnant and postpartum individuals in North Carolina. The NCDHHS Office of Communications will incorporate the outreach and marketing products developed by the National Postpartum Support International and National Maternal Mental Health Hotline. The media plan will also include the development of additional Maternal Mental Health/Substance Use Disorders (MMH/SUD) messages to educate pregnant or postpartum women and their families about MMH/SUD, with an aim to reduce the stigma of seeking care. These additional media products will be used on various social media platforms.

In FY25, educational opportunities will be developed based on needs identified during monitoring visits or technical assistance requests. The nurse consultants will ensure that the local agencies are collaborating with the CMHRP team to meet the needs of clients who have behavioral health concerns based on the pregnancy risk screening tool or assessments. The WICWS nurse consultants will provide TA to help local agencies integrate behavioral health tools into the electronic medical record as well as determine whether to incorporate Health Behavior Intervention Services.

The WICWS RSWCs will provide support to the CMHRP Care Managers on topics related to behavioral and mental health issues by developing an in-depth training on the newly implemented CMHRP Maternal Mental Health Pathway which provides education on for Perinatal Mood Disorders and guidance on best-practice screening and follow-up This Pathway guides care managers in providing the most current, best practice interventions for patients identified with any level or type of perinatal mood disorder and the subsequent training provided will ensure that CMHRP care managers understand potential mental health issues and have the resources they need to appropriately screen and refer to applicable resources as well as follow up. Care management interventions from this Pathway will be highlighted in the monthly CMHRP program update. CMHRP Care Managers will be trained on various resources available through Postpartum Support International, which hosts the National Maternal Mental Health Hotline, and NC MATTERS, which incorporates NC-PAL, for providers. The CMHRP Program plans to partner with WICWS Matters staff members and the WICWS State LCSW to provide on-going mental health training to CMHRP Care Managers throughout the year.

Perinatal Oral Health

The Perinatal Oral Health Program will continue to offer perinatal oral health educational training to medical providers, dental providers and pregnancy support service professionals during FY25. The following items are included in the Program's FY25 Action Plan:

- Program expansion to include pregnant individuals as a target audience.
- Develop and strengthen relationships with internal and external stakeholders (CMHRP, WIC).
- Medical Dental Educational Integration

Newborn Screening Follow-Up Team

In FY25, the 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 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 FY25 (Mucopolysaccharidosis Type II [MPS II] and Guanidinoacetate N-Methyltransferase [GAMT]).

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

FY25 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 equity.

The team at UNC will continue to provide clinical genetic services, genetic counseling services, and genetic testing for approximately 2500 unduplicated patients in FY25. 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 the NCDHHS. 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. The NBS Follow-Up Team at DCFW will provide initial notification abnormal Pompe disease results to the follow-up team at Duke and will work in conjunction with Duke to provide follow-up services to these infants. Duke will continue to provide expertise and consultation to the SLPH related to Pompe disease screening and follow-up care for infants identified through NBS.

The NCBDMP will continue to work with the NC Healthcare Association and other partners to improve reporting of CCHD data into the statewide WCSWeb database by birthing hospitals, free-standing birthing centers, and other health care providers attending deliveries of newborns. NCBDMP staff will also continue to review screening results for case-finding, to compare results with cases identified within the registry to determine false positive and false negative results, and to link screening results with the registry to determine timing and method of diagnosis. DCFW/WCHS EHDI consultants will do outreach with staff while working with birthing hospitals about the CCHD reporting requirements. EHDI staff will continue to disseminate the prenatal information sheet, *North Carolina's Newborn Screening Program*, to help with increasing awareness about several newborn screenings.

The EHDI program will continue its activities in FY25. 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 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 D/HH children across the state to improve early identification and quality intervention through the Spanish bilingual parent consultant and the continuation of the Parent Support Team. The EHDI program will finalize and distribute an updated on-line Residency Training Module to educate medical residents on EHDI 1-3-6 goals. The EHDI program was awarded a new five-year cycle for Funding Opportunity HRSA-24-036 in March 2024. During FY25, the program will conduct a needs assessment regarding our state's infrastructure to coordinate services across the statewide EHDI system for DHH children to improve language acquisition outcomes. Areas to be assessed include, but are not limited to: 1) increasing data capacity and interoperability of data systems; 2) improving training and educating health care and other services providers; 3) building partnerships with other EHDI stakeholder organizations and entities that focus on early intervention; and 4) strengthening mechanisms to engage families, including those traditionally underserved by EHDI, in DHH adult-to-family supports and services.

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

Work to reduce the infant mortality disparity ratio, which is the underlying framework of the PHSP, will continue in FY25 through a variety of methods. The PHSP's adapted framework is designed to focus on equity and social determinants of health to address infant mortality, maternal health, and the health status of individuals of reproductive age. Upcoming PHEC meetings will include increased opportunities for collaborative partners to share their efforts in

implementing the PHSP.

In addition, work to support the NC CFTF will continue. Specific priorities for FY25 will be established later this year, but they will likely include continuing to work on legislation to allow Medicaid reimbursement of doula services and legislation supporting Fetal and Infant Mortality Reviews (FIMR), along with paid family leave, youth suicide prevention, firearm safety, nicotine use prevention, and motor vehicle safety.

The WICWS will host a virtual Safe Sleep Summit in October 2024 in observance of Safe Sleep and Sudden Infant Death Syndrome month. The Summit will feature presentations and research on safe sleep interventions, current and new Safe Sleep efforts in NC. The Summit will convene safe sleep advocates from hospitals, childcare centers, LHDs, community health centers, and community-based organizations to discuss how NC can continue to promote safe sleep environments and resources to support birthing families.

Infant Mortality Reduction Programs/Initiatives

In FY25, Healthy Beginnings expects to serve a minimum of 400 minority women during pregnancy, the postpartum period, and up to two years interconceptionally as described in the PIH Domain Annual Report. Healthy Beginnings will provide monthly care coordination services to all program participants to help improve birth outcomes.
The two Healthy Start sites-NC BLP and Southeastern NC Healthy Start (SENCHS) programs will continue to provide the services described earlier in the PIH Domain Annual Report, and the programs will continue its enhanced focus on mental health, breastfeeding, co-parenting, and improving self-sufficiency for FY25. NC BLP will continue to participate in community events and outreach where permitted and appropriate to increase awareness of enrollment in program services.

In FY25, five ICO4MCH sites representing nine counties will continue implementation of six evidence-based strategies (EBSs) to improve maternal health and infant birth outcomes. The strategies include reproductive life planning and improving preconception and interconception health. Other strategies include 10 Successful Steps for Breastfeeding (with specific focus on Steps 3 and 10), tobacco cessation and prevention, Triple P and Family Connects newborn home visiting.

In FY25, the RIMC program will implement EBSs that are proven to be an effective means to improve birth outcomes through addressing pregnancy intendedness, preterm birth, and/or infant mortality. At least 50% of all program participants served will represent a minority population under each of the following EBSs: Breastfeeding Support Services, Centering Pregnancy, Doula Services, Infant Safe Sleep Services, and Preconception and Interconception Health Services. LHDs are required to incorporate partnerships with community-based organizations to help implement their chosen evidence-based strategies and reach individuals not being served at the LHD.

Strategic Plans Prioritizing Breast/Chest and Human Milk Feeding

As reported in the PIH Annual Report, multiple state strategic plans in NC have prioritized breast/chest and human milk feeding objectives, strategies, and action. Work to propel those plans forward will continue in FY25 under the leadership of the NC DPH/DCFW Breastfeeding Coordination Team.

WIC Breastfeeding Peer Counseling Program

The COVID-19 pandemic necessitated a shift in the structure of the WIC BFPC Program. While the model for providing prenatal and postpartum support to participants remained sustainable within pandemic safety protocols,

there was a significant disruption in the recruitment of participants for the BFPC program. Recruitment was predominantly dependent on local WIC agencies through education by nutritionists or interactions with peer counselors during WIC certification appointments. During the pandemic, the adaptations made were considered temporary, which resulted in a lack of a long-term strategy for maintaining WIC participant enrollment in the BFPC program. This disruption in referrals extended beyond internal referral mechanisms to include external partners. The WIC LATCH aims to support local WIC agencies by evaluating their internal and external processes to enhance program enrollment, which has declined due to the pandemic. Establishing and maintaining referral processes that foster collaborative partnerships is a time-intensive endeavor that WIC LATCH will continue to work with each local WIC agency during FY25. Moreover, the BFPC program demands substantial effort in managing and tracking participant enrollment, necessary contacts, and completed interactions. This administrative workload detracts from efforts directly aimed at achieving the program's goal of increasing breastfeeding rates. Consequently, for FY25, the NCDHHS aims to pursue updates to the management information system to alleviate the administrative burdens associated with the program.

Regional Lactation Training Centers

During FY25, the first grant cycle of the LATCH will be completed. This process will include an analysis to determine whether the grant deliverables achieved the desired outcomes, as well as the drafting, posting, and awarding of the subsequent grant period. The current organization, Eastern AHEC, is contracted through 2025 and will continue to fulfill its deliverables, including assisting with lactation orientation and continuing education training for our WIC Program staff. Additionally, it will work to strengthen connections between public health and private providers to improve continuity of care within the policies, systems, and environments in which WIC families operate. Furthermore, LATCH provides community continuing education sessions to medical providers to ensure consistent messaging about breastfeeding, which supports the primary goal of continuity in lactation support services for families.

Breastfeeding Friendly Designations

Competing priorities due to short staffing and the implementation of the multi-tiered training curriculum have previously delayed activities related to Breastfeeding Friendly Designations. Despite these challenges, it remains essential that the NC Maternity Center Breastfeeding Friendly Designation reflects the current guidance from the WHO and CDC. Therefore, updating the NC Maternity Center Breastfeeding Friendly Hospital Designation application to align with the WHO's updated Ten Steps to Successful Breastfeeding and the revised Baby-Friendly, USA guideline evaluation criteria remains a goal for DCFW/CNSS for FY25. CNSS will coordinate the endorsement of the application with the NC Healthcare Association, NC Pediatric Society, NC Child Fatality Task Force, NCIOM, and other relevant professional organizations. Additionally, in FY25, DCFW/CNSS will collaborate with CCHCs and other childcare partners to develop a Making It Work tool specific to early care and education settings. Following its development, complementary trainings and the implementation of the NC Breastfeeding Friendly Child Care Designations will be prioritized.

Additional Breastfeeding Efforts by Infant Mortality Reduction Programs/Initiatives

Plans are underway to establish a 24/7 statewide Breastfeeding Hotline. Funds have recently been approved through Medicaid under CHIP authority. The RFP is being reviewed for approval and release. The goal is to have the Breastfeeding Hotline in place during FY25.

The RIMC program will provide Breastfeeding Support Services in four LHDs. In FY25, each LHD will provide prenatal and postpartum breastfeeding support services to at least 25 unduplicated individuals and provide Ready,

Set, BABY education to at least 60 unduplicated pregnant individuals. Breastfeeding Support Services program staff received WIC Breastfeeding Peer Counselor Core training by the DCFW/CNSS, and Ready, Set, BABY training by the Carolina Global Breastfeeding Institute. In FY25, each LHD will conduct community education and advocacy work to increase the number of employers with breastfeeding-friendly policies and establish at least two new breastfeeding-friendly community spaces or workplaces/employers.

The Healthy Beginnings program will provide breastfeeding education and support to all pregnant and postpartum/interconception program participants. At least 35% of interconception program participants will initiate breastfeeding and maintain for at least six months. All Healthy Beginnings program staff received WIC Breastfeeding Peer Counselor Core training. In FY25, all breastfeeding program participants will receive monthly breastfeeding assessments and support to maintain breastfeeding for six months or longer.

To increase the percentage of participants who breastfeed in FY25, the NC BLP staff will maintain their relationships with WIC Breastfeeding Peer Educators within each health department. BLP staff will increase efforts to make early referrals to breastfeeding peer educators to strengthen the bond with participants prenatally. The goal of these efforts is to strengthen the connection during the prenatal period and build a network of support during the postpartum period. Familial support continues to be a critical component of breastfeeding initiation and impacts duration. Representatives of the NC BLP program will continue their participation in the Community Consortium (formerly known as Local Action Networks (LANs)) to elevate the community's responsibility in supporting breastfeeding families. The Community Consortium will continue implementation of action plans to promote schools and businesses adopting policies to support breastfeeding families. Staff at the newly funded SENCHS site will engage in similar efforts to establish relationships and referral networks in the two-county rural catchment area so that client referrals can be made smoothly. SENCHS staff will receive training emphasizing the importance and benefits of breastfeeding at least once annually.

ICO4MCH grantees will continue their focus on Steps 3 and 10 of the Ten Steps for Successful Breastfeeding. FY25 strategies for ICO4MCH continue to include: 1) provide education, consultation, and information to businesses/work to utilize resources for increasing breastfeeding-friendly businesses/work sites, such as, *Making It Work* Toolkit and the *Businesses Leading the Way; 2)* collaborate with communities in their services areas to increase the support for the breastfeeding family through the implementation of the Breastfeeding Friendly City Program; and 3) implement shared decision-making tools to assist patients to contemplate options, gather additional information, consult with provider and family to make an informed decision to breastfeed. During FY25, ICO4MCH projects will also continue their work with LHDs to establish public lactation rooms.

The MIECHV and non-MIECHV (NFP and HFA evidence-based models) Programs will continue to implement HFA and NFP models in NC in FY25 and support their ongoing strategies to promote breastfeeding. 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. 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. Breastfeeding educational materials are provided to families, and there are ongoing trainings for home visitors throughout each year.

The SCCNC will partner with the Carolina Global Breastfeeding Institute and the NC CCHSRC to offer Breastfeeding Friendly Child Care train the trainer opportunities to CCHCs and Birth-to-Three Specialists across the state to increase the number of trainers advocating, supporting, and promoting breastfeeding in child care settings.

Additional Strategies to Increase Breastfeeding Rates

Additional strategies to increase breastfeeding rates in FY25 include:

- Continuation of the DPH/DCFW Breastfeeding Coordination Team. This 20+ multidisciplinary team will meet on a quarterly basis (July, October, January, and April) and small workgroups will be formed to work on specific projects that may benefit the whole team. The PNC will continue to schedule those and work with volunteer meeting facilitators from the team to plan the agendas, etc.
- Supporting the work of LHDs who are working toward or awarded the NC Breastfeeding Coalition's Family Friendly (Breastfeeding) Clinic Award for outpatient healthcare clinics. This is primarily accomplished through the Child Health Agreement Addenda 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, TA, and coordination with the DPH/DCFW Breastfeeding Coordination Team will help to increase the total number of LHDs and other partners receiving this award.
- Training provided by the PNC and/or in coordination with DPH/DCFW Breastfeeding Coordination Team members for programs administered through DCFW and DPH. As interest and need is determined, additional trainings will be developed, administered, and evaluated.
- Working with the Office of Rural Health and the many partners involved in CHW training, explore if breast/chest/human milk-feeding information (and as feasible, food insecurity and other important nutrition topics) can be included in the training or contribute to specialization training for CHWs to increase their breast, chest and human milk feeding knowledge, skills and support.
- In FY25, the PNC and other members of the Breastfeeding Coordination Team will continue work with the NC Office of State Personnel to provide training and resources for state employees and HR personnel about the updated OSHR Lactation Policy. Proposed objectives to the training and resources include increasing knowledge of the policy, identifying the benefits to employers and lactating state employees, and identifying ways to implement the requirements of the policy for state employees. Some focus of this training will be to share information about the *NC Making It Work* toolkit and resources and to share additional resources like the www.BreastfeedNC.com site.
- Continuing dissemination and use of the *NC Making It Work* toolkit, including promotion of the *North Carolina Worksite Breastfeeding Support in Action Webinar* to help breastfeeding mothers return to work. Given the recent legislative actions in support of breastfeeding, the team is also in the beginning stages of reviewing the toolkit for updates to ensure the most relevant information is included.
- As noted above, work by DCFW to create an early childhood education specific *Making It Work* tool will be incorporated into the other *Making It Work* tools and promoted by the DPH/DCFW Breastfeeding Coordination team when available.

The Community and Clinical Connections for Prevention & Health Branch (CCCPH) was awarded funds through the Physical Activity and Nutrition (SPAN) grant from the CDC to implement a four-year phased plan to increase equitable access to human donor milk across NC. In FY25, the WICWS State Nutrition Consultant will work closely with the CCCPH team and the Wake Med Mothers' Milk Bank to implement this project. During FY25, it is planned to expand the presence of donor milk dispensaries in designated pilot counties. The pilot counties include Cumberland, Durham, Jackson, Mecklenburg, and Pasquotank. In the pilot counties, outpatient dispensaries will be established to ensure equitable access to donor milk resources.

The SCCNC will continue to participate in the DPH/DCFW Breastfeeding Coordination Team in FY25 to represent early educators and children in child care settings. Additionally, the Consultant will partner with the Carolina Global Breastfeeding Institute and the NC Child Care Health and Safety Resource Center to offer Breastfeeding Friendly

Child Care train the trainer opportunities to CCHCs and Birth-to-Three Specialists across the state to increase the number of trainers advocating, supporting, and promoting breastfeeding in the child care settings.

Prenatal Tobacco Cessation Activities

Interventions by the CMHRP Care Managers to assist pregnant persons described in the PIH Annual Report will continue in FY25. The Tobacco Cessation Pathway, updated in partnership with You Quit, Two Quit/UNC CMIH, will continue to be utilized by CMHRP Care Managers to ensure the most current best practice, evidenced based information is available. WICWS Regional Social Work Consultants will look for ways to partner with Medicaid Managed Care Pre-paid Health plans on tobacco cessation efforts for pregnant people. Care manager training will be provided on the linkage between low-birth weight and preterm birth and tobacco usage.

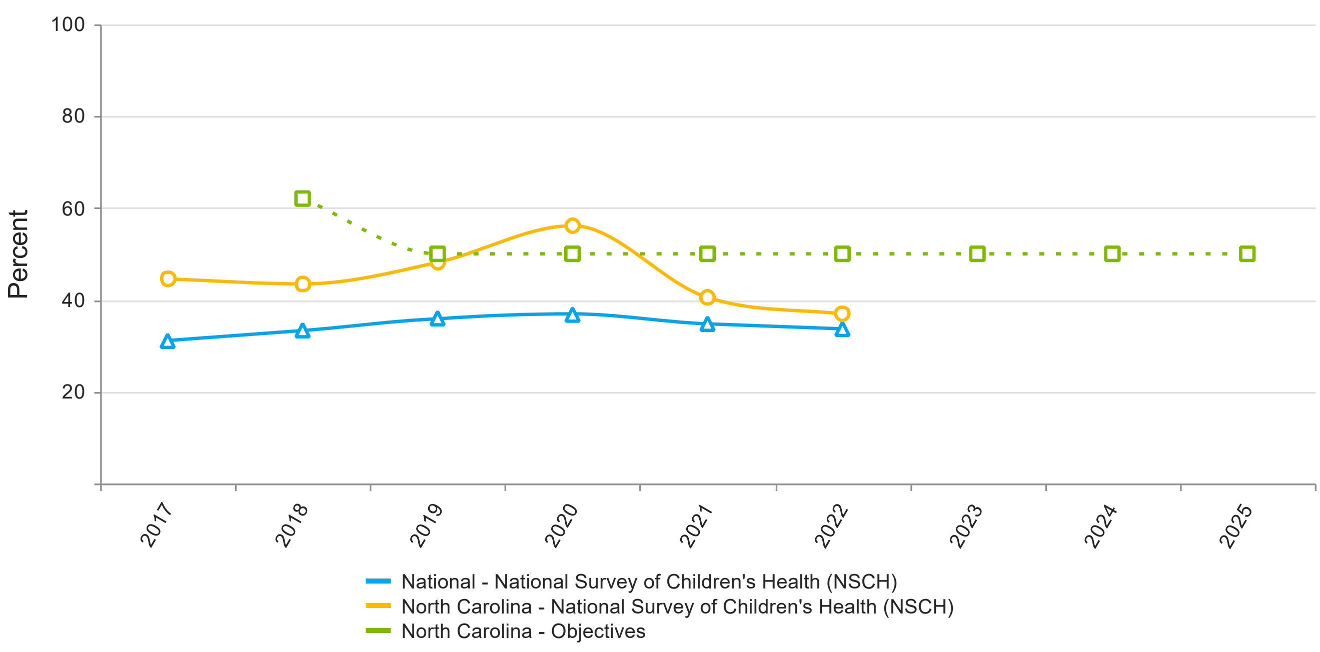
All Healthy Beginnings program staff are trained to provide evidence-based tobacco use screening and cessation counseling using the 5 A's (Ask, Advise, Assess, Assist, Arrange) evidence-based intervention. In FY25, a minimum of 400 program participants will receive education and monthly tobacco use assessments and cessation counseling when needed during pregnancy and postpartum/interconception.

The PHW Program Manager will engage in the recruitment of prospective WATCH members in FY25. A brief survey will be developed and launched to assess member level of interest, determine availability and meeting frequency as well as identifying potential priority areas for WATCH to address. Also, a subset of WATCH members will be recruited to review the *Guide for Helping to Eliminate Tobacco Use and Exposure for Women* to determine a plan for utilization in the future. The ICHB will continue to collaborate with the Tobacco Prevention and Control Branch to conduct statewide trainings to address individual tobacco use along with broader community policy implications. At least two trainings will be arranged in collaboration with the UNC CMIH and other WATCH partner organizations and provided to WICWS and DCFW staff and contracted partners on the 5As of tobacco cessation, women's health, QuitlineNC, and e-cigarettes in FY25.

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 (Developmental Screening, Formerly NPM 6) - DS Indicators and Annual Objectives**




| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** |
| Annual Objective | 50 | 50 | 50 | 50 | 50 |
| Annual Indicator | 43.0 | 48.1 | 39.5 | 39.5 | 37.1 |
| Numerator | 112,720 | 119,658 | 94,883 | 94,883 | 92,922 |
| Denominator | 261,906 | 249,001 | 240,161 | 240,161 | 250,771 |
| Data Source | NSCH | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2017_2018 | 2018_2019 | 2020_2021 | 2020_2021 | 2021_2022 |

| Annual Objectives | | |
|---|---|---|
| | **2024** | **2025** |
| Annual Objective | 50.0 | 50.0 |

**Evidence-Based or –Informed Strategy Measures**

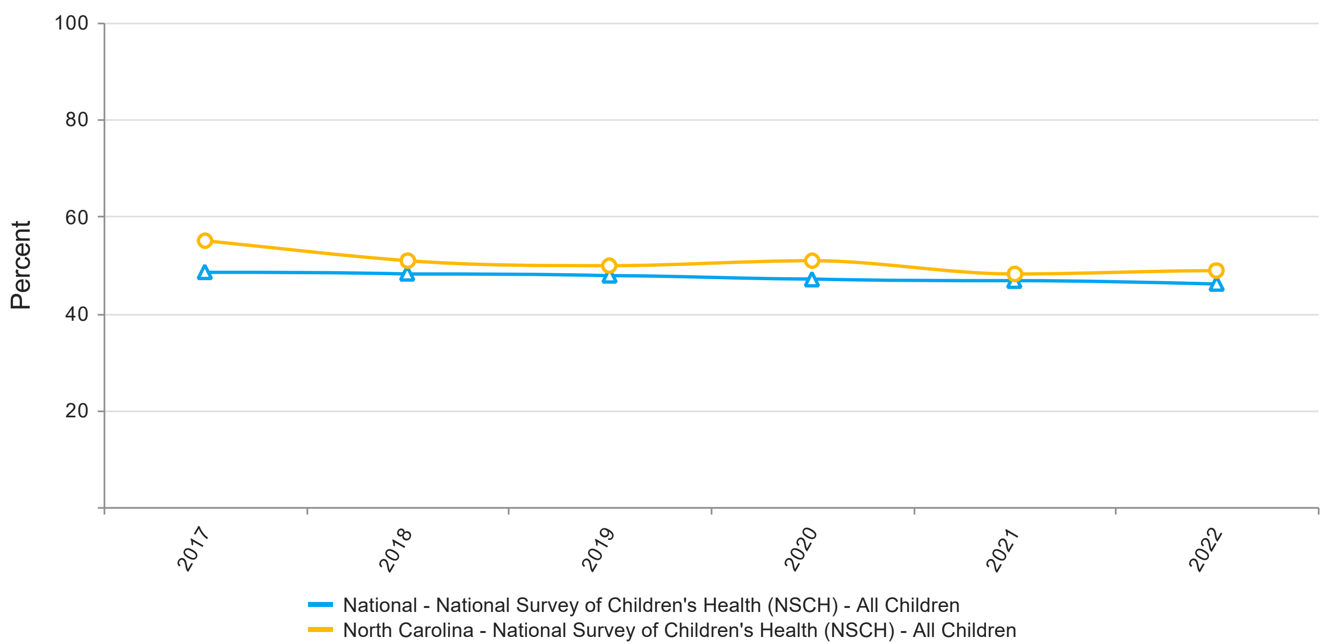
**ESM DS.1 - Percent of LHDs whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children during state fiscal year**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 80 | 85 | 90 |
| Annual Indicator | | 75 | 80.9 | 75.4 | 80 |
| Numerator | | 51 | 55 | 49 | 52 |
| Denominator | | 68 | 68 | 65 | 65 |
| Data Source | | 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 |
| Provisional or Final ? | | Final | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 95.0 | 100.0 |

**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH**
**Indicators and Annual Objectives**




**NPM MH - Child Health - All Children**

| Federally Available Data | |
|---|---|
| Data Source: National Survey of Children's Health (NSCH) - All Children | |
| | 2023 |
| Annual Objective | |
| Annual Indicator | 48.9 |
| Numerator | 1,120,042 |
| Denominator | 2,292,452 |
| Data Source | NSCH-All Children |
| Data Source Year | 2021_2022 |

**Evidence-Based or –Informed Strategy Measures**

**ESM MH.1 - Percent of children with special health care needs who received family-centered care**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 88.7 | 85 | 87 |
| Annual Indicator | 85 | | 80.8 | 80.3 | 84.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | 2018-19 NSCH | | 2019-20 NSCH | 2020-21 NSCH | 2021-22 NSCH |
| Data Source Year | 2018-19 | | 2019-20 | 2020-21 | 2021-22 |
| Provisional or Final ? | Final | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 90.0 | 90.0 |

**ESM MH.2 - 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: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 10 | 12 | 18 |
| Annual Indicator | | 8 | 9 | 17 | 13 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | 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 |
| Provisional or Final ? | | Final | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 15.0 | 16.0 |

## State Performance Measures

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

| Measure Status: | Active |
|---|---|

**State Provided Data**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 15 | 15 | 15 |
| Annual Indicator | 15.3 | | 16.6 | 17.8 | 18.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | 2018-19 NSCH | | 2019-20 NSCH | 2020-21 NSCH | 2021-22 NSCH |
| Data Source Year | 2018-19 | | 2019-20 | 2020-21 | 2021-22 |
| Provisional or Final ? | Final | | Final | Final | Final |

**Annual Objectives**

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 14.0 | 14.0 |

**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 | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 90 | 90 | 90 |
| Annual Indicator | 80.1 | | 75.9 | 76.5 | 72.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | 2017-19 National Immunization Survey | | 2018-20 National Immunization Survey | 2019-2021 National Immunization Survey | 2020-2022 National Immunization Survey |
| Data Source Year | 2019 | | 2020 | 2021 | 2022 |
| Provisional or Final ? | Final | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 90.0 | 90.0 |

**State Action Plan Table**

| State Action Plan Table (North Carolina) - Child Health - Entry 1 | |
|---|---|
| **Priority Need** | |
| Promote safe, stable, and nurturing relationships | |
| **NPM** | |
| NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS | |
| **Five-Year Objectives** | |
| CH 4A. By 2025, increase the percentage of children that are screened for developmental, psychosocial, and behavioral health concerns by 5% by year. | |
| **Strategies** | |
| CH 4A.1. Carry out the activities in the NC Essentials for Childhood Initiative, including those that overlap with the NC Early Childhood Action plan and Pathways for Grade Level Reading. | |
| CH 4A.2 DCFW/WCHS staff members will provide statewide trainings on developmental, psychosocial, and behavioral health screening, identification, management, and referral and other EPSDT services that impact children, youth, and their families to LHD child health clinical staff, child care providers (through CCHCs), CMARC providers, Innovative Approaches staff, Triple P trained providers, and private providers. | |
| **ESMs** | **Status** |
| 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 | Active |
| **NOMs** | |
| NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR | |
| NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS | |

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

### Priority Need

Promote safe, stable, and nurturing relationships

### NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

### Five-Year Objectives

CH 4C. By 2025, increase the percent of children having a medical home by 9% from 50% (NSCH 2017-18 baseline) to 54.5%.

### Strategies

4C.1. Provide education, training, and support to providers on delivering a medical home approach to care: 1) Collaborate with the NC Chapter of American Academy of Pediatrics to promote PCMH and educate and train providers; 2) CMARC care managers and Home Visitors will do outreach to primary care providers.

4C.2. Provide education, training, and support to families on medical home approach to care. Provide information and resources to families through a variety of methods including fact sheets, an enhanced website, CYSHCN Help Line, Family Partnership, and trainings.

| ESMs | Status |
|---|---|
| ESM MH.1 - Percent of children with special health care needs who received family-centered care | Active |
| ESM MH.2 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion | Active |

### NOMs

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

## State Action Plan Table (North Carolina) - Child Health - Entry 3

### Priority Need

Promote safe, stable, and nurturing relationships

### SPM

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

### Five-Year Objectives

CH 4B. By 2025, reduce the percentage of children with two or more Adverse Childhood Experiences to 14%.

### Strategies

CH 4B.1. Continue to support the Learn the Signs Act Early and Reach Out and Read campaign and resources among child care providers (through CCHCs), CMARC and MIECHV home visitors, Innovative Approaches, Triple P, and LHD child health clinical staff and private providers.

CH 4B.2. Administer Title V funding to be used to offer a variety of evidence-based and informed strategies for low-income families as part of the Child Health 351 Agreement Addenda – Attachment C, including but not limited to non-medical drivers of health such as language and literacy skills, firearm safety, and access to nutritious and physical activity opportunities.

CH 4B.3. 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 4B.4. Support and participate in several initiatives to align efforts, including, but not limited to, the following: Early Well; 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 4.B.5. Continue to collaborate with various external partners (including families) to improve safe, stable and nurturing environments for children, birth to 21 years including but not limited to Exceptional Children's Assistance Center; NC Partnership for Children; Positive Childhood Alliance NC; NC Child; NC Pediatric Society; NC Academy of Family Physicians; NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; NC Division of Social Services; NC Division of Child Development and Early Education; NC Department of Public Instructions; Child Fatality Task Force; NC Early Childhood Foundation, Prevent Blindness NC; and Commission on CSHCN.

## State Action Plan Table (North Carolina) - Child Health - Entry 4

### Priority Need

Improve immunization rates to prevent vaccine-preventable diseases

### SPM

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)

### Five-Year Objectives

CH 5A.1. By 2025, 90% of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4). (Baseline for 2018 NIS is 75.2%.)

CH 5A.2a. By 2025, 80% of adolescents aged 13-15 years will have received one or more doses of Tdap vaccine (2018 Baseline – 88.9%)

CH 5A.2b. By 2025, 80% of adolescents aged 13-15 years will have received one or more doses of MenACWY vaccine (2018 Baseline – 87.4%)

CH 5A.2c. By 2025, 80% of female adolescents aged 13-15 years will have received 2 or 3 doses of HPV vaccine as recommended (2018 Baseline – 45.9%)

CH 5A.2d. By 2025, 80% of male adolescents aged 13-15 years will have received 2 or 3 doses of HPV vaccine as recommended (2018 Baseline – 47%)

## Strategies

CH 5A.1. NC Immunization Program (NCIP) will recruit and maintain a network of public and private providers to administer: 1) VFC vaccines to program-eligible populations and 2) Section 317-and state-funded vaccines to eligible adult and pediatric populations.

CH 5A.2. NCIP will be actively engaged with various provider organizations and agencies (including the NC Pediatric Society and NC Medicaid) that potentially serve VFC eligible children through attendance at meetings, phone calls, and emails at least twice a year.

CH 5A.3. NC Title V Program will work across branches and throughout NCDHHS to promote childhood immunizations within all its direct service programs.

CH 5A.4. Maintain an up-to-date web site containing information regarding the Standards for Child and Adolescent Immunization Practices, Standards for Adult Immunization Practice and ACIP.

CH 5A.5. NCIP will actively partner with the NC Immunization Coalition (NCIC), and the North Carolina Immunization Advisory Committee (IAC) on efforts to reduce morbidity and mortality associated with vaccine-preventable diseases.

CH 5A.6. NCIP will assess vaccination coverage using NIS, NC IIS data and school-level survey data annually to identify geographic areas with low vaccination coverage.

CH 5A.7. NCIP will implement communication strategies to increase coverage for recommended vaccines in priority populations and to address current immunization barriers with healthcare providers and partners.

CH 5A.8. NCIP will provide training opportunities and/or resources to assist immunization providers in communicating with patients and/or parents.

CH 5A.9. NCIP will initiate the Immunization Quality Improvement for Providers (IQIP) process according to CDC requirements with 25% of CDC-defined IQIP candidate providers and follow-up activities with those VFC providers who received IQIP site visit in budget year one according to the IQIP timelines.

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 DCFW/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 DCFW/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.

NC is one of seven states awarded a cooperative agreement from the CDC for *State Essentials for Childhood Initiative: Implementation of strategies and Approaches for Child Abuse and Neglect Prevention.* The NC Essentials for Childhood (NCE4C) Initiative was funded for five years (2018-2023). In the final year of funding, NCE4C focused on policies which promote economic mobility for families and norms change regarding support for positive parenting. A continued focus remained on policy, practice and norms change related to family friendly workplace policies with an emphasis on paid family leave. Accomplishments in FY23 included:

- Education of key stakeholders on brain science, Adverse Childhood Experiences (ACEs), and resilience.
- Sponsored the Economic Supports for Families: A Path to Reduce Childhood Adversities summit. The focus of this summit was to work toward research and solutions focused on the use of family economic supports to prevent child maltreatment and other ACEs. This convening brought together national and state speakers to provide an opportunity to discuss the growing needs of children and families across NC.
- Sponsored two statewide Policy Institutes: Storytelling to Achieve Change and Make Impact.
- Provided support to Prevent Child Abuse NC's (PCANC) Connection Matter norms change campaign. Seven Connections Matter trainings were held. PCANC worked with the faith community and local communities.
- Promoted family friendly workplace policies by partnering with the NC Early Childhood Foundation (NCECF), MomsRising, and PCANC.
- Provided support to the NCECF to implement the Family Forward NC certification program. The aim of this certification program is to increase employer- based family workplace policies. Thirty-six organizations received certification.
- Provided technical assistance to 43 small and medium sized businesses with human resources experts, resources, and support needed to expand employer-based family friendly workplace policies through Family Forward.
- Provided a series of webinars and podcasts to businesses.
- Provided support to MomsRising to provide technical assistance to four local governments to build capacity to implement or expand family friendly workplace policies.
- Engaged 25 new story tellers and developed family stories on the impact of paid family leave.

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 spectrum and try to provide parents and caregivers and their young children different levels of supports and resources to promote social and emotional development and prevent and gain access to assessment, management, and treatment of mental health issues as early as possible.

DCFW has many programs and efforts that are addressing infant early childhood mental health (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) was a co-leader with the NC Early Intervention (EI) Director of an IECMH planning group of about 10 staff from the WCHS and EI Section in DCFW. The IECMH planning group was asked to decide if reconvening the Early Childhood Matrix Team (ECMT) around IECMH was a good way to approach this work. The IECMH planning group would also determine what needed to happen before the ECMT could reconvene. The idea was to have the ECMT use an internal strategic planning process over six months to create the following products:

1. Agree 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 need to collect or use to measure how improvement on the internal and external priority for DCFW is achieved;
6. Create an action plan to address the shared priority areas for DCFW in IECMH; and
7. How to determine success for this first phase of strategic planning.

During FY23, the IECMH planning group met three times to align and understand more about each other, external partner efforts, and share how staff can collaborate and support efforts on one priority to support the mental health of infants and young children. The DCFW SMD and several members of the IECMH planning group created and continued to update a slide deck about IECMH efforts internal and external to DCFW to help inform DCFW leadership and other DCFW staff. The group focused efforts on creating a survey to assess efforts internal and external to DCFW related to IECMH including practices, policies, and partnerships. The survey was distributed to staff across DCFW in the summer of 2023 and will help inform group priorities.

One of the key external IECMH efforts is the EarlyWell initiative (which was formerly the NC Initiative on Young Children's Social Emotional Health). EarlyWell continued to be led by NC Child, in collaboration with early childhood leaders including the NCECF, to promote and try to 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. The Title V CYSHCN Director and other staff members continued to participate on the EarlyWell Initiative advisory committee. An important report, *From Equity to Issue Campaigns: The Next Stop on the Road Map to Childhood Mental Health in North Carolina*, was released in June 2022 that 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 be shared with DCFW staff involved with IECMH efforts during FY23.

In addition to these efforts, representatives from the DCFW/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, Infant Mental Health Association, and staff from the IECMH Technical Assistance Center at Georgetown University which continued to involve a TA grant from Georgetown. The external IECMH

workgroup identified equity, research, and evaluation as focus areas of TA, specifically looking at training for workforce on the impact of structural racism on children's mental health and identifying meaningful metrics for outcomes and data sources. The external IECMH work group worked to develop a survey for advocates and for those professionals who provide IECMH consultation with plans to distribute in later 2023 to determine the extent of needs and activities in NC related to IECMH consultation.

The State Child Care Nurse Consultant (SCCNC) participated in the Yay Babies! work group which, in partnership with the Division of Child Development and Early Education (DCDEE), engages with partners and focuses on promoting access to early childhood services for young children experiencing homelessness. In FY23, Yay Babies! continued efforts to develop an *Action Plan for an Early Childhood Homelessness Support System*.

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 appropriate care for further assessment. Per the 2021-22 NSCH, 37.1% of children in NC between 9-35 months had received appropriate developmental screening which is higher than the national average of 33.7% (Developmental Screening NPM).

The DCFW/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, social determinants) 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 FY23, 80% of the 65 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 DCFW/WCHS State Child Health Nurse Consultant (SCHNC), Regional Child Health Nurse Consultants (RCHNCs), and the DCFW SMD who still serves in a role of the Pediatric Medical Consultant for Title V, provided monthly Child Health Provider 30-minute webinar trainings titled *Strategies and Recommendations: Helping with Delivery of Child Health Services* for child health clinical staff and CMARC care managers working in LHDs. The webinars included information related to caring for children during COVID-19 and connecting staff with resources such as NC-PAL, CYSHCN Hotline, and safe firearm storage. 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, safe sleep, respiratory viruses (flu, RSV), immunization updates, monkeypox, and refugee health resources. 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 about the impact of COVID-19 on infant and child mental health and grief due to losses of family and other caregivers during FY23. 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, COVID-19, and flu updates and especially about changes in vaccine recommendations, referrals to early intervention services and the processes available to physicians for exchanging information such as developmental screening results with early intervention service providers.

Child Health Program Monitoring resumed June 2022. Monitoring visits were held either virtually using Microsoft Teams or onsite at the LHD. Due to the demands of COVID-19 on LHD staff, the CH Program Monitoring - Clinical Chart Review process was adjusted to provide additional technical assistance 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 (EI) continued with training to increase use of screening using the Ages and Stages Questionnaires®: Social-Emotional statewide. Due to the COVID-19 pandemic, the 2022-23 Child Health Training Program (CHTP) was provided in a combination of onsite and virtual training sessions using Microsoft Teams technology. COVID-19 precautions were followed when meeting onsite. Four training opportunities were presented during the CHTP which included information on developmental, psychosocial, and behavioral screening.

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 LHDs and CHTP students during FY23 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:

- November 2022 – Refugee Child Health: An Overview for Healthcare Worker
- December 2022 – Welcoming Families to the Table: Enhancing Our Work by Centering & Partnering with Family Leaders
- April 2023 – From ACES to Resilience: Reverse Narrative
- May 2023 – Communication and Engagement: Current Medicaid Engagement Initiatives

Consultation and technical assistance were provided to several new LHD providers and current providers who presented questions regarding well child visit components. Guidance was provided regarding 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 technical assistance to meet the needs of the individual providers related to evidence-based strategies to support developmental screening, anticipatory guidance, management, and referral.

HFA and NFP home visiting models complete developmental screenings with enrolled families between ages 4 months to 30 months. The 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 FY23, the developmental screening completion rate for all participants at MIECHV sites was 84.1%. 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.

During FY23, the PNC continued to integrate and enhance breast, chest and human feeding 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. Also, this year, the PNC updated and recorded the *Well Child Nutrition Risk Screening* webinar and presented live the *Well Child Nutrition Risk Screening, Healthy Feeding Relationships, and Breastfeeding & Food Insecurity* virtual training for the CHTP. Both trainings were well received with very good evaluations. Evaluation results for the Nutrition Risk Screening showed that 80-90% of survey respondents rated each portion of the recorded webinar as Excellent or Good. For the latter presentation, when asked which aspects of this nutrition training helped the most,83% noted that identifying and referring clients to food assistance programs and 50% rated assisting parents and caregivers in developing healthy feeding relationships with their children as their second favorite sections of the live presentation.

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

During FY23, 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), Fostering Health NC, Children and Families Specialty Plan, 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 support staff to navigate enhancements and reports in Virtual Health/Care Impact Platform documentation systems. The CMARC staff continued to provide technical assistance 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 FY23 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 with plans to update the document in the fall of 2023. 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. As Tailored Care Management (TCM) launched in December of 2022 for children ages 3-5 years and April 2023 for children 0-3 years, staff continue to ensure the

children who were eligible for TCM had a warm handoff to staff at the LMEs/MCOs.

Another role the PNC has is to provide regular and timely monitoring, technical assistance 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 $20K) for children referred to the LHD with no other funding source. These are often children with special nutrition needs. During FY23, DCDPH provided 514 MNT units and 41 patient consultations with medical providers, with 116 new clients served. Durham County reported that positive changes in behavior, knowledge, weight and/or clinical measures occurred in 97% of subsequent nutrition visits in FY23 for all clinic nutrition services.

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 at Chapel Hill, and Prevent Child Abuse NC), the Triple P Design Team (The Impact Center and Triple P America), the State Triple P Partners Coalition, and the LIAs. This system was still in place for 2023, but not without a lot of flexibility from across the partnership to determine ongoing timelines for agencies that were still reeling and impacted by the COVID pandemic. One of the things learned and practiced at the PSG leadership level is to practice flexibility with regards to deliverables, especially relative to the “Scale-Up Plan.” In FY23, LIAs developed their 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 FY23, the DCFW/WCHS continued to support the Triple P System in NC through Title V funding by employing a State Triple P Coordinator, funding the LIAs for infrastructure and training support with Title V funding, and providing a part-time data specialist to work in coordination with the DCFW/WCHS Data Manager to support statewide data collection and reporting and using data for local CQI projects.

In addition, the DCFW/WCHS continued partnering with the NC Division of Social Services (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 the Triple P program. The DCFW/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 FY23, 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 statewide 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. There was an ongoing focus for FY23 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 during FY22 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 FY23. Durham County) implemented the Family Connects Home Visiting Program.

In FY23, in various disciplines, sectors and settings, the Triple P Program newly accredited 172 practitioners, trained 26 DSS staff members, served 4,757 parents/caregivers, and reached 7,170 children.

NC Child Care Health Consultation Resources

The SCCNC position supported by Title V funding collaborated with programs within the DCFW/WCHS as well as other state partners addressing early childhood public health efforts in FY23. The SCCNC worked closely with the NC Child Care Health and Safety Resource Center (CCHSRC) to support the health and safety of children ages zero to five attending early care and education settings through child care health consultation. 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 offer support through training, technical assistance, and coaching services to 83 Child Care Health Consultants (CCHCs) providing local and regional coverage for 5,505 licensed child care programs across the state. New Standards of Practice for Active CCHCs were created and implemented in January 2023 by the CCHSRC in collaboration with the SCCNC. Key CCHC guiding documents, including the CCHC Orientation Guide and the *Hiring Agency Guide* were also updated.

The CCHSRC offered three cohorts of the NC CCHC course for 15 new CCHCs in FY23. The SCCNC and CCHC coaches from the CCHSRC served as course instructors. Medication Administration and Child Care Development Fund Overview Train-the-Trainer Courses were offered within the CCHC courses. Additionally, the Infant/Toddler Safe Sleep and Sudden Infant Death Syndrome (ITS-SIDS) Risk Reduction in Child Care (ITS-SIDS) course was offered three times resulting in 30 new trainers. Additionally, the Emergency Preparedness and Response (EPR) courses was offered two times to CCHCs and other technical assistance providers across the state, resulting in 23 new trainers. Both ITS-SIDS and EPR courses are reviewed annually and offered to CCHCs and other technical assistance providers. The CCHSRC developed and distributed four quarterly e-newsletters with health and safety themes that were made publicly available in English and Spanish. Additionally, the CCHSRC hosted a toll-free line/website inquiry form and responded to 691 inquiries. A CCHC Resource Library was maintained providing training tools and resources reflective of current health and safety requirements, including recommendations for meeting best practice standards for child care facilities.

In FY23, 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 monthly meetings. Four core agencies including CCHSRC, DCFW, DPH, DCDEE and NCPC provided a joint governance structure for the NC CCHC system. Continuing in FY23, Child Care and Development Block Grant funds were used to sustain local CCHC positions in 50 counties that did not previously have CCHC services and participated in the expansion efforts following the pandemic Approximately 85% of the counties that received expansion services were counties designated as Tier 1 (most economically distressed) and Tier 2 counties by the NC Department of Commerce. The SCCNC and CCHSRC continued to provide support to hiring and funding agencies in CCHC expansion counties and provided coaching support for CCHCs and their supervisors.

The SCCNC and Regional CCHC Coach from CCHSRC, serving as subject matter experts, continued to collaborate with DHHS, including DPH and DCDEE, to maintain the NC DHHS ChildCareStrongNC Public Health Toolkit which provided COVID-19 guidance for child care settings until it's sunsetting on August 31, 2022. At which time the ChildCareStrongNC Managing COVID-19 Cases in Child Care Facilities was published. Additionally, the SCCNC presented with DHHS, including DCDEE leadership, on a Town Hall for Early Care and Learning Professionals to provide guidance on COVID-19, vaccines, testing and treatment as NC transitioned away from a crisis response towards a communicable disease prevention and management.

The SCCNC, serving as nurse planner, and the CCHSRC partnered to offer professional development opportunities for CCHCs on various health and safety topics addressing young children in early care and learning settings in FY23. Topics included Early Childhood Development and Resources; Unintentional Injuries in Child Care, Prevention and Control; Child Abuse and Neglect Awareness and Strategies for Prevention; and Asthma in Child Care. 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. On average, 44 CCHCs serving child care facilities across the state participated in the learning collaboratives.

For the CCHC fall conference in September 2022, the WCHS Assistant Director and the Child and Family Wellness Unit Manager co-presented *Building Bridges* for a plenary session to highlight DCFW/WCHS and DCDEE programs that impact infant and childhood health across the state. The SCCNC presented *Sneezes, Itches and Germs: Preventing Spread in Child Care Settings* at the NC Public Health Association fall conference in September 2022. Additionally, the SCCNC, in collaboration with CCHSRC staff, *presented Puzzles and Partnerships* at the annual Child Care Resource and Referral (CCR&R) Institute in November 2022. In partnership with the Carolina Global Breastfeeding Institute, CCHSRC staff, and a TA provider from Buncombe County Smart Start, the SCCNC also led one Breastfeeding Friendly Child Care train-the-trainer event (June 2023) for 13 CCHCs and Birth to Three Specialists from the CCR&R TA System.

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

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 2021-22 NSCH indicate that 18.5% of children in NC experienced ≥2 ACEs as reported by their parents. It is comparable to the

2021-22 national rate of 17.4% 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 racial, ethnic, gender, and disability status diversity among school and childcare leadership and staff.

In FY23, 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 social determinants of health screening. Programs and services supported by Title V and implemented at the local level include CMARC, the Child Health Program in LHDs, Title V and MIECHV supported home visiting, child care health consultation, Triple P, School Health Centers (SHCs), the EHDI program, and school health 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 FY23. Additional technical assistance 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 FY23, 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 addition, the MIECHV Professional Development Coordinator received LTSAE resources and distributed the materials to the MIECHV home-visiting site staff. 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 CHERRNs. During FY23, five LHDs provided ROR using Title V funds through the Child Health AA.

Child Health Agreement Addenda

The DCFW/WCHS continued to refine the Child Health AA with LHDs in FY23 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 technical assistance to LHDs to support the use of additional evidence-based services and resources for children.

The FY23 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) Healthy Eating Active Living Coalitions to reduce the risk for obesity; 8) Reproductive health services for teens based on a sliding fee scale; 9) Funding for school nurses; 10) Funding for family strengthening initiatives such as Triple P and Innovative Approaches;11) Accommodations to improve access to care for children with disabilities after site surveys for wheelchair scales and accessible examination tables; 12) Training related to skill development related to evidence-based services; 13) Mother-Baby Breastfeeding Friendly Outpatient Healthcare Clinics; 14) Funding for CCHCs; 15) Nutrition and Physical Activity Coalition; 16) Addressing Food Insecurity and/or Healthier Food Access; 17) Teen Friendly Clinics; and 18) Firearm Safe Storage.

Home Visiting and Parenting Education (HVPE) System

In FY20, a Home Visiting and Parenting Education (HVPE) System was implemented to assess the current system, identify and coordinate funding sources, establish a governance system, and standardize data collection and reporting with the goal to create a family-centered, coordinated system that uses current resources effectively and includes planning and activities ensuring high quality services can be scaled up to be accessible and offered in an equitable manner. In early 2023, the HVPE Collaborative Board and other work groups were no longer meeting, and communications from HVPE leadership stopped. In the summer of 2023, all HVPE work was put on hold until further notice. 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.

In FY22, NFP was granted an additional $1.5 million dollars in recurring funds in the state budget to support sustainability and expansion of the program. The funding was allocated in FY23 and enabled NFP to serve 150 additional families across the state. DCFW/WCHS continued working with the NFP sites in FY23 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. State Nurse Consultants have worked through monthly consultation to ensure that each site has an individualized plan for referral outreach and caseload maintenance. The NFP National Service Office (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. The NFP NSO has developed a report that shows client attrition in relation to the phase that each client is discharged from the program and the actual reason given for the discharge. This report has proved to be helpful in developing quality improvement plans to decrease discharges noted to be caused by addressable reasons.

In FY23, the NFP NSO hired a new Government Affairs Manager to work at the state level to identify sustainability opportunities at existing sites. All NFP Supervisors in NC received Facilitated Attuned Interaction (FAN) education.

This six-month process focused on a new way of using reflective supervision in practice.

Progress on integrating home visiting data into the NC Early Childhood Integrated Data System (ECIDS) continued in FY22. After meetings between the NC ECIDS team and data staff, as well as meetings between NC MIECHV's Local Implementing Agency (LIA) supervisors and data partners, a formal memorandum of agreement (MOA) was signed and implemented in 2022 (for Healthy Families America [HFA] data) and 2023 (for Nurse Family Partnership [NFP] data). NC MIECHV's Continuous Quality Improvement/Data Manager and data partners then worked with the NC ECIDS staff to determine which data elements and indicators to integrate into NC ECIDS. A data dictionary and secure file transfer protocols were established. Since then, MIECHV participant data has been shared with the NC ECIDS team, with archival data sent in summer 2023. New participant data will be sent quarterly moving forward.

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 included perinatal mood and anxiety disorders; the Internal Revenue Service Volunteer Income Tax Assistance program; exploring the developmental progression of parenthood and early intervention; inclusive lactation support for LGBTQ+ families; Medicaid Managed Care; supports and resources for serving kinship caregivers; and the Advancing Resources for Children Project: connecting North Carolina's systems to strengthen infant and early childhood mental health outcomes. Additionally, professional development opportunities which include webinars, journal articles, and upcoming conferences/trainings are emailed 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).

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 DCFW/WCHS, supports all 100 local CFPTs through Title V

funds and ongoing technical assistance. 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. With shared members, approximately 80% of local CFPTs and CCPTs meet as one combined team.

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.

With a new full-time state CFPT Coordinator having started in early 2022, focus from the interim state CFPT Coordinator continued with development of training for team roles of CFPT to aid the counties setting up new teams, continued maintenance of the database of submitted review forms, prioritizing visits to local CFPTs, and establishing unique avenues of communication to connect teams across the state.

After several months of planning, a state-wide Child Fatality Prevention System Summit was held in March 2023. The state CFPT Coordinator was a member of the planning team and led several presentations at the event. Over 150

individuals registered for the event and even more tuned in virtually for the plenary session. The Summit reached a variety of individuals involved in work related to child fatality and provided presentations on topics such as: addressing secondary trauma: bringing a diversity and equitable lens to child death reviews: youth suicide and youth mental health; prevention strategies: medical examiner terminology interpretation: social determinants of health: data trends and much more. Based on collected Summit evaluation responses, 95% of respondents agreed the Summit was a good use of their time, and over 90% came away with new ideas to use within their work as a result of attending it.

During FY23, the state CFPT Coordinator conducted 15 in-person visits and 14 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. In addition to this conversation opportunity, the state CFPT Coordinator continued to provide webinar opportunities with five occurring in FY23.The Coordinator also conducted 12 virtual 4-hour regional meetings. The regional meeting format had not been utilized for several years and attendance reflected the needs and excitement for training, collaboration, and sharing of information.

During FY23, there were 1,372 completed fatality report forms 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 CFPS structure.

Additional Strategies to Promote Child Health and Decrease ACEs

The DCFW/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 promote use of NC-PAL housed in the DCFW/WCHS Child Behavioral Health unit. NC-PAL provides phone consultation to support primary care providers with the 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 which include ACEs impact mental health. A statewide youth [mental health care dashboard]() from Medicaid claims data from 2017-18 continued to be available on line for providers. The DCFW SMD continued to promote the resources available through NC PAL to primary care providers and with private and LHD child health providers in multiple presentations during FY23 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 Care for Meeting the Needs of Underserved and Vulnerable Populations, Including CYSHCN component of the Overview of the State section.

In FY23, 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.

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 to create a mockup of prescriptions for primary care providers to give them directions to address elevated lead level follow up which includes testing and referrals. SCHNC and RCHNCs partnered to provide technical assistance 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 7,220695 doses of vaccine, including 299,340 doses of influenza vaccine and 3,049,250 doses of COVID vaccine in FY23.

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 2020-2022 National Immunization Survey (NIS) results (for children born 2019-20) were released in November 2023. 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 72.3%, which was higher than the national estimate of 69.1%, but lower than NC's previous year NIS results of 76.5%.

Results of the 2022 NIS-Teen, released in August 2023, 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 93.2%, which was higher than the national estimate of 89.1% and a 4% increase from the 2018 baseline of 88.9%. The 2022 meningococcal conjugate coverage estimate in NC was higher for teens age 13 to 15 than the national estimate (90.9% v. 87.5%) and was an increase of 4% 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 2022 NC estimate was lower than the national estimate for all teens regardless of gender (52.3% v. 58.6%), and 54.5% of females were up to date while 50.2% of males were. However, it is important to note that the differences in national and state estimates for each of the HPV metrics are not statistically significant.

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. Technical and grammatical 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 FY23, IB initiated 294 IQIP visits.

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 to medical exemption requests. The DCFW SMD also provided almost monthly webinars to child health clinic staff in LHDs during FY23 that included highlighting the need for well visits, routine immunizations, and immunizations against COVID-19 and flu, addressing vaccine hesitancy.

**Child Health - Application Year**

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

NC was one of 12 states to receive the CDC for the Essentials for Childhood: Preventing ACEs through Data to Action grant awarded in fall 2023 to continue their NCE4C work. In the next five years, NCE4C will seek to measure and prevent ACEs in NC through the following:

- Enhance infrastructure for state-level data collection, analysis and application of ACEs data.
- Strengthen economic supports to families by informing programs and policies that strengthen household security through the earned income tax credit and child tax credit.
- Work with minority owned businesses to increase employer-based family friendly workplace policies.
- Promote norms that protect against violence and early adversity through statewide expansion of Connections Matter.
- Update the NCIOM's Task Force on Essentials for Childhood.
- Conduct data to action activities to leverage statewide ACEs data to inform prevention activities.

The Title V Director and SMD will continue to be part of the leadership working on efforts to move work on the NC State Health Improvement Plan (NC SHIP) related to several HNC 2030 objectives related to women and children's health. The SMD has served as a co-chair with three of the NC SHIP work groups which have met monthly or every other month to work on finalizing priorities and action steps to address three HNC 2030 objectives related to ACEs, short term school suspensions and third grade reading. The priority that the third grade reading work group will continue to work on is related to developing a map of professional development efforts across the state related to early literacy. The priority that the short-term suspensions work group will work on is to learn from and spread efforts used in the New Hanover school systems that now does not allow suspension of children from K through third grade. There are two priorities for the ACEs work group: to improve data available on trauma and ACEs at the local level and to increase funding for and embed community-rooted, culturally affirming family and community support programs into existing initiatives. Local and state community leaders have been involved on each of the NC SHIP work groups from different sectors including but not limited to education, public safety, private and governmental local, regional, and state agencies across the state.

The Title V CYSHCN Director, SMD and other DCFW/WCHS staff members will explore the implementation of strategies highlighted by the refresh of the NC ECAP and the foundational strategies from the Pathways to Grade Level Reading. The NC ECAP refresh was released in spring 2024 and is focused on four of the original goals: 1) Healthy Babies; 2) Food insecurity; 6) Permanent Families for Children in Foster Care; and 8) High-Quality Early Learning. In addition, there will continue to be participation of the Title V CYSHCN Director, SMD, SCCNC, NC EHDI coordinator, Child Behavioral Health Unit staff, Infant Toddler Program Part C State Program Director, and other DCFW staff in the statewide efforts to address IECMH Consultation regarding professionals in early childhood settings such as child care, DSS placement, early intervention, and preschool. DCFW/WCHS staff members will also continue to participate in the EarlyWell Initiative advisory committee, Advancing Resources for Child Health (ARCh) Project efforts, Think Babies, NC InCK to help suggest changes in how providers and systems engage and support families and medical homes in IECMH.

In FY23, DCFW chose to reconstitute the Early Childhood Matrix Team (ECMT) as the Infant Early Childhood Mental Health (IECMH) Planning Group. The IECMH Planning Group is internal to DCFW and composed of staff from DCFW/WCHS and EI (SCHNC, SCCHC, EHDI coordinator, SMD, Title V CSHCN, SACH unit manager, two MIECHV program staff, several child behavioral health unit staff, and three CDSA directors) with the addition of a family partner and two key staff from DCDEE. The Planning Group is engaged in a several month-long strategic planning process, facilitated by Frank Porter Graham's Impact Center, to develop an action plan centered around

two identified IECMH priority areas, one internal and one external to DCFW. The IECMH Planning Group's action planning process will include analyzing data from the initial 2023 landscape survey; identifying the internal and external priority areas; creating an inventory of internal and external efforts, partnerships, and challenges; and determining how to strategically address key elements including metrics and data, policy, workforce, practice (i.e., screening, management, and treatment), interface with families, and funding. The action plan will also determine data that needs to be collected to measure how we are achieving improvement on the identified internal and external priorities and will establish an implementation team to address the priorities and implement the plan. The Early Childhood Behavioral Health Program Consultant hired in FY24 will lead the efforts to implement the action plan.

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

The DCFW/WCHS SCHNC, RCHNCs, and the SMD will continue to include information about the importance of developmental surveillance and screening, identification, management, and referral in trainings for LHD child health clinical staff. Including guidance and resources is important because many children experience different social drivers of health, settings for care, play and learning in homes, communities which include early learning, child care and school settings.

The DCFW/WCHS SCHNC, RCHNCs, and PNC work collaboratively to update the CH Program Monitoring Calendar and to schedule monitoring visits with LHDs. The SCHNC and RCHNCs will continue to utilize Microsoft Teams technology to meet with LHD Child Health Program clinical staff virtually as well as to make onsite visits to provide consultation and TA. DCFW/WCHS staff members will continue to review child health services and provide TA and education concerning best practices to LHD staff about well child visits which include developmental surveillance, screening, identification, management, and referral. The SMD will continue to use and update a self-assessment tool for new advance practice providers and physicians to determine resources to support delivery of developmental surveillance, developmental screening, social-emotional, behavioral, and psychosocial screenings during well child and sick visits. The SMD will also share ways to access resources for anticipatory guidance and how to look for a variety of local community partners when concerns are identified for children and families cared for by LHDs based on the most current Bright Futures and AAP recommendations. The DCFW/WCHS SCHNC and RCHNCs will provide TA and complete chart reviews of various LHD EHR platforms based on the Office of the Chief Public Health Nurse EHR guidance and Medicaid requirement to provide, document, and discuss the results of developmental and behavioral health screenings with families, review charts for other billing and coding issues as well as scope of practice. Nurse consultants, along with the SMD, will continue to train and update LHDs on content from and changes to the Medicaid requirements and reinforce the need for ongoing developmental surveillance and the need to use the most current developmental screening tools. For example, the Parents Evaluation of Developmental Status was revised and updated in 2023, and is now called the PEDS-R. As a result, there is a need for LHDs to change to the most current tool.

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

The SMD, SCHNC, and RCHNCs will continue to hold monthly statewide webinars to provide child health programmatic updates including topics such as ACEs/toxic stress, relational health, positive childhood experiences, trauma informed care and enhanced well visits for infants, children and youth in foster care, and family engagement. The Child Health Program will continue to pilot a new monthly 30-minute webinar called Clinic Connections. This is an opportunity for LHD staff across the state to come together to discuss challenges in delivering care among themselves and for the SMD, SCHNC and RCHNCs to bring concerns from LHDs to be discussed. For example, there is an issue of being able to partner with community health care providers and school nurses to identify and then provide school health assessments (SHA) for new students coming into a school district in a timely manner. The Child Health Program recommends that a full well child visit be completed as part of completing the SHA which

would include a developmental and a behavioral health screening for students. Another example is having LHDs share how they plan to transition from using the old PEDS developmental screening tool to a more current developmental screening tool. The possibility of holding a statewide Biennial Child Health Conference or regional meetings in FY26 will be explored in FY25. In the meantime, the SMD, SCHNC, and RCHNCs will continue to lead efforts to bring topics that provide the opportunity to earn nursing continuing professional development (NCPD) contact and Certified in Public Health (CPH) recertification hours during several of the statewide webinars. The SMD, SCHNC, and RCHNCs will continue to provide at least one training about developmental surveillance and screening, identification, management, and referral for the CHTP participants and include this as part of additional trainings. The CHTP will also continue to include training on vision system assessment and lead screening and will share the archived webinars with child health clinic staff in LHDs. In addition, they will provide ongoing TA to CHERRNs, physicians, advance practice practitioners, and CMARC care managers in LHDs on topics such as developmental screening, refugee health updates, growth and development (nutrition and obesity), oral health prevention and screening in addition to other topics as needed.

CMARC state staff will continue to work with NC DHB/Medicaid to assure that care management services are maintained and enhanced for children ages zero to five who meet the program population criteria. Care management services will continue to include developmental screening, mental health screening, and screening for SDOH using the Survey of Well Being of Young Children (SWYC). Additional TA will be provided to CMARC staff and health care providers in LHDs and private practice on the use of the SWYC tool and linking to resources to address concerns in the community. CMARC care managers will continue to conduct general developmental screenings using the Life Skills Progression Assessment and share the results with the appropriate medical home practitioners and facilitate EI referrals.

The SMD will continue to work with local CDSA directors and staff to increase outreach to primary care providers in practice, hospitals, FQHCs, and other referring providers about developmental screening, management and appropriate referrals to EI and other agencies. This will include encouraging CDSAs to share an outreach letter to explain the CDSA process and need to include information about developmental screenings when done by the referring provider. The SMD will work with state ITP leaders and CDSA local directors and staff to create trainings for ITP staff about eligibility based on a newly developed established condition list. The trainings will include reasons for changes and guidance that explains use of informed clinical opinion (ICO) based on the results of a developmental evaluation done at the CDSA to determine eligibility even if the child does not meet the developmental delay eligibility definition.

Triple P

In FY24, the DCFW/WCHS will continue to support the Triple P System through Title V funding as noted in the CH Domain Annual Report. The NC Triple P System will satisfy select strategies stated in CH 4A.3 relative to statewide trainings on preventive screening, assessment, and treatment of parents and caregivers struggling with custodial child abuse and neglect issues, in coordination with its partners. This occurs via specific training, TA, and through the four levels of Triple P intervention services across the state, both face to face and via the Triple P Online Program.

In FY24, the State Triple P Coordinator will regularly lead meetings with support partners, funders, LIA data team leads, PSG, NC Smart Start and more to enhance collaboration. Additionally, the Coordinator will conduct meet and greets with each of the LIAs and their teams to increase understanding of system needs, challenges and successes. Prior to the meet and greets, the Coordinator will send questions to each LIA team to review. After the meet and greets, the Coordinator will follow up with each LIA team to share the responses they provided for the LIA team to review to confirm their reflections. The Coordinator will compile the responses from each LIA into a document to

assemble a report to share with the PSG, support partners, funders and LIAs to inform strategic positioning and provide concrete guidance to the Triple P system for improvements moving forward. The recommendations from the meet and greet responses and PSG meetings will inform FY25 activities for the system.

In FY25, LIAs will continue the implementation of the Model Scale-Up Five-Year Plan by making updates to their plans. The Model Scale-Up Five-Year Plan is a living document, subject to change based on individual LIA needs. The Triple P Support Team, including the Design Team and the PSG, will work with each LIA to assist with challenges identified through the plan and to recommend solutions to those challenges. Local practitioners are also considered in these recommendations since their buy-in is essential. The Model Scale-Up Five-Year Plan also assists in the goal of addressing strategy CH 4A.3 since the plan potentially gauges any needs related to screening, assessment, training, treatment, and prevention of child abuse/neglect.

In addition, the NC Triple P State Learning Collaborative will continue to engage all LIA Coordinators, state team members, practitioners, and partners in FY25. As a central strategic networking and training opportunity, participants engage in training, ongoing problem-solving, and learning about innovative ways to recruit and coordinate Triple P training events, as well as build their professional competencies, which satisfies some components of the CH 4A.3 strategy. The NC Triple P Program will continue partnering with DSS.

NC Child Care Health Consultation Resources

In FY25, the SCCNC will continue to work collaboratively with programs within the DCFW/WCHS and across Divisions, as well as engage with local and state partners, to educate, establish and maintain links, and advocate for the population of children 0-5 years old attending early care and education programs. Specifically, the SCCNC will continue to partner closely with the NC CCHSRC to support child care health consultation across NC, supporting 60 local and regional based CCHCs. The SCCNC will continue to represent DCFW on NC CCHC System workgroup through a shared governance structure in coordination with the NC CCHSRC, NC Partnership for Children, and DCDEE. The CCHC Resource Library offered through the CCHSRC website will be maintained and enhanced to include training resources and materials, information on current health and safety requirements, including recommendations for meeting best practice standards for early learning settings. The NC CCHSRC, in collaboration with the SCCNC, will continue to offer the NC CCHC Course for new CCHCs and affiliates online and in person twice a year, fall and spring. Regional CCHC coaches from the NC CCHSRC in addition to the SCCNC will continue to provide coaching services to CCHCs in FY25. Additional supports for the NC CCHSRC from the SCCNC will include contributing to quarterly webinars for CCHCs and supervisors, as well as serving as instructors for the NC CCHC Course and other courses.

The CCHC System Workgroup, established in FY21, will continue its work in FY25. Outreach efforts by the SCCNC and regional CCHC coaches to promote and support hiring in counties that remain without local/regional coverage will continue.

In FY25, the SMD will continue to work with the SCCNC and the NC CCHSRC to enhance professional development activities and resources for CCHCs through Learning Collaboratives addressing health and safety topics specific to children aged birth to five years in child care settings. The SMD will also continue to provide TA and consultation to the NC CCHSRC and regional CCHC coaches to review processes and procedures related to topic areas as requested such as anaphylaxis, immunizations and implementation of DCDEE requirements and child care rules.

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

CMARC staff will continue to provide LTSAE as handouts and accessing the website as part of the CMARC Care

Management Patient Education Standard, Triple P, and the Small Moments, Big Impact materials to promote child development and strong parent-child relationships. The NC ITP will continue to promote the LTSAE campaign both on its website and by sharing it with families seen at the CDSAs. In addition, the SMD, SCHNC, CMARC program manager, SCCNC, and several other Title V staff will continue to work with LHDs, NC Pediatric Society providers, the LTSAE NC Ambassadors, CCHCs, MIECHV home visitors, Healthy Social Behaviors Specialists, and other early childhood professionals to increase use of the LTSAE materials and ROR with families and medical home providers. In addition, in FY25, the NC Triple P program, both from the state office and its funded LIAs will continue to support both the LTSAE and ROR Campaign via referrals and coordinator/practitioner training updates.

Child Health Agreement Addenda

The FY25 Child Health Agreement Addenda with LHDs for child health services will continue to support a variety of services for low-income families using the Attachment C Sample Evidence Based Strategies as reported in the CH Domain Annual Report. The Child Health Agreement Addenda primarily focuses on ensuring health services for children, including parenting education, nutrition, well child care, school health, genetic services, newborn screening, childcare health consultation, developmental screening, early intervention, health care transition and self-management of care, linkages with medical homes, screening and treatment clinics, resource lines, and CYSHCN.

Care Management for At-Risk Children (CMARC) Agreement Addenda

The FY25 CMARC Agreement Addenda with LHDs for care management will continue to include the same primary areas that the Child Health Agreement Addenda includes. The CMARC Agreement Addenda supports care management of services for low-income families using different tools that look at development, behavior, and stress in the child's family environment as well as risk for autism spectrum disorder.

NC Home Visiting and Parenting Education System & NC Home Visiting Consortium

As mentioned earlier, by the summer of 2023, all HVPE work was put on hold until further notice. Currently, a core group of HVPE leadership (includes the Title V CYSHCN Director) is meeting and strategizing the next steps to reengage partners (e.g., NC Home Visiting Consortium [NCHVC]) to resume implementation of the initiative. Many former HVPE partners are current members of the 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, the NC MIECHV program has facilitated the Consortium 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, Positive Childhood Alliance NC (PCANC) and NCPC began providing HVPE updates during the Consortium meetings. The NCHVC will continue to work with PCANC and NCPC moving forward 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.

North Carolina Early Childhood Integrated Data System

Integration of home visiting data for the six MIECHV LIAs into ECIDS will be completed by the end of FY24 before considering how to integrate the last MIECHV HFA LIA, as that process will be different due to their host agency and database system. The continued integration of MIECHV data into NC ECIDS in FY25 will enhance the implementation of home visiting across the State, allowing NC MIECHV to better identify priority populations and service gaps.

Nurse Family Partnership

The NC NFP All-State Community of Practice will be held in November 2024 in western NC. The first day will have a breakout session for all supervisors and a separate breakout session for the administrative assistants. The second day will be for all NFP staff including the nurse home visitors. These sessions will be in person with the option to participate virtually.

NC Child Fatality Prevention System

In FY25, the State Coordinator for local CFPTs will continue to:

1. Provide opportunities for local CFPT chairs and review coordinators to collaborate and share ideas, questions, and conversation about their work.
2. Provide webinars to local CFPTs on pertinent topics such as member engagement, creative approaches to prevention work, and meeting facilitation.
3. Collaborate with partners to conduct interactive webinars on fatality or injury topics of interest.
4. Conduct needs assessments with all 100 local CFPTs through the annual activity survey.
5. Accept quarterly reports from local CFPT and develop an annual report.
6. Provide individualized trainings to new CFPT Chairpersons and support county level staff taking on local CFPT responsibilities.
7. Conduct monitoring activities for 33 local teams via virtual meetings and site visits.
8. Update the process of local CFPT reviews to collect additional data points and distribute aggregate data state-wide.
9. Onboard all local CFPTs with the CFPT procedural manual and outline the operations of each individual team.
10. Collaborate with DHHS partners to meet legislative requirement changes to NC's state-wide Child Fatality Prevention (CFP) System set forth by the passing of the 2023 Appropriations Act [Section 9H.15 of Session Law 2023-134].

The State Office of Child Fatality Prevention was established by the 2023 Appropriations Act to oversee the coordination of State-level support functions for the NC Child Fatality Prevention System to maximize efficiency and effectiveness and expand system capacity. Recruitment for the Office of Child Fatality Prevention Director began in May 2024, and this position will be responsible for establishing the new Office and providing administrative direction, guidance, and leadership to the Office employees to promote efforts to prevent child deaths who will be hired in FY25.

Additional Strategies to Promote Child Health

In FY25, funding through Title V and state appropriations will continue to support coverage of vision screening for both school-age and preschool age children with Title V funding preschool services through a contract with Prevent Blindness North Carolina. Educational materials will be 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 insurance will also be provided. On-site vision screening services will continue to occur as well as conducting multi-county trainings and certifications of vision screeners to assure qualified personnel are conducting screenings.

In FY25, the DCFW/WCHS and WICWS will continue to collaborate with the NC Childhood Lead Poisoning Prevention Program to help eliminate childhood lead poisoning and maintain lead screening in LHDs and with community. DCFW/WCHS will continue to share the revised guidelines for lead screening with a lower blood reference level. In FY25, the SMD and a RCHNC will work with the NC Childhood Lead Poisoning Prevention

Program and other partners to provide ongoing review of program materials and guidance.

The PNC will continue in FY25 to integrate breast/chest and human milk feeding education, family engagement and Life Course Nutrition into the Child Health program through trainings conducted as part of the CHTP CHERRN course and through other Child Health programs, including work with programs that specifically target CYSHCN. This will include food insecurity and weight inclusivity topics addressed in other areas of the MCH Block Grant FY25 State Action Plan. The PNC will also continue her active involvement in the Association of State Public Health Nutritionists (ASPHN) through the MCH Nutrition Council and the Fruit and Vegetable Nutrition Council. In addition, the PNC will continue being involved in the NC Farm to Preschool Network and the Farm to School Coalition of NC in a variety of leadership positions. The NC Farm to Preschool is applying for a small 2-year grant from ASPHN (called FARMWISE) through funding from USDA to enhance Farm to Child and Adult Care Food Program (CACFP). If awarded, the funding (or if chosen as a collaborative coalition without funding), the PNC and other Network leaders would be reporting for FY25-FY26 on progress and outcomes both for the grant and based on strategic priorities that the Network established in 2023.

In FY25, the PNC will also continue collaborative partnerships with the NC Partnership for Children, Go NAPSACC, Integrating Healthy Opportunities for Physical Activity and Eating (I-HOPE), the CDIS State Physical Activity and Nutrition (SPAN) grant staff, the SCCNC, the Community and Nutrition Services Section, the Food & Nutrition Services Section, the State Nutrition Action Coalition, Eat Smart, Move More NC 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. This could include consistent messaging related to breastfeeding and healthy eating that partners could use, especially with a diversity, equity, and inclusion lens. Another activity continuing in FY25 is that the PNC will monitor a special nutrition project Agreement Addendum for the Durham County Department of Public Health that furnishes medical nutrition therapy and nutrition consultation services for children referred to the LHD with no other funding source. Another continuing strategy into FY25 that the PNC is involved with is advising and providing technical nutrition expertise to DHB, on food and nutrition services being offered to address food insecurity and improve nutrition among high-risk “members” (which includes infants, children, adolescents, pregnant women and adults with chronic health conditions) as part of the HOP. HOP efforts are described more fully in the CCSB section of this plan. With potential of the HOP going statewide in October 2024 and beyond, this work and involvement by the PNC will likely take on some new direction.

In FY25 the PNC will engage the Oral Health Section and appropriate DCFW/DPH staff members to explore evidence-based nutrition and oral health screening assessment questions that are or could be incorporated into medical and dental health professionals' practices. As time and staffing allows, the PNC will work with appropriate staff to draft an oral health and nutrition toolkit that includes resources and consistent messaging that can be used in at least one prioritized setting: prenatal, perinatal and/or child health setting (in both medical and dental homes) to support pregnant individuals, infants, children, adolescents and their families.

Increase Percent of Children with Medical Home

In FY25, the CMARC program will continue to collaborate with other agencies and programs, such as EI and CMHRP, to ensure an effective system of care. The CMARC program in conjunction with the Prepaid Health Plans will continue to require 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 those children engaged in CMARC services, as collaboration with the medical home will ensure the healthiest outcomes for the child. CMARC staff will also continue to support the work of NCDHHS’ Plan of Safe Care to meet Child Abuse Prevention and Treatment Act requirements for substance-affected infants. The program will continue to provide TA

and training per the *NC Medicaid Program Guide for Management of High-Risk Pregnancies and At-Risk Children in Managed Care* to enhance performance assessment and improvement processes to ensure program expectations are met. The CMARC staff will collaborate in FY25 to promote the HOP and continue to coordinate care management efforts with the NC InCK pilot program and Community Care of NC.

The SMD, in partnership with the remaining CDSA physician, will offer and implement strategies to increase outreach to medical homes about referrals and collaboration with the 16 CDSAs across the state. The SMD will work to develop materials to share during trainings and outreach to medical homes in the community about the use of established conditions versus developmental delay as eligibility categories.  The SMD, in partnership with the EI Section Chief and CDSA management, will work on recruiting a state level pediatrician dedicated to working at the state level with the ITP.  The SMD will also work to create eastern and western regional pediatrician positions to provide TA and consultation for CDSAs and do outreach with hospitals, community providers and others in their regions.

The CHTP will continue to be held annually to train new CHERRNs to help LHDs serve as medical homes for children or work with the child's medical home. The SCHNC, RCHNCs, and the PNC will continue program monitoring and review of services and policies in LHDs to provide consultation related to age-appropriate HCPG requirements, billing and coding guidance, as well as scope of practice. The SMD, SCHNC, and RCHNCs will continue to provide TA and consultation to LHDs serving as medical homes to children to decrease barriers to access and improve their quality of care. The SMD, SCHNC, and RCHNCs will continue to promote and require communication and collaboration with health care providers serving as medical homes for the ongoing acute and chronic care of children that are seen in LHDs.

Priority Need 5. Improve immunization rates to prevent vaccine-preventable diseases

Vaccines for Children Program Strategies

In FY25, the NCIP will continue to implement the strategies described both in the CH Domain Annual Report and below to recruit and maintain public and private providers in the VFC program and strengthen the program.

NCIP Partnerships

One IB staff member is designated as liaison to the NCIC and will continue serving as an ad hoc member on the steering committee and a committee member on NCIC's HPV subcommittee.

IB leadership and staff plan to continue partnering with the N.C. Pediatric Society on joint messaging and promotion of childhood immunizations, with a particular focus on the time period prior to the start of the new school year and during the annual observance of Adolescent Immunization Awareness Month in North Carolina in the month of July.

Immunization Quality Improvement for Providers

The Immunization Branch will continue to provide IQIP visits in FY25. Although Tele-IQIP Visits are now authorized as a permanent option for conducting IQIP, the IB plans to conduct in-person visits when applicable or necessary. Regional Immunization Consultants will focus on CDC's four core strategies (scheduling the next immunization visit before the patient leaves the provider site; leveraging immunization information system (IIS) functionality to improve immunization practice; giving a strong vaccine recommendation for patients; and a custom CDC-approved strategy titled, "Address Health Disparities in Immunization Coverage" when conducting IQIP visits, and will work with each provider to implement at least two of those strategies. Subsequent follow-up and re-assessment of rates will track

provider progress through each 12-month IQIP cycle.

Additional Immunization Activities

The Child Health Program will continue to promote immunizations for children and youth according to AAP/Bright Futures schedule as part of the well-child visit. Information and updates will continue to be shared with LHD staff through provider webinar updates, child health clinical staff webinar updates, and through the annual CHTP. In addition, the Best Practice Nurse Consultant will restart the process of reviewing clinical charts to assure that program and clinical guidelines are met.

The CMARC Program will encourage parents to adhere to the AAP/Bright Futures guidelines for well-child visits, including receiving appropriate immunizations. CMARC care managers are often embedded in pediatrician or family practice settings or work in close collaboration with the child's medical home.

In addition, well visits with the medical home that follow AAP/Bright Futures guidelines will be encouraged by nurse home visitors. Often the nurse home visitor goes with the parent to the medical appointments to assure coordination between the provider and community-based services. Nurse home visitors will often go to the medical appointment with the family to reassure the family and to discuss needed community-based services.

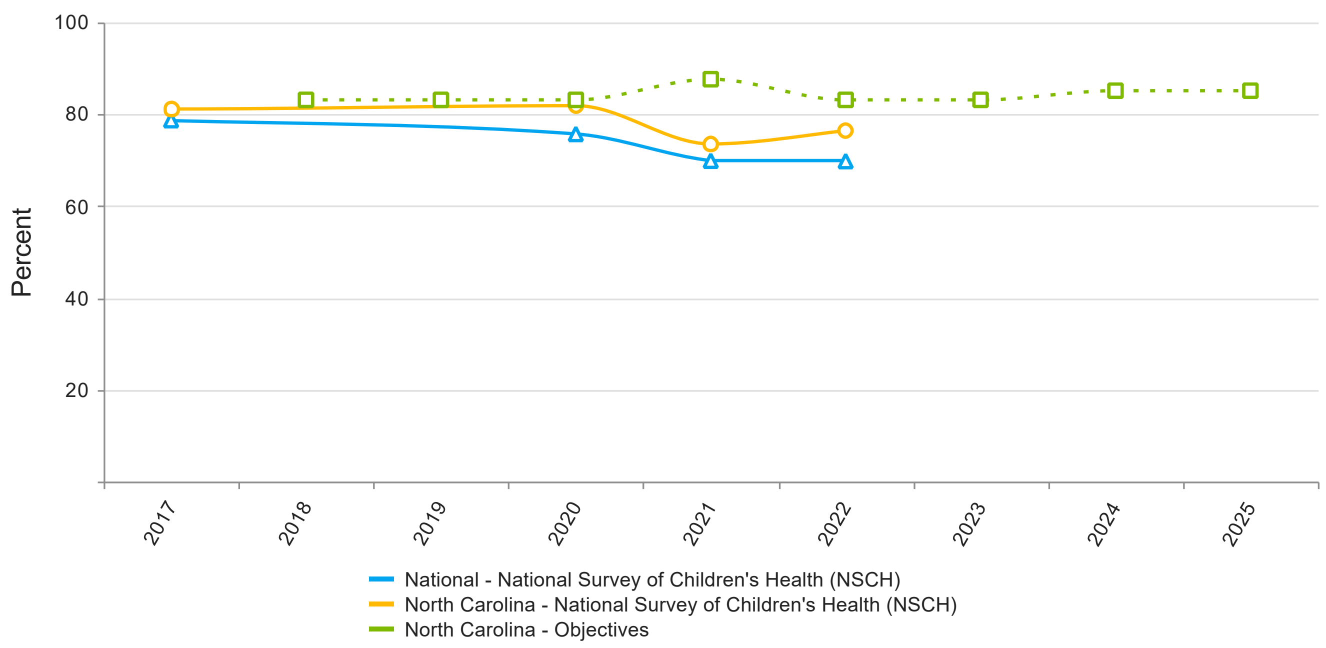
Among the many impacts of COVID-19 on NC is a marked decrease in the rates of well child visits and childhood vaccinations. In FY24, the Title V Office will continue to monitor vaccination rates closely and work with partners on outreach and sharing of best practices to increase vaccination rates and well child visit rates.

The SMD will continue to do outreach and presentations to child health providers at LHDs and in other practice settings and to agency representatives about the need to address decreased rates of well child visits and vaccinations as well as clinical guidance and NCDHHS materials related to improving COVID-19, influenza and other childhood vaccination rates in children and adolescents and addressing vaccine hesitancy.

## Adolescent Health

### National Performance Measures

**NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV**
**Indicators and Annual Objectives**




| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** |
| Annual Objective | 83 | 83 | 83 | 83 | 83 |
| Annual Indicator | 81.0 | 87.3 | 72.4 | 72.4 | 76.3 |
| Numerator | 638,902 | 786,182 | 588,143 | 588,143 | 619,903 |
| Denominator | 788,733 | 900,582 | 812,116 | 812,116 | 812,165 |
| Data Source | NSCH | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2016_2017 | 2019 | 2020_2021 | 2020_2021 | 2021_2022 |

| Annual Objectives | | |
|---|---|---|
| | **2024** | **2025** |
| Annual Objective | 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 | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 24,225 | 8,000 | 17,000 |
| Annual Indicator | | 16,676 | 7,656 | 16,169 | 18,265 |
| 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 |
| Data Source Year | | 2020 | 2021 | 2022 | 2023 |
| Provisional or Final ? | | Provisional | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 20,000.0 | 26,222.0 |

**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 | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 66.3 | 75 | 77 |
| Annual Indicator | | | 71.6 | 71.2 | 51.8 |
| Numerator | | | 4,334 | 5,073 | 5,207 |
| Denominator | | | 6,054 | 7,122 | 10,045 |
| Data Source | | | LHD/HSA | LHD/HSA | LHD/HSA |
| Data Source Year | | | SFY20-21 | SFY21-22 | SFY22-23 |
| Provisional or Final ? | | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 80.0 | 82.0 |

**State Action Plan Table**

| State Action Plan Table (North Carolina) - Adolescent Health - Entry 1 |
| --- |
| **Priority Need** |
| Improve access to mental/behavioral health services |
| **NPM** |
| NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV |
| **Five-Year Objectives** |
| AH 6. By 2025, increase the percent of adolescents with a preventive medical visit in the last year by 5% from 81% (Baseline 2016-17 NSCH) to 85%. |
| **Strategies** |
| AH 6A.1. Encourage development of teen clinics and outreach to teens by LHDs using Title V funding (351 Child Health Agreement Addendum Attachment C). |
| AH 6A.2. 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. |
| AH 6A.3. Continue Child Health Enhanced Role Registered Nurses training to include a focus on quality adolescent health services. |
| AH 6A.4. Provide training on adolescent health needs and provision of services at the Annual School Nurse Conference. |
| AH 6A.5. School Health Centers (SHC) 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 when behavioral health services are offered locally. |
| AH 6A.6. Partner with youth statewide through the Youth Public Health Advisor program to promote youth voice within programs and promote positive public health messaging to adolescents across the state. |
| AH 6A.7. Continue to work with the Division of Health Benefits and Prepaid Health Plans to expand outreach to increase both the number of visits and the quality of the care provided during the adolescent preventative visits provided to Medicaid and Health Choice enrollees. |
| AH 6A.8. Convene the NC-PAL Implementation Team in support of grant objectives for Pediatric Mental Health Care Access (PMHCA) and NC MATTERS. |
| AH 6A.9. Partner with NC DPI and other collaborators on statewide mental health initiatives including the School Mental Health Initiative and Social Emotional Learning in schools. |

| 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 |
| --- |
| NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM |
| NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle |
| NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide |
| NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC |
| NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX |
| NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS |
| NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS |
| NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu |
| NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV |
| NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP |
| NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN |
| NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB |

**Adolescent Health - Annual Report**

Adolescent Health promotion and services are present in many programs in NCDHHS, especially recognized in the School, Adolescent, and Child Health (SACH) Unit. The DCFW/WCHS and Title V Office support adolescent health around the state by coordinating health initiatives, expanding the use of evidence-based programs, practices, and policies, and providing adolescent health resources for youth, parents, and providers through multiple programs across NCDHHS. Adolescents are served across the DCFW/WCHS in all programs and represent almost half of the school age population. NC is fortunate that providing comprehensive school health services remains a priority of both DPI and NCDHHS. The DCFW/WCHS houses the State, Regional and Charter School Health Nurse Consultants who are responsible for planning, training, and consulting for school nurse positions located in LHDs, schools, and hospitals throughout the state, and also houses support for school health centers (SHCs). Although the school health nurse consultants (SHNCs) are paid for by a variety of funding types, six of the school health nurse consultants are supported through Title V funding.

Priority Need 6 – Improve Access to Mental/Behavioral Health Services

The Title V Office uses the Adolescent Well-Visit NPM (percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year) to monitor improvement about Priority Need 6 (Improve access to mental/behavioral health services). Behavioral health screening (as part of developmental surveillance, mental health screening, and substance use screening) is an important part of a preventive medical visit. Training has been provided to LHDs and SHCs about the importance of using behavioral health screening tools (i.e., HEEADSSS [Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety], PHQ-2/PHQ-9, and CRAFFT [Car; Relax; Alone; Forget; Friends; Trouble]). Technical assistance has been provided by the DCFW SMD, State Child Health Nurse Consultant (SCHNC) and Regional Child Health Nurse Consultants (RCHNCs) to consult with advanced practice providers or physicians and/or follow agency policies to connect adolescents with community-based services when concerns are identified with screening or with observations or conversations during the well visit. An archived HCPG webinar training was provided for LHD child health clinical staff which includes Bright Futures National Guidelines guidance on psychosocial-emotional and behavioral health screenings to increase provider awareness that these screenings should be offered at every well child visit, or a referral must be offered to address any identified risks or concerns during the visit. Guidance was also shared regarding the recommendation from Bright Futures National Guidelines and the US Preventive Services Task Force that depression screening should be offered starting at age 12 years. When screening is not available or risk factors are identified, a referral must be offered to address these concerns. The DCFW SMD also provided a two-part training on Adolescent Health to Public Health Nurses enrolled in the CHTP to increase awareness of screening, referral and follow-up. In addition, the DCFW/WCHS partnered with DPI to increase support to adolescents through the Support Teams in each school, which includes a behavioral health specialist.

Adolescent Well-Visit NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

Data from the 2021-22 NSCH indicate that parents report that 76.3% of adolescents in NC received a preventive medical visit in the past year. While the revisions to imputation and weighting by race and ethnicity for the 2021-22 NSCH do not yet allow for comparison to the data from the 2016-17 survey, NC did have a higher percentage than the nation in both the 2016-17 (78.7%) and 2021-22 (69.7%) surveys, although the confidence intervals overlap, so there is probably not a significant difference. 2021-22 NSCH results show that in NC, YSHCN were more likely to have received a visit than those youth without a special health care need (YSCHN – 90.2% v. non-YSHCN – 69.5%).

In one effort to help increase this percentage, the Title V Office chose ESM AWV.1 (Number of adolescents age 12

to 17 receiving a preventive medical visit in the past year at an LHD child health clinic or SHC) for this NPM. The number of adolescents receiving a preventive medical visit (CPT codes 99384 and 99394) in LHDs in FY23 was 10,045 which is a 41.1% increase from the number receiving visits in FY21 (6,054), but a 19.8% decrease from pre-COVID-19 FY19 (12,521). The decrease in the number of adolescents that received a preventative visit is correlated with the impacts of the COVID-19 pandemic. In addition, data for school year 22-23 indicate that 8,220 preventive medical visits occurred at the SHCs. For FY23, there was a combined total of 18,265 adolescents receiving preventative medical visits at the LHDs and SHCs.

An additional ESM chosen for this NPM is ESM AWV.2 (Percent of adolescents who had a behavioral health screening at time of preventive care visit at an LHD). For FY23, 51.8% of adolescents age 12 to 17 received a behavioral health screen at the time of their preventative care visits (CPT 99384 or 99394) at an LHD. Baseline data for this measure were collected in FY21 with 71.6% of adolescents who had behavioral health screenings during a preventive health visit at their LHDs during that time. In FY23, SHCs also completed 4,829 total depression screenings. The DCFW/WCHS continued to promote integrating mental health screenings during well-child visits and use of consultation to determine follow up for concerns through regularly scheduled child health webinars. The use of NC-PAL was promoted during several monthly child health webinars. Additionally, NC-PAL was one of the K-12 COVID mental health offerings through CDC Reopening Schools funding. The twelve other offerings were: 1) Trauma-informed leadership training, 2) PrimeCare4Youth (student training and placement in school behavioral health), 3) School Health Advisory Councils (SHACs), 4) System of Care convenings/webinars/action plans, 5) 988 hotline and media campaign, 6) Open to Care Campaign (improving connections to community), 7) Healthier Together for K-12 (supporting BIPOC and LGBTQIA+ students), 8) Youth Risk Behavior Survey, 9) NCCARE360 preparation for onboarding schools, 10) school EHR system, 11) IDHub (single identifier to link students across siloed data systems), and 12) Benefits cross-enrollment (matched data to identify individuals enrolled in benefit programs; SNAP, WIC, Medicaid).

Supporting the Development of Teen Friendly Clinics

SCHNC and RCHNCs continued to encourage LHDs to choose to allocate Title V Child Health AA funds to support the development of teen friendly clinics. A sample Attachment C template continued to be promoted in trainings and included on the LHD AA Resource page to assist LHDs in choosing evidence-based strategies to improve adolescent preventative care. While no LHDs chose to use funding to support the development of a teen friendly clinic in FY23, the SCHNC, RCHNCs and the SMD continued to provide TA to LHDs about the use of evidence-based strategies from the Attachment C template with LHDs as part of providing TA and trainings to LHDs. The following are examples of strategies that can be used to provide more adolescent-focused preventive care:

- Implement improvements in youth accessibility through hosting adolescent-friendly hours (later afternoon or evening hours), walk-in appointments, longer appointments, web-accessible information, and/or office space/check-in space for adolescents.
- Provide information and counseling through telephone, text messaging, or email hotline(s) to increase access and engagement.
- Engage providers and staff in professional development opportunities to further support their expertise and skillset in serving the adolescent population. Suggested trainings include:
  - Positive Youth Development
  - Motivational interviewing
  - Minors consent and confidentiality
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - Adolescent Health Initiative Spark Trainings
  - Implicit Bias

- Social Determinants of Health
- LGBTQ-friendly care
- Trauma-informed screening and assessment
- Wellness Recovery Action Plan (WRAP)
- Youth Mental Health First Aid

- Evaluate policies and procedures for adolescent confidentiality; review may include suggestions/modifications to the Electronic Medical Record that improve adolescent confidentiality, procedures for informing adolescents and guardians of confidentiality practices and more.
- Engage in an adolescent-friendly clinic review process and develop an improvement plan based on the findings:
  - Youth Friendly Services Assessment Tool and Guide (free)
  - Youth-Led Assessment Tool (Free)
  - Adolescent Champion Model (Fee-based)
- Complete an organizational assessment tool to evaluate behavioral health integration readiness.
- Implement behavioral health service integration through universal or targeted behavioral health screening practices.
- Develop and engage with a new or existing youth advisory group with an emphasis on raising awareness of the value of preventive care. Promote evidence-based clinical preventive services for adolescents among providers in the community.
- Develop a community-based strategy to promote adolescent preventive care visits via web/electronic resources, social media, meetings and events, and/or traditional media.

Technical Assistance and Training on the Components of the Annual Well Adolescent Visit and Quality Adolescent Health Services

The DCFW/WCHS continued to help support the provision of preventive health services to children from birth to 21 years of age primarily through LHD clinics which follow the most current Bright Futures national recommendations for preventive pediatric health care. The Bright Futures recommendations from 2021 were incorporated into the most current version of the HCPG which was last updated in 2021. The HCPG is used by the Medicaid program as the standard for preventive health care for children up to 21 years of age. During FY23, the DCFW SMD, SCHNC, and RCHNCs provided ongoing TA to LHDs about the required and recommended components of adolescent preventive health care and the importance of following the most current Bright Futures and AAP best practice recommendations to provide a complete well visit for those adolescents who come into LHDs asking for pre-participation physical evaluations (sports physicals) which is limited in scope. Guidance from the NC High School Athletic Association continued to be shared with LHDs and NC Pediatric Society providers to allow for safe athletic participation and clearance which now includes screening for depression and anxiety and for signs and symptoms related to complications concerning having a COVID-19 infection. In addition, the DCFW SMD and the SCHNC continued to promote the guidance for coding for sport physicals (Preparticipation Physical Evaluations) with the NC Office of the Chief Public Health Nurse which continued to be posted on their website as a resource to help with adolescent well visits. LHD staff continued to be provided information and articles about mental health, substance use, and behavioral health/psychosocial screening, and preparticipation physical evaluations for adolescents as well as links to past webinars on motivational interviewing and use of the HEEADSSS interview tool and the CRAFFT substance use screening tool. The DCFW SMD continued to use a self-assessment tool with new providers to LHDs about their knowledge, skills, and abilities related to all the well child preventive visit components. This tool specifically asks about these skills in relation to adolescents and skills with use of specific adolescent screening tools which include behavioral health and preparticipation physical evaluations. During FY23, the tool was used by the DCFW SMD and three advanced practice providers in providing targeted technical assistance to meet the needs of these providers.

Child Health Program audits of LHDs completed by the Best Practices Nurse Consultant (BPNC) resumed once COVID-19 travel restrictions were lifted and the demands on LHD staff due to COVID decreased. Consultation and TA continued to be provided by the SCHNC and RCHNCs regarding compliance with current HCPG age-appropriate requirements, billing and coding requirements and scope of practice. All the HCPG requirements and updated Bright Futures recommendations for an adolescent visit were promoted and shared with LHDs by the DCFW SMD and RCHNCs and included as quality improvement opportunities during audits when not present. These recommendations and requirements continued to apply to all adolescents served by the LHDs in addition to adolescents enrolled in Medicaid who were cared for in other practice settings.

The DCFW SMD, SCHNC, and RCHNCs provided TA and training as needed to new LHD providers about the requirements and recommendations for the annual well adolescent visit. The Consultants and DCFW SMD provided specific TA with LHDs to improve confidentiality and share best practice strategies for interactions with adolescents and with use of LHD EHRs. Monthly COVID-19 related webinars offered to LHDs by the DCFW/WCHS included information about the importance of doing outreach and providing well visits to adolescents. The DCFW SMD also discussed the toll during and after the pandemic had on adolescent emotional wellness and social connectedness and the ongoing need for screening for mental health risks, strengths, and coping skills.

Child Health Training Program (CHTP) for Child Health Enhanced Role Nurses (CHERRNs)

The CHTP continued as an accelerated and specialized public health course that teaches RNs how to obtain a pediatric health history and perform a physical assessment for clients from birth to 21 years of age. The purpose of the CHTP is to train Public Health RNs to become CHERRNs. Once RNs are officially rostered as CHERRNs, they are considered billing providers with NC Medicaid and can provide and bill for well child preventative visits for clients from birth to 21 years of age. The role of the CHERRN is to improve access to care and to link children and adolescents with a medical home, if the LHD does not serve as a medical home. The course includes examples of specific history and physical examination techniques to help with care of adolescent patients as well as clinical practice scenarios to enhance critical thinking skills and to help with learning documentation and billing. Students are expected to see a set number of adolescent patients during their clinical practicum period and share documentation from one adolescent visit with the CHTP faculty.

The CHTP is usually held once per year over a period of six months. Due to the COVID-19 pandemic, the 2022-23 CHTP was provided in a combination of onsite and virtual trainings using Microsoft Teams. COVID-19 precautions were followed when meeting onsite. Course content covered in FY23 as part of the remaining modules of the CHTP included CHERRN legal issues, confidentiality related to minor's consent, adolescent health, behavioral health, nutrition assessment, and current HCPG requirements/ recommendations specific to adolescent patients. These modules included several sessions that focused on adolescents or adolescent related issues such as: Bright Futures services for adolescents; required and recommended adolescent screenings; adolescent psychosocial/behavioral health/substance use screening tools; immunizations; use of gender-neutral language; and confidentiality issues for adolescents. These trainings also included information about developing resiliency in adolescents and addressing HCT. HCPG archived webinar trainings also continued to be required training components for the CHTP.

Continuing Professional Development regarding the following topics related to adolescent health was provided for CHERRNs during FY23:

- Communication and Engagement: Current Medicaid Engagement Initiatives
- From ACEs to Resilience: Reverse Narrative
- Welcoming Families to the Table: Enhancing Our Work by Centering & Partnering with Family leaders

- Refugee Child Health: An Overview for Healthcare Workers

Annual School Nurse Conference

The Annual School Nurse Conference has been held for the past 38 years and is attended by around 50% of the state's more than 1,600 school nurses. Participant evaluations and input from adolescents support the planning and topics to be covered at the next year's conference. The Public Health Nursing Institute for Continuing Excellence, the NC Institute for Public Health/UNC Gillings School of Global Public Health, and the DCFW/WCHS held the 38th Annual North Carolina School Nurse Conference on December 7-8, 2023. The conference was funded via the CDC Public Health Workforce grant. Additional initiatives funded via the grant are mental health modules for school personnel, and the SHACs conference to be completed in FY24.

School Health Nurse Consultation

School nurses facilitate the well-being and educational success of NC's children and youth through services directed towards keeping students healthy and ready to learn. Currently, six school nurse consultants are supported by Title V funding. FY23 continued to bring an improvement in the average NC school nurse to student ratio, moving from 1:833 to 1:809; however, these positions are largely supported through temporary COVID and ARPA-related funds. There was sustained difficulty to fill school nurse positions during FY23 with districts reporting 128 vacancies for longer than 6 months. Any sustainable impact on school nurse ratios and FTEs will require a permanent funding response.

The SHNC team held Regional Lead School Nurse Update meetings biannually during FY23 to provide TA for school nurses and school staff that provided care to adolescent students. The updates provided a forum for discussion related to a variety of emerging local adolescent needs and issues. Specific topics covered during the updates included teen substance abuse, naloxone availability, telehealth, and case management of adolescent students with chronic health conditions, including mental/behavioral health.

School Nurse Chronic Conditions Case Management

An average of 15% to 17% of the NC student population receives services in school each year related to chronic health conditions such as asthma, diabetes, seizures, severe allergies, and behavioral health conditions. Optimal control of health conditions supports student wellness and access to education. Learning self-management is also a goal for students who may often live with these conditions for many years. School nurses work with students, families, staff, and providers to assure that needed care and support are in place, often through providing case management services directed to individual student needs. The SHNC team provides TA, consultation, professional development, and resources to support school-based chronic condition case management services. Chronic condition case management guides created by the RSHNCs, including one for mental and behavioral health, are available to school nurses to assist and support student health and chronic condition management within a collaborative multi-tiered system structure. School nurse case management is defined as the intentional use and documentation of the nursing process in a manner that achieves individualized health and educational goals for students. Case management services by school nurses has been a priority focus since 2006. The number of school districts implementing a standards-based program, used by all district nurses, has improved over time. Growth in standards-based case management programs in NC Local Education Agencies continued progressively throughout FY23.

School Health Nutrition Consultation

The PNC serves on the DPI Healthy Schools "Choir" team (along with SHNCs) which meets quarterly to share information among nutrition and physical activity partners in the state whose focus is the school setting. In October

2022, the PNC reviewed and provided extensive feedback for the current NCDPI Healthful Living Standards on the nutrition and physical activity specific ones for all grades K-12.

School Health Centers (SHCs)

DCFW/WCHS funds 30 of the state's 90 plus SHCs for the purpose of increasing access to primary and preventive health care for older children and adolescents, ages 10 to 19 years old. Many of whom are living in underserved and high-risk communities across the state and may have limited access to healthcare. For most SHCs, this includes nutrition and mental health services. SHCs are considered to be one of the most effective and efficient ways to provide preventive health care to adolescents. Few programs are as successful in delivering health care to adolescents at low or no cost to the patient, particularly on-site or near school campuses. SHCs provide primary and preventive care for the purpose of improving adolescents' and pre-adolescents' health and academic success, which directly contributes to the effort by DCFW/WCHS to meet the Adolescent Well-Visit NPM. During FY23, the SHCs recovered from the effects of the pandemic, as SHCs returned to normal capacity and normal operating hours. All SHC facilities have returned to normal operation hours to accommodate a schedule more consistent with full-time attendance and full-time staffing. SHC staff members were fully employed and continued to provide telehealth when necessary and fully available for all students attending school.

School Health Center Credentialing

The DCFW/WCHS SACH Unit continues to maintain credentialing/re-credentialing processes with SHCs based on best practice guidelines. All documents submitted by SHCs scheduled for re-credentialing are reviewed by an interdisciplinary team (Behavior Health, Nutrition Services, Medical, and Preventive) within the SACH Unit. Applicable and appropriate action is taken to evaluate SHCs for a credentialing status via a review of compliance with "NC Quality Assurance Standards for SHCs" and a Medical Record Review of a minimum of ten random de-identified patient records for all applicable medical services provided. During FY23, SHCs continued to receive support/TA as schools assumed normal operating hours. While normal operation has occurred, the marked increase in the number of students needing behavioral health services has focused more attention on ways to appropriately diagnose and support youth mental health in SHCs. School nurses, counselors, social workers, teachers and SHCs are working to provide a safety net by providing high quality health care where youth spend most of their time.

Normal credentialing processes resumed as students returned to school and COVID-19 restrictions were lifted. Monitoring assistance and advising has remained consistent for all SHCs. Scheduling changes due to employment vacancies and transition as well effected re-credentialing delays. Mental health services experienced an increase in the number of behavioral/mental health procedures with SHCs reporting 17,006 behavioral/ mental health procedures during FY23. The increase was notable as it seems to indicate the residual effect of the social isolation created by COVID and lack of engagement amongst students.

Youth Leadership and Partnership

During FY23, the Youth Health Advisors (YHA) Team convened virtually twice monthly to provide support to programs in the DCFW/WCHS that serve adolescents. The team engaged in a process of Youth Participatory Action Research (YPAR), a research and intervention process led by principles of positive youth development and social justice. Throughout the year team members identified a youth health problem within their school or community, developed a research question, collected and analyzed data, and came up with data-driven solutions. Team members shared their research findings in schools and with community groups.

The YHA Team also continued to extend their expertise to DCFW/WCHS partners throughout FY23 in matters of social and emotional learning, adolescent preventive care and education, reproductive health programming, and youth behavioral health. The Adolescent Health Coordinator (AHC) continued to serve on AMCHP's Youth Voice Amplified Committee, and one youth leader was able to attend the annual AMCHP conference, committing to ensure the inclusion of diverse and inclusive youth experiences in AMCHP's programs and policies as well as the broader MCH field.

Outreach Efforts to Medicaid and Health Choice Enrollees

Through partnerships with DHB (NC Medicaid), the PHPs for NC Medicaid Managed Care, LHDs, and SHCs, the DCFW/WCHS staff continued to provide quarterly training events for clinical staff in promoting well care for adolescents, including use of screening tools for social emotional assessments to expand outreach to increase both the number of visits and the quality of the care provided during the adolescent preventative visits provided to Medicaid and Health Choice enrollees.

SCHNC, RCHNCs, DCFW SMD, and other WCHS staff continued to work with parents, adolescents, health care providers, LHDs, and health care professional agencies to promote the importance of the well visit to youth and parents when youth come in for visits that are not well visits such as when receiving a sports physical (preparticipation physical evaluation) which is best done as part of the well visit. DCFW continued to do outreach under the MOU with NC Medicaid to increase enrollment of CYSHCN into Medicaid and Health Choice and linkage to a medical home for ongoing care which includes adolescent well visits. Outreach efforts that were conducted during FY23 are described in the CYSHCN Domain Annual Report.

NC Psychiatric Access Line (NC-PAL)

NC-PAL's is a free telephone consultation and education program helping health care providers address the behavioral health needs of pediatric and perinatal patients. The NC Title V Director, CYSHCN Director, DPH/WICWS staff, Adolescent/Behavioral Health Coordinator, DCFW SMD, and other DCFW/WCHS staff, particularly those in the Child Behavioral Health Unit, continued to advise and participate in NC-PAL implementation work during FY23.

Behavioral Health Consultants respond to questions about behavioral health and local resources and connect providers to one of the on-call psychiatrists. Consultation and training are provided to primary care providers, specialty care providers, educators, program staff, community-based organizations and facilities that care for individuals with behavioral health needs in the timely identification, diagnosis, management, treatment, and referral of patients with behavioral health concerns and conditions. NC-PAL is available to all 100 counties in NC.

The Title V Director and DCFW/WCHS staff members continued to meet virtually every month with NC-PAL staff to provide and receive updates. To date, the program has taken over 3,000 provider calls from 65 of NC's 100 counties.

With continued funding through Mental Health Block Grant funds, Medicaid and HRSA, NC-PAL continued to work on the following during FY23:

- Building infrastructure including 2 additional HUBs in the Western (Tribal) and Eastern parts of the state. These HUBs will provide resources and do additional outreach to primary care providers
- Pilot work with 3 CDSAs providing consultation and training
- Pilot work with 3 local DSS offices, by providing consultation and training in an effort to decrease crisis and

out of home placements.

- Participate in Rapid Response meetings – daily clinical staffing calls with NCDHHS, county DSS, and PHP staff to focus on children in Emergency Departments or DSS offices awaiting medically recommended behavioral health services. NC-PAL provides recommendations on services, needed assessments, and medication reviews.
- Pilot consultation and education with select school districts
- REACH training for psychiatrists and other practitioners to support behavioral health needs of children in their practices and local communities.

School Mental Health and Social Emotional Learning

The DCFW/WCHS worked with DPI and DMH/DD/SAS on mental health access and school mental health for adolescents as well as participating with DPI's mental health initiatives for planning and implementation at the local level. These efforts include engagement on the statewide implementation team for social and emotional learning standards. RSHNCs and the Adolescent Health Coordinator also engaged in the state School Mental Health Initiative, a multi-disciplinary partnership of partners providing support to promote healthy social and emotional wellbeing and address the continuum of supports and services for student mental health and substance use. RSHNCs also continued to support local school nurses as part of the Specialized Instructional Support Personnel to address behavioral issues, suicide and bullying in schools.

School behavioral health services play a pivotal role in addressing the needs of youth. During FY23, DCFW/WCHS, in partnership with NC DHHS and NC DPI, released the NC School Behavioral Health Action Plan. Strategies from this plan included recommendations for investments in training and education, prevention and supportive services, direct access to school-based services, and more.

Additionally, DCFW in conjunction with DPI restructured the advisory committee (including its vision) to the State Board of Education to have decision makers from various departments, divisions, and other agencies at the table. The restructured advisory committee was named the Whole Child NC Advisory Committee. The vision of the committee is "State agencies and partners will coordinate so that all children thrive in a nurturing environment and have the resources and supports they need, provided the way they need them, and when they need them. The WCHS Assistant Director serves as a planning group member for the committee.

Furthermore, leadership and staff from both DPI and DCFW met monthly to touch bases on initiatives regarding school mental health to strengthen collaboration and coordination.

Youth Suicide Prevention Coordinator

Title V funding supports the position of the Youth Suicide Prevention Coordinator housed in the CDI Section. This position was filled on September 1, 2023, after having been vacant since August 2021. In FY25, this position will continue to collaborate on activities with NCDHHS and the DCFW/WCHS which include data dissemination, participation in health equity trainings, and provision of technical assistance, education, and training. The CDI Section also receives funding Comprehensive Suicide Prevention (CSP) Programs funds the CDC, so this position helps extend that work by working with unfunded CSP counties to increase efforts to collaborate and coordinate services and provide youth CSP program management.

Triple P

Triple P has a free online evidence-based adolescent component to help families manage behavioral problems along with the face-to-face adolescent component. As described in the CH Domain Annual Report, DCFW/WCHS continued working in partnership with other internal and external partners through the NC PSG and the Triple P State Learning Collaborative to support the continued implementation of Triple P which includes a focus on adolescents. Additionally, the PSG convened the NC Triple P State Partners Coalition which represents all the internal and external partners who either support and/or have a vested interest in the success of Triple P in NC.

Promote Importance of Adolescent Preventive Care Including Behavioral Health Risk Assessment

DCFW/WCHS continued to raise awareness with LHDs, other health care providers, and professional agencies about the NC DSS recommendations for the frequency and content of the visits for adolescents who come into care. These recommendations, which have been aligned for several years with the majority of the AAP recommendations, include: an acute visit within the first week of placement in care; a comprehensive visit within 30 days of placements in care; and then well visits (which include a behavioral health risk and strengths assessment and mental health screening) every six months. During FY23, the DCFW SMD and Title V Director worked with Fostering Health NC and DSS to promote guidance during the pandemic for social workers and foster parents involved with caring for children and adolescents in foster care to continue receiving enhanced preventive health care visits in person and/or via telehealth according to these established DSS recommendations. This means following the national AAP recommendations for visits every 6 months and visits that include mental health screenings at each visit and other behavioral health risks. See here for more resources from AAP in addition to those from the Fostering Health NC Online Library (temporarily off line and will be relocated to a location related to NC DSS.) Title V staff members have worked closely with Fostering Health NC Transition Age Youth (TAY) Work Group and Fostering Health NC staff to review and develop several of these resources.

Reduce Weight Bias/Stigma and Promote Weight Inclusive Care for Children and Adolescents

In FY23, the PNC continued to ensure trainings for health professionals, supported through some programs (Child Health and School Health) through DCFW and with outside partners (i.e.., Eat Smart, Move More NC [ESMMNC]), included appropriate messaging to promote Health at Every Size® and Weight Inclusive principles and practices to reduce weight bias, especially for kids in larger bodies who can be at greater risk for bullying, eating disorders, and other trauma that can affect their mental health. In December 2022, the PNC was asked by NC DPI Healthy Schools staff (based on staff hearing a presentation the PNC had done for ESMMNC) to present and share resources at their NC Healthy Schools Office Hours about Weight Bias and Weight Inclusive Resources for Schools. The PNC also co-planned and presented to approximately 75 school nurses at the December 2022 School Nurse Conference on Weight Inclusive Approaches to Health in Schools.

Overall Nutrition and Physical Activity TA & Consultation

Throughout FY23, the PNC also continued to share up-to-date nutrition and physical activity information and resources related to adolescents (i.e., Joyful Movement showcasing teens in larger bodies and updates on Child Nutrition Programs and food insecurity) with the SHNCs and CHNCs, the AHC, and the SHCs Consultant on a regular and ongoing basis.

**Adolescent Health - Application Year**

Priority Need 6 – Improve Access to Mental/Behavioral Health Services

The COVID-19 pandemic has highlighted challenges related to decreased rates of well visits and vaccinations among adolescents as well as increasing rates of youth mental health that had been building even before the pandemic. DCFW will advocate for annual preventive well visits with a need to screen, identify and manage mental health concerns and specifically screen for risk for suicide. The creation of DCFW includes a focus area on children's mental health, staff members who came from DHM/DD/SAS, and a unit dedicated to behavioral health. One deliverable for DCFW was the creation of a children's mental health dashboard for the state, and the Child Behavioral Health Dashboard was unveiled in February 2024. In FY25, there will be additional measures for the dashboard including, but not limited to, data related to emergency departments, Psychiatric Residential Treatment Facilities, and LMEs/MCOs mental health follow up for beneficiaries.

The pandemic has also presented some unique issues related to the need to promote shared decision making and assessing the decisional capacity of adolescents. This has come up in NC related to the ability of adolescents to use minor's consent to receive vaccines that are not FDA approved to prevent COVID-19. DCFW will continue to work with state and community partners to improve shared decision making and informed consent especially related to youth in foster care or former foster youth about annual well visits and the preventive health components of these visits.

Supporting the Development of Teen Friendly Clinics

In FY25, LHDs will still be able to choose to allocate Title V/351 Child Health Agreement Addenda funds to support the development of teen friendly clinics. LHDs will be encouraged to adopt the strategies outlined in the Adolescent Health (AH) Domain Annual Report to provide more adolescent-friendly preventive care which also includes screening, identification, management, and referral for behavioral health issues (mental health and substance use). Specific plans for FY25 to support teen friendly clinics include exploring how to highlight several LHD efforts to improve access to well child visits for adolescents. The DCFW/WCHS will also continue to provide targeted TA and consultation to increase the number of LHDs who offer adolescent reproductive health services in the child health clinics at the same time as the well child visit.

Technical Assistance and Training on the Components of the Annual Well Adolescent Visit and Quality Adolescent Health Services

In FY25, HCPG archived webinar trainings will continue to be required training components for LHD Public Health RNs who are enrolled in the CHTP to become CHERRNs and made available to all LHDs for review on the Child Health Provider Resource page. In addition, the archived webinar about sudden cardiac death and the 2021 CDC STI Recommendations will continue to be made available to LHDs.

The DCFW/WCHS Child Health Nurse Consultants (state and regional) and the SMD will continue to provide TA and training as needed to new LHD providers about the annual well adolescent visit based on the NC HCPG. The HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety) behavioral risk and strength interview will continue to be promoted as a required part of the well visit that meets the developmental surveillance requirement for the HCPG. TA on best practices for how to provide a sports physical (preparticipation physical evaluation) and school health assessment which are recommended to be done as a well visit as per the AAP will also be provided. The SMD will continue to use a revised self-assessment tool for CHTP students and preceptors and also for new providers working in LHDs to determine TA and resources related to

recommended and required components for adolescent well visits.

Child Health Enhanced Role Nurses (CHERRN) Training

The CHERRN training will continue to include information about improving access to care for all children, including adolescents. Plans for FY25 include beginning training for another class of CHERRN students which will continue to include two live sessions on adolescent health with specific focus on confidentiality, minor's consent, strengths and risks for adolescents (i.e., ACEs and SDOH), an archived webinar on use of the HEADSSS, and screening, identification and consulting with physicians and advanced practice providers to address substance use in adolescents.

Annual School Nurse Conference

Topics related to adolescent health are regularly included in the Annual School Nurse Conference. Planning for the December 2024 conference began in early 2024. RSHNCs and local school nurses will participate on the planning committee. The Youth Health Advisor Team Coordinator and representatives from the Youth Health Advisor Team will provide input for the planning process in session proposal review. The Program Planning Committee is seeking proposals on topics relevant to NC School Nurses in their clinical work as well as in their role as a member of the school-based team that addresses barriers to student health and access to education. Adolescent health topics that have been prioritized include mental health crisis/suicide prevention, anxiety and other mood disorders, vaping, and substance use prevention.

In FY25, the PNC will continue to work with RSHNCs, RCHNCs and others to ensure trainings for health professionals, supported through programs through DCFW and with outside partners, include appropriate messaging and resources to promote Health at Every Size® and Weight Inclusive principles and practices to reduce weight bias, especially for adolescents in larger bodies who can be at greater risk for bullying, eating disorders, and other trauma that can affect their mental health.

School Health Centers

Specific plans for SHCs in FY25 include continuation of funding for 30 of the state's >90 SHCs. SHCs are now fully functional and have recovered from the pandemic related experienced activity. All 30 SHCs have returned to becoming appropriately staffed to support the needs of children. In FY25, SHCs will continue to strengthen their workforce and explore ways to improve, increase, and provide ongoing quality services to students. Nutrition resources will continue to be provided and will remain a consistent priority in the effort to assure educational success. Creative ways of providing or improving mental health services will also continue to be prioritized as COVID produced a considerable need for attention to youth mental health. The monitoring and TA for SHCs will remain an ongoing process to assure that resources and guidance are readily available. While TA is performed primarily in the form of email and phone calls, assistance and resources may as well be provided in the form of requested trainings, contract development and revisions, processes, budget advising and assistance, data collection and resource sharing.

The NC SHC Program will also continue its family and youth engagement through their participation in the bi-annual NC School Health Advisory Council Meetings and on behalf of their state funded health centers at the DCFW/WCHS meetings. The NC School Health Advisory Council CHOIR collaborates with the NC SHC Program to address, advise and respond to the Program's policies, procedures and proposals and provide input into and feedback about programmatic decisions affecting state funded SHCs. Presentations will be provided for council members and DCFW/WCHS staff about student positive SHC experiences. They will also continue to share feedback about how

youth are effectively communicating with their peers and health care staff while suggesting ideas for increasing adolescent enrollment at their SHCs. Through these activities, the NC SHC Program will continue to increase internal collaborations with the FLS and FP and external collaborations with youth, families, and SHC staff. Additionally, SHCs will continue to have access to the SMD for the purpose of providing medical consultation.

School Health Center Credentialing

In FY25, the SACH Unit will continue to maintain credentialing/re-credentialing processes with SHCs based on best practice guidelines as described in the AH Domain Annual Report. The credentialing process has returned to normal activity. During FY25, the plan is to complete all required credentialing. Submission of Medical Record Audits is still required and will occur by the SHCs for review of all applicable medical services provided. Policies will also continue to be developed and reviewed through a collaborative effort with the local and national School Based Health Alliance. In addition, policy, quality assurance, and credentialing will also be reviewed, enhanced and continuously developed through an ongoing collaborative engagement with the NC School Health Advisory Councils.

NC Youth Health Advisor (YHA) Team

The YHA team will continue to meet bimonthly to provide support to programs in the DCFW/WCHS that serve adolescents in FY25, building upon partnership work established during FY24. 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 FY25. 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 Youth Advisors sharing pertinent and timely messages for teens. In FY25, the PNC will continue to work with the Adolescent Health Coordinator and YHA team to ensure trainings for health professionals include appropriate messaging to promote Health at Every Size® principles as described above. The PNC will also continue to share nutrition and physical activity resources with the Adolescent Health Coordinator, RSHNCs, the SHC Coordinator, and staff members in the Child Behavioral Health Unit. The Adolescent Health Coordinator will also continue to coordinate health related presentations by partnering with public health related entities designed to inform and address relevant issues concerning youth. In FY25, the 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.

Outreach Efforts to Medicaid Beneficiaries

Title V staff will continue to do outreach under the IMOA with DHB to increase enrollment in Medicaid of CYSHCN and linkage to a medical home for ongoing care which includes adolescent well visits. (See CYSHCN Domain Annual Plan for more details of plans for outreach efforts.) In addition, DCFW/WCHS, in partnership with other divisions in NCDHHS, will continue to promote shared decision making and informed consent with adolescents during adolescent well visits about different services. The SMD will continue to participate in a DSS well-being design committee that will be restructured to include perspectives of young adults with lived experience in foster care and agencies who serve them to promote and develop materials about shared decision making and informed consent about the appropriate option for Medicaid for preventive health care for adolescents which includes screening for mental health risks and concerns.

RCHNCs, SCHNCs, RSHNCs, SMD and other DCFW/WCHS staff will also continue to work with youth, parents, LHDs, other health care providers, and health care professional agencies to promote the importance of the well visit

to parents and adolescents. Opportunities to promote the well visit will continue to be explored during visits with pharmacists who may offer access to COVID-19 vaccines, oral contraceptives, and nicotine replacement therapy using the appropriate pharmacy and state health director standing orders.

North Carolina Psychiatry Access Line (NC-PAL)

NC-PAL has become even more critical with the mental health crisis for children and adolescents that has been exacerbated by the pandemic. The purpose of the program is to promote behavioral health integration into pediatric primary care by supporting the planning and development of statewide, regional, or tribal pediatric mental health care tele-consult access programs. The pediatric mental health care team provides tele-consultation, training, technical assistance, and care coordination support for pediatric primary care providers (PCPs) to diagnose, treat, and refer children with behavioral health conditions. NC-PAL programming has had considerable growth since its inception and will complete a 5-year grant cycle at the beginning of FY24.

During FY24, the program will apply for a three-year grant continuation that will allow the program to continue to expand access to, coordinate, and improve the quality of behavioral health services that PCPs and other providers can provide to children, adolescents, and their families, including in sites such as schools. The program will continue to convene an advisory committee to promote efforts across the state in partnership with the NC Pediatric Society, NC Academy of Family Physicians, family medicine residency programs, and other agencies to increase use in all counties to utilize the NC-PAL. NC-PAL will continue to target specific strategies to work with PCPs: scheduled case consultation on panels of patients with mental health issues; working with AHEC in regions to offer local consultation; exploring ways to develop a hub for mental health support in the western part of the state; and working with PCPs in counties experiencing increased cases of mental health crises in youth. In addition, REACH trainings will continue to be offered to PCPs to increase competencies of PCPs to address child and adolescent mental health identification and management. DCFW/WCHS staff members will also continue to promote the use of the NC-PAL with child health clinic staff at local health departments, school health centers and school nurses. NC-PAL has received support from the state of NC and now will be able to work with Rapid Response Teams to address the complex behavioral health needs of children involved with child welfare in crisis for assessment and placement in care in facilities and therapeutic foster homes. NC-PAL will continue to provide telehealth consultation support to local CDSAs and schools via consultation services or other program offerings through continued grant funding during FY24. During FY25, the PNC will meet with NC-PAL staff and the SMD to explore opportunities to collaborate including ensuring that disordered eating, eating disorders, and related nutrition, physical activity and mental health concerns and other specialty care providers are being included where and when appropriate into services and supports.

School Mental Health Initiative and Social Emotional Learning

The DCFW/WCHS will continue to work with DPI and DMH/DD/SAS on mental health access and school mental health for adolescents as well as participating in DPI's mental health initiatives for planning and implementation at the local level. In FY24, RSHNCs will continue to support local school nurses as part of the School Resource Team to address behavioral issues, suicide and bullying in schools. In addition, the Adolescent Health Coordinator will co-lead an effort to establish parent and youth councils to partner with DPI and other agencies to collaborate on the statewide vision and implementation of social and emotional learning in NC schools. During FY25, the Adolescent Health Coordinator will continue to serve on a multidisciplinary state team receiving national technical assistance to enhance collaborative TA and professional development for student and school staff well-being. In addition, the PNC will continue to be a resource to the DPI Healthy Schools team to provide trainings, resources, and messaging to promote Health at Every Size® and Weight Inclusive principles and practices and to reduce weight bias, stigma, distorted body image concerns and other mental health and nutrition related health issues (eating disorders and disordered eating).

Triple P

During FY24, the NC Triple P System will continue to focus on adolescents through the work of the NC PSG, LIAs, and the Triple P State Learning Collaborative. Specific activities planned for this funding period include: 1) Provide parent education and support to caregivers for adolescents, utilizing a specific Triple P System of interventions targeted for caregivers of adolescents; 2) Implement interventions which range from brief to more intensive support, depending on the needs of the adolescent, caregivers, and family; 3) Implement interventions which include options for practitioner-facilitated sessions as well as self-paced online modules (Triple P Online); 4) Implement interventions that provide parents/caregivers with concrete strategies for developing relationships with adolescents and parents/caregivers, encouraging more practices that parents/caregivers want to see from adolescents such as teaching adolescents new skills and behaviors; 5) Implement adolescent focused strategies to increase parent/caregiver competency and confidence in utilizing these concrete strategies, caregiver parenting improves adolescent adjustment/well-being and consequently, family conflict decreases; and 6) Support overall parent/caregiver adjustment, which results in parent/caregiver competency, allowing them to be better equipped in using effective strategies proactively.

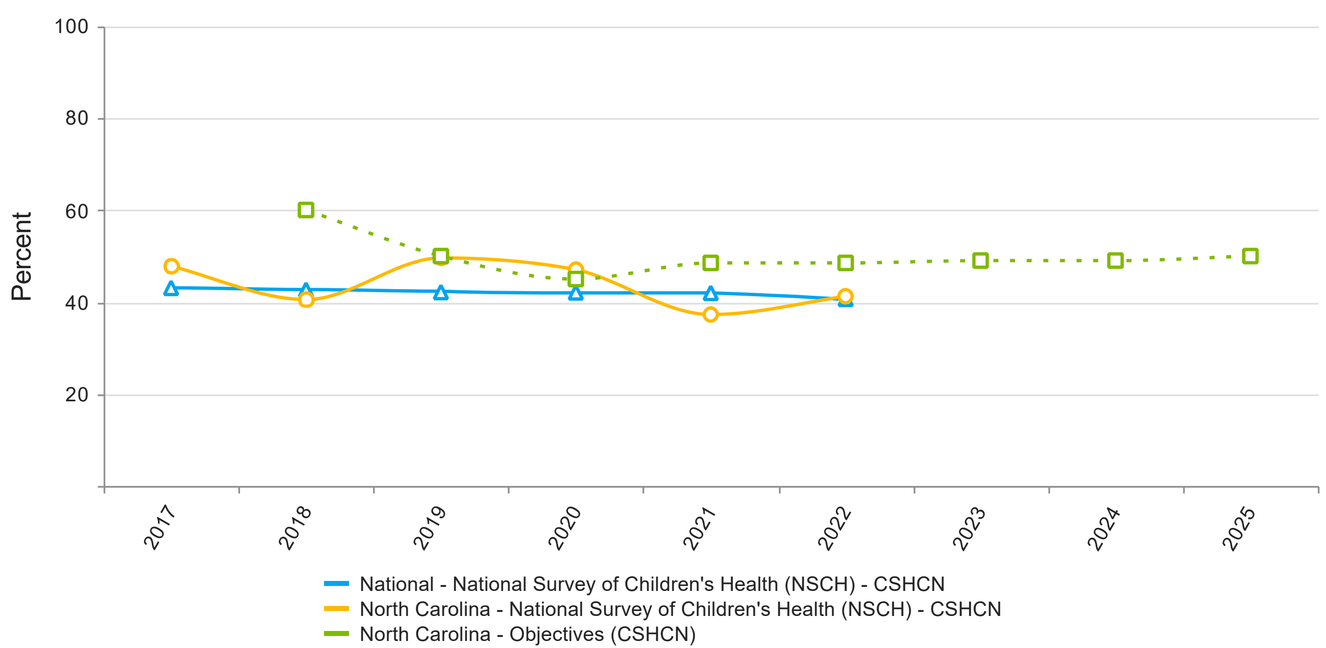
Promote Importance of Adolescent Preventive Care Including Behavioral Health Risk Assessment

The SMD and CYSHCN outreach staff will continue to promote the importance of adolescent preventive care including behavioral health risk assessment in policies and processes and during meetings, presentations, and discussions with state and community agency partners. These partners include but are not limited to the NC Coalition to Promote Children's Health Insurance, Fostering Health NC, NC DHB, NC Pediatric Society, health care providers, NC Public Health Association, academic centers, DSS, and AHECs. DCFW/WCHS SCHNC and RCHNCs will continue to monitor adolescent well visits in LHDs and explore additional data sources for monitoring adolescent well visits and its components including CPT codes for behavioral health risk assessments in Medicaid and other payors.

## 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 (Medical Home, Formerly NPM 11) - MH**
**Indicators and Annual Objectives**




**NPM MH - Children with Special Health Care Needs**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| Data Source: National Survey of Children's Health (NSCH) - CSHCN | | | | | |
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | 50 | 45 | 48.5 | 48.5 | 49 |
| Annual Indicator | 41.0 | 48.4 | 36.3 | 36.3 | 41.2 |
| Numerator | 199,181 | 241,421 | 184,239 | 184,239 | 211,221 |
| Denominator | 485,743 | 498,468 | 507,316 | 507,316 | 512,437 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2017_2018 | 2018_2019 | 2020_2021 | 2020_2021 | 2021_2022 |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 49.0 | 50.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM MH.1 - Percent of children with special health care needs who received family-centered care**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 88.7 | 85 | 87 |
| Annual Indicator | 85 | | 80.8 | 80.3 | 84.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | 2018-19 NSCH | | 2019-20 NSCH | 2020-21 NSCH | 2021-22 NSCH |
| Data Source Year | 2018-19 | | 2019-20 | 2020-21 | 2021-22 |
| Provisional or Final ? | Final | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 90.0 | 90.0 |

**ESM MH.2 - 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: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 10 | 12 | 18 |
| Annual Indicator | | 8 | 9 | 17 | 13 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | 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 |
| Provisional or Final ? | | Final | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 15.0 | 16.0 |

## State Action Plan Table

### State Action Plan Table (North Carolina) - Children with Special Health Care Needs - Entry 1

#### Priority Need

Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN

#### NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

#### Five-Year Objectives

CYSHCN 6A. By 2025, increase the percent of CYSHCN having a medical home by 9% from 41% (NSCH 2017-18 baseline) to 45%.

#### Strategies

CYSHCN 7A.1. Provide education, training and support to providers on delivering a medical home approach to care: 1) Collaborate with the NC Chapter of American Academy of Pediatrics to promote PCMH and educate and train providers; 2) CMARC care managers and Home Visitors will do outreach to primary care providers.

CYSHCN 7A.2. Provide education, training and support to families on medical home approach to care. Provide information and resources to families through a variety of methods including fact sheets, an enhanced website, CYSHCN Help Line, Family Partnership, and trainings.

CYSHCN 7A.3. Engage parents of CYSHCN in DCFW/WCHS program planning, implementation and evaluation, and in training opportunities to be collaborative leaders at the community, state, and national level.

CYSHCN 7A.4. DCFW/WCHS outreach staff will continue to provide outreach for insurance enrollment and assistance in navigating children's health insurance programs, with an emphasis on minority and underserved populations as well as CYSHCN.

CYSHCN 7A.5. Explore potential modifications to improve the Innovative Approaches (IA) Initiative to meet emerging needs.

CYSHCN 7A.6. Continue to train parents, caregivers, and dental providers serving CYSHCN in best oral health practices and the importance of a dental home.

CYSHCN 7A.7. Continue to partner with internal and external partners to assure a supportive system of care for CSHCN in child care facilities, receiving genetic counseling services, and for children and youth with hearing loss, including parent choice in communication modes for their child.

CYSHCN 7A.8 The NC Office of Disability and Health (NCODH) will continue to provide technical assistance and education to partners to support increased access and inclusion of CYSHCN in public health activities and health care settings.

| ESMs | Status |
| --- | --- |
| ESM MH.1 - Percent of children with special health care needs who received family-centered care | Active |
| ESM MH.2 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion | Active |

| NOMs |
| --- |
| NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC |
| NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX |
| NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS |
| NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC |

## State Action Plan Table (North Carolina) - Children with Special Health Care Needs - Entry 2

### Priority Need

Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN

### NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

### Five-Year Objectives

CYSHCN 7B. By 2025, increase the percentage of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care by 30% from 16.5% (NSCH 2018-19 baseline) to 21.5%.

### Strategies

CYSHCN 7B.1 Continue a medical home work group to prioritize recommendations related to medical home and health care transition from the DCFW/WCHS CYSHCN Strategic Plan.

CYSHCN 7B.2 Collaborate with DSS to support health care transition for youth in foster care.

CYSHCN 7B.3 Explore modifying language in the agreement addenda for LHDs and SHCs to include a requirement to implement a strategy to support health care transition.

CYSHCN 7B.4 Explore development of sample language for Transition of Care Policy for youth and young adults.

| ESMs | Status |
|---|---|
| ESM MH.1 - Percent of children with special health care needs who received family-centered care | Active |
| ESM MH.2 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion | Active |

## NOMs

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

## State Action Plan Table (North Carolina) - Children with Special Health Care Needs - Entry 3

### Priority Need

Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN

### NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

### Five-Year Objectives

CYSHCN 7C. By 2025, increase the percentage of children ages 4 months to 5 years with sickle cell disease who are placed on prophylactic antibiotics by 4% from 73% (2019 baseline) to 76%.

### Strategies

CYSHCN 7C.1. Provide education to parents on the importance of prophylactic antibiotics during Educator Counselors initial contact.

CYSHCN 7C.2. Provide webinar for providers on the importance of prophylactic antibiotics.

| ESMs | Status |
| --- | --- |
| ESM MH.1 - Percent of children with special health care needs who received family-centered care | Active |
| ESM MH.2 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion | Active |

### NOMs

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

Priority 7 – Improve Access to Coordinated, Comprehensive, Ongoing Medical Care for CYSHCN

As detailed in the Child Health Domain, the 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 DCFW/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 FY23 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 DCFW/WCHS programs. Much work is being done to improve the Medical Home NPM. Data for NC from the 2021-22 NSCH indicate that 41.2% of CYSHCN had a medical home as compared to 51.1% of children and youth without special health care needs (non-CYSHCN). National rates for this measure are 40.7% for CYSHCN and 47.4% 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.

2021-22 NSCH data for ESM MH.1 showed that 84.3% of respondents said their CYSCHN received family-centered care which was slightly higher than the national rate of 82.2%, 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 FY23 there were at least thirteen relevant meetings where medical home promotion was discussed. This number was lower than in FY22 due to several vacancies in staff positions.

Several DCFW/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 FY23, the Advisory Committee met three 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 FY23, 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 2022-23 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: Community and Engagement: Current Medicaid Engagement Initiatives; From ACEs to Resilience – Reverse Narrative; Welcoming Families to the Table: Enhancing Our Work by Centering and Partnering with Family Leaders; and Refugee Child Health: An Overview for Healthcare Workers. 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 support 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 used opportunities with the NCPS (weekly Solution Share and practice managers listserv), NC Medical Society Leadership College Program, and other events 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 Children with Special Health Care Needs Help Line via presentations. The DCFW SMD continued to try to stay current on clinical policy changes related to Medicaid and Health Choice to provide TA 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 also 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. Additionally, the DCFW SMD participated in, presented twice, and brought issues for discussion to two meetings of the Pediatric Advisory Committee which has looked at issues for CYSHCN and the different tiers recognized as Advanced Medical Home under Medicaid Managed Care. The managed care chief medical officers from PHPs attend both of these advisory group meetings. The NCODH continued to offer accessibility reviews for LHDs at their request to enhance the care of CYSHCN and to assist in achieving accreditation requirements.

The DCFW SMD provided presentations for pediatric providers in LHDs (9 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. These presentations included updates relevant to medical home and other providers on a variety of timely topics for care of children: the status of COVID-19 cases and implications for CYSHCN; the clinical guidance changes related to use of and availability of COVID-19 vaccines for children and youth and especially those who are higher risk with special health care needs (i.e., immunocompromised); mental health; use of masks for CYSHCN; and resources to address special nutrition needs and the impact of food security on CYSHCN.

To increase the percentage of families of CYSHCN who report that their children receive family-centered care, the DCFW/WCHS continued several programs and activities during FY23. 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 DCFW/WCHS continued its partnership with the DSS, DMH/DD/SAS, PHPs, and other partners to provide care coordination 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 continued to identify children and families whose health could be impacted by social determinants of health and connected them to community resources. There were 12 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. A webinar about care management for asthma was developed and planned for the summer of 2022 with the DCFW SMD and staff from Healthy Homes to address roles for care managers to address medical and non-medical influences on asthma control and management with medical homes.

Title V funding continued to be used to support CMARC services although the CMARC Program Nurse Consultant was vacant during FY23. Recruiting efforts for the position continued. The CMARC care managers use 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.

DCFW/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 DCFW/WCHS Minority Outreach Coordinator leads this effort.

DCFW/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 an additional workgroup (Pediatric Home Nursing) formed in FY23. 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 DCFW/WCHS also fostered Title V Parent Representatives to participate on the Commission and it's four workgroups. Bimonthly throughout FY23, the Commission hosted 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.

The Commission hosted senior representatives from the five PHPs again in FY23. Commission members and partners provided feedback and recommendations on issues ranging from care management to access to quality providers. Family representatives and providers shared personal stories in trying to access care management services only to hear that they were not available. The PHP representatives took this information back to their staff and expressed the need for additional training and recruitment. In response to many concerns raised about access to quality providers, the PHP representatives discussed strategies in recruiting quality providers to serve CYSHCN while acknowledging the ongoing workforce shortage crisis in NC. A Health Policy Analyst from NC Child kept the Commission members current with regular legislative updates on topics that impact health services for families including the launch of the Tailored Plan, NC Medicaid/Health Choice merger, Medicaid eligibility determinations and disenrollment, and Medicaid Expansion to ensure the availability and accountability to provide services to families. The Commission monitored news about the Innovations Waiver and invited a litigation expert from Disability Rights NC who provided context regarding the lack of adequate home and community-based services for people with

intellectual and developmental disabilities (I/DD). The Commission continued to watch the status of the Samantha R case (lawsuit filed by Disability Rights NC on behalf of people with I/DD who were institutionalized or risked institutionalization because the state failed to make sure they could get essential services in their communities) and its impact on the reduction of the wait list for Innovations Waiver Slots. Representatives from NC Medicaid presented about the HOP and fielded many questions from Commission meeting participants about the timeline, data collection, and how the project's services are delivered to families, especially regarding the care management piece.

The Commission's longstanding Behavioral Health Workgroup met monthly (as needed) to consider issues relevant to children and youth with special behavioral health care needs in the state. It responded to requests for feedback from NC Medicaid on three 1915i service definition documents (which support individuals with I/DD who are on the Innovations Waitlist) and on the CAP/C Waiver proposal. The workgroup monitored ongoing developments in behavioral health care from various sources with particular attention on barriers to the Tailored Plan launch and reported back to the Commission at all meetings. The Oral Health Workgroup continued to provide recommendations to promote access to a dental home for CYSHCN to encourage whole child health. The workgroup, along with WCHS FPs, developed messaging to address the confusion related to Medicaid Managed Care and dental coverage that families of CYSHCN had reported. Two part-time program consultants, both dental hygienists, continued to conduct presentations for dental providers to encourage inclusion of CYSHCN in their practices by addressing access needs and clinical strategies. The Oral Health Workgroup's initiative to provide education about the importance of a dental home resulted in 23 trainings reaching 539 healthcare providers in FY23.

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. Representatives (including a physician and two registered nurses) from a hospital that provides care for children with complex medical needs and DCFW/WCHS staff members regularly attend the quarterly CAP/C Workgroup meetings. The workgroup partnered with the Community Alternatives Program Waiver Operations Manager to streamline the complex CAP/C referral/application process using a Commission member's hospital as a pilot site, liaised to align the waiver program's intentions with families' and providers' experiences, and offered bidirectional suggestions on how to improve outcomes.

The Pediatric Home Nursing Workgroup of the Commission arose in FY23 in response to the pediatric nursing shortage crisis in NC. The workgroup included parents/caregivers of children who receive home nursing along with physicians and other agencies who support these families and met monthly to prioritize goals and develop clear messaging. The workgroup hosted several experts to gain knowledge and broaden perspective about how home nursing is organized in the state. A data request letter (focusing on the number of children who are getting Private Duty Nursing, the number of hours approved, and the number of hours used) was drafted by the workgroup, approved by the Commission, and sent to the Deputy Secretary for NC Medicaid to raise awareness.

Expanding the Help Line outreach into medical practices across the state remained a goal for the DCFW SMD because it is beneficial and encourages new partnerships for all those working with CYSHCN.

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 DCFW/WCHS staff members who received ongoing feedback from families and partner agencies. Additionally, FPs contributed family stories about their personal

journey and engagement in DCFW/WCHS activities.

The DCFW/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. The Help Line Coordinator position become vacant in August 2022 and backup was provided by WCHS staff for the remainder of the fiscal year. The CYSHCN Help Line contact volume for FY23 was 417 inquiries. Families and caregivers of CYSHCN reflect 74% of the call/email volume. Most Help Line users (75%) utilized direct phone contact which allows callers to talk directly with staff. Eighty-one percent of Help Line users communicated in English, 19% in Spanish, and one caller spoke Mandarin. For their child's primary insurance, 46% of Help Line users reported Medicaid, 18%-private insurance, and 12% reported their children were uninsured. Sixty-seven 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 consistent with the prior FY: 35% from birth to 5 years old, 33% from 5 to 11, 21% from 12 to 18, and 11% over 18 years old. The top three topics discussed with Help Line users were health insurance (21%), financial resources (23%), and exceptional children's services (15%). Help Line users indicated they learned about the Help Line using various methods: 47% via the website, 30% as a referral from a state/local agency, and 8% 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 sent me the information that I needed and I have already contacted a few of the resources that she suggested. Thank you for your service and support!"
- "The resources shared with me were very helpful and I am pleased I found the helpline number because I was not aware of the resources prior to calling. As a mother of a disabled child there are many challenges and finding the correct resources and tapping into them is a challenge because my child requires a high level of care. Thank you very much!"

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 which in FY23 reflected 694 families. DCFW/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. A total of 9,681 Help Line info cards were distributed via mail (2,610) and at outreach events (7,071) in FY23.

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 DCFW/WCHS FP. In FY23, two virtual presentations addressing families of CYSHCN were completed, reaching 28 families. DCFW/WCHS staff and FPs recognized the need to revise the training for families to better meet their informational needs and time constraints. This revision, led by DCFW/WCHS FPs, will begin 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 FY23.

In FY23, DCFW staff gathered information about developing a medical home training for parents/caregivers of CYSHCN. A "Parent Training Choices" survey was conducted to assess medical home training preferences for topics, setting and length to ensure offerings meet parent/caregivers' needs. The training framework will be informed by the 97 survey participants consisting of 68 parents/caregivers, 27 professionals, and 2 who identified as both. The most preferred topics for medical home training content collected in the survey included communicating health needs (with medical providers, schools, and child care), setting goals for your child (for medical visits, waivers, or school), and healthcare transition to adulthood. Additionally, contact information was collected from interested survey participants to serve as reviewers to give feedback as the medical home training is drafted.

Increasing Family Engagement

Cultivating family and youth engagement between state Title V programs is a continuous journey. The DCFW/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 DCFW/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, 38 FPs were reimbursed for 332 documented hours in FY23 towards DCFW/WCHS program efforts. The FLS position experienced a vacancy until April 2023 requiring other staff to support family engagement efforts. In addition, the DCFW/WCHS continued to employ two part-time Parent Consultants who served the EHDI Program. The CYSHCN Access to Care Specialist role provided technical assistance to the FPs in addition to managing the FP reimbursement system. Activities conducted by the Youth Health Advisors (YHA) are described in the Adolescent Health Domain Annual Report.

The DCFW/WCHS FP Steering Committee, which represents nine FPs with extensive experience in NC's System of Care and DCFW/WCHS activities, continued to inform and add value to program development within supported activities for both FPs and DCFW/WCHS staff members. The Committee met four times in FY23 and participated in bidirectional communication regarding topics including the CYSHCN Blueprint for Change, parent training cadre updates, the AMCHP scholarship and recipient presentations, community events, and DCFW/WCHS staff roles and transitions.

The DCFW/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. The PACL trainings are provided virtually 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 29 trainings (11 in English and 18 in Spanish) to 169 parents/caregivers of CYSHCN across the state during FY23. Ninety-nine percent (99%) of attendees felt the training contributed to their knowledge and skills for leadership. Participants reported:

- "I plan on getting more involved in my community and helping improve the special needs services to children that need them."
- "I found hearing other's perspectives most helpful"
- "Me siento mucho más preparado para poder trabajar en grupos, poder trabajar con otros padres y defender a mi hijo y a otros niños que lo necesitan." (I feel much more prepared to be able to work in groups, to be able to work with other parents, and to advocate for my son and other children who need it.)

In addition to the dental home and parent leadership training offerings, work resumed on parent/caregiver informed

development of a sexual health training, *Teaching Parents of Children with Disabilities about Sexual Health*, to add to the parent training cadre and launch in the next fiscal year.

The DCFW/WCHS continued to invest in Title V family leadership development by sponsoring FPs to attend national conferences, specifically AMCHP (three attendees) and the National EHDI (one attendee) conferences in FY23. 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. One FP co-presented to a national audience alongside DCFW/WCHS staff at the 2023 AMCHP conference (*A Dental Home for Children and Youth with Special Health Care Needs: Engaging Families and Providers to increase Access and Inclusion in Oral Health Care Settings).* All the attending FPs reported back to either the FP Steering Committee or the DCFW/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 DCFW/WCHS committees, workgroups, and activities by promoting and applying information gained through attending the conferences. Additionally, the FPs and WCHS staff members who attended the 2023 AMCHP Conference were able to see NC's CYCHSN Director receive the Emerging MCH Professional Award for Region IV.

Other FP engagement opportunities during FY23 included:

- Joining the Minority Outreach Coordinator position interview team
- Reviewing newly developed genetics fact sheets for families
- Reviewing *Consumer Direction Care Plan for CAP/C Participants at a Skilled Level of Care* draft form
- Participating on the NC Triple P Partnership for Strategy and Governance/NC Learning Collaborative
- Contributing to the MCH Block Grant review process
- Partnering with the PMC to develop and co-present *Family-Centered Care Makes a Difference* at the 2023 NC Emergency Medical Services Expo
- Co-chairing the NC Genetics and Genomics Advisory Council
- Co-Chairing the NC-EHDI Advisory Committee, and
- Serving as Parent Mentors on the NC-EHDI Parent Support Team

Outreach Efforts

The DCFW/WCHS outreach team (comprised of the Minority Outreach Coordinator, Help Line 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 Minority Outreach Coordinator resulted in 330 outreach activities incorporating 66 exhibits (tabling at community events), 53 presentations (in both virtual and in-person formats), and 330 collaborations (meetings with community partners) to reach priority populations. Specific outreach activities addressed Smart Start (NC Partnership for Children), local Interagency Coordinating Councils (LICCs), public schools, churches, CYSHCN parent support groups, Community Medicaid Health Plan Expos, and community health centers in counties with a high rate of uninsured children. The Minority Outreach Coordinator promoted Medicaid and Help Line information and increased networking opportunities at *Listening Sessions for New Americans* alongside others with the shared goal of fostering a more inclusive and diverse community, an innovative outreach activity for FY23.  A total of 7486 (English/Spanish) NC Medicaid informational flyers were distributed in FY23; Outreach staff circulated 5386 flyers at community events and mailed 2100 flyers to site contacts for inclusion in their distribution efforts.  Educational

materials for other children and youth programs such as 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.

To specifically reach families of CYSHCN populations, the outreach team piggybacked abbreviated NC Medicaid presentations onto virtual PACL training modules and attended a Sensory Friendly Playtime event at Marbles Museum.

Outreach staff, in cooperation with the NC Pediatric Society, 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 DCFW/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 NC Partnership for Children. In FY23, the Coalition hosted subject matter experts who presented about NC Medicaid, NC Navigator Consortium, HOP, Refugee and Newcomer Health, and legislative updates. The group engaged in rich discussion on topics including Tailored Care Management, NC Medicaid/Health Choice merge, and post public health emergency plans for Medicaid recipients. The meetings also offered an opportunity for participants to provide updates from their communities.

Innovative Approaches Initiative

FY23 marked the first year of the new three-year (2022-2025) funding cycle for Innovative Approaches (IA). The DCFW/WCHS funded two LHDs (serving three counties) to assess and improve the local systems of care for CYSHCN through their IA initiatives. During FY23, all IA sites experienced significant staffing changes as a result of the new funding cycle. The IA coordinators in all counties were new to their roles and required extensive training and onboarding 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 of families of CYSHCN, priorities were established, and strategies were developed.

All IA sites hired Parent Outreach Coordinators to help guide the local IA Steering Committees in prioritizing critical issues for their respective counties. In Cabarrus County, two Parent Outreach Coordinators were hired – one to serve English-speaking families and the other to serve Spanish-speaking families. In Polk County, a rural western community, a bilingual and bicultural Parent Outreach Coordinator was hired to bring diverse families to the table. The Parent Outreach Coordinators' primary purpose was to perform outreach activities to engage parents of CYSHCN and to recruit their active involvement in the IA initiative. In FY23, the Parent Outreach Coordinators continued virtual meetings as a result of COVID-19 and provided communications through multiple platforms (Facebook pages, websites, communication portals, etc.) to increase awareness about educational opportunities, meetings, and IA projects.

Parent Advisory Councils (PAC), a diverse group of parents and guardians of CYSHCN, were newly established in Cabarrus and Polk counties. The Henderson County PAC, which existed in the previous funding cycle, continued to focus on advocacy and education for other families, agencies, and health care professionals on issues that affect CYSHCN. PAC members met monthly to promote collaboration and make recommendations to the IA Steering

Committee.

In FY23, the Henderson County IA continued its focus on its accessibility initiatives through Accessibility Reviews of two additional trails and parks. NCODH staff, seven family members, three CYSHCN, a community partner, directors of both parks, and state staff provided feedback and recommendations to park staff. One of the parks, Mills River Park, received a grant to improve accessibility in the park and playground.

All three IA sites purchased sensory tents, therapy tools and toys for use at community events. The feedback received so far has been positive and parents have appreciated having a sensory friendly environment at busy events. The sensory tents were deployed at various community events in the counties and the sites continue to evaluate their effectiveness in meeting families' needs. Polk County IA purchased one tent and distributed it to event organizers upon request. Local organizations adhered to guidelines developed by Polk IA to ensure that the tent is maintained and utilized appropriately at events. Henderson County purchased a total of five tents and deployed them to select organizations on an ongoing basis. An MOU was developed to ensure proper usage. The IA sites will continue to gather data on their effectiveness in the community.

Additional Strategies to Support CYSHCN

The SCCNC working collaboratively with the NC CCHSRC, continued to provide training, technical assistance, and support for 83 local and regional Child Care Health Consultants (CCHC) to develop strategies for the inclusion of CSHCN 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 CSHCN.

During FY23 the SCCNC, serving as nurse planner, in collaboration with the NC CCHSRC offered quarterly professional development opportunities on various topics pertaining to health and safety; as well as the inclusion of CSHCN; as well as health and safety, fin early learning settings serving children ages zero to five years. CCHC Learning Collaboratives topics included Early Childhood Development and Resources; Unintentional Injuries in Child Care, Prevention and Control; Child Abuse and Neglect Awareness and Strategies for Prevention; and Asthma in Child Care. 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 agency, DCDEE, DSS, PCANC, early educators, and the Asthma Alliance of NC. On average, 44 CCHCs serving child care facilities across the state participated in the quarterly learning collaboratives. The SCCNC and NC CCHSRC began planning for a Learning Collaborative on the topics of communicable disease and infant/child social emotional wellbeing for FY24.

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, an additional cross-sector workgroup was created and led by Dr. Marian Earls and Dr. Sharon Loza focusing 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. Additionally, the SCCNC led a sub-workgroup looking at existing data sources around IECMH and determining ideal data metrics for the state. The SCCNC also participated with a second sub-workgroup formed and tasked with defining IECMHC for NC.

In September 2022, the SCCNC, along with a Section FP participated in the Welcoming Families to the Table Train the Trainer, provided by DCDEE through Preschool Development Grant (PDG) funds. The pilot training was facilitated by trainers from the Early Childhood Investment Corporation (ECIC) of Michigan. The SCCNC and the Section FP subsequently provided two interactive trainings with early childhood professionals, engaging in conversations around the importance of family voice and representation at the decision-making table. In December 2022, the SCCNC partnered with the SCHNC to provide a training for more than 80 local health department staff across the state. In collaboration with ECAC, training was provided at a regional conference to 11 LICC members in May 2023.

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 DHH and their families. NC-EHDI sponsored 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 two teen dinners planned by the Charlotte Hitch-up, one family picnic planned by the Triangle Hitch-Up and a Deaf Awareness Day picnic offered by Children of Deaf Adults (CODA) Inc.

NC-EHDI sponsored an in-person Care Project Parent-Professional Collaborative in February 2023. The Care Project invited the Title V CYSHCN Director to serve on the conference planning group, and to be the keynote speaker. The Title V CYSHCN Director presented *Catalysts for Change: Advancing Anti-Ableism* (touched on the *Blueprint for Change*). This event brought 30 parents and 106 professionals together for a two-day learning experience covering a range of topics presented through a diversity, equity, and inclusion lens.

NC-EHDI launched the DHH Heroes program to provide opportunities for DHH adult-to-family interaction. This program was originally created by Kentucky Hands & Voices. The team recruited seven 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 5 EHDI sponsored family events.

The NC-EHDI part-time Spanish speaking parent consultant increased outreach and engagement with the Hispanic community by organizing three support groups across the state 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 learning community developed two new fact sheets for Spanish-speaking families: What to Expect if Your Baby Did Not Pass the Rescreen and When Your Baby is Diagnosed with a Hearing Loss.

As required by the HRSA EHDI funding, NC-EHDI developed a plan to expand state capacity to support hearing screening in young children 0-3 years of age. This plan was developed in collaboration with key partners in the early childhood space with a focus on development of a comprehensive education/awareness/outreach plan to one or more target audiences with long-term goals to increase evidence-based objective hearing screening among

infants/toddlers, earlier identification of late-onset hearing loss and prompt connection to resources and appropriate interventions.

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 is diverse in race/ethnicity, communication mode, language (American Sign Language [ASL], Spanish), geographical location, and type of hearing technology used (hearing aids, cochlear implants, no technology). The EHDI program partnered with the Early Learning Sensory Support Program for Children with Hearing Impairment to enroll families in this support program.

The NC-EHDI team continued to look for ways to collaborate with and educate partners on these important issues that make an impact. Three sensitivity trainings focused on newborn hearing screeners, pediatric audiologists, and EI providers, include information and resources on cultural competency/humility, implicit/unconscious bias, social determinants of health, and health equity and are shared with key partners. Trainings also include family stories both in English and Spanish. Open captioning is provided to make the trainings more accessible.

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.

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.

The AAP NC-EHDI Chapter Champion, who is Deaf, carried out these and other activities in FY23: 1) participated on the EHDI Advisory Committee; 2) provided consultation and support to new learning communities created across the state; 3) continued to provide feedback on program materials and correspondences targeting the medical home; and 4) collaborated with NC-EHDI on a recorded presentation for the NCPS Open Forum Meeting.

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, 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. The EHDI program continued to coordinate a state-wide Cytomegalovirus (CMV) workgroup to provide education to healthcare providers and the general public on CMV in efforts to increase awareness.

In FY23, the PNC with input from the CDSA nutritionists transitioned their quarterly calls/meeting to biannual (November and February). The purpose of these biannual meetings is to connect CDSA nutritionists (and those RD's serving in similar roles) to be able to share resources, best practices and explore topics of mutual interest. The PNC

shared CYSHCN nutrition resources (including an ASPHN webinar) with the CDSA nutritionists and also created relationships with CDSA directors who were recruiting RDNs to serve at their CDSA.

As noted in other Block Grant sections, the PNC began 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 continued to integrate the health concerns of persons with disabilities, including CYSHCN, into state and local public health programs in FY23. This integration helped to promote access to care, inclusion and health equity 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, technical assistance and resources and conducting on-site accessibility reviews. During FY23, NCODH provided accessibility reviews for 19 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. Additionally, NCODH along with other DCFW/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 FY23 as the NCODH strengthened the partnership with NC Emergency Management (NCEM), ensuring efforts to include CYSHCN remained during periods of transition within 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 FY23, 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 also continued collaboration with the NC Office of Health Equity (OHE) to address inclusion of people with disabilities and CYSHCN in efforts to address health equity. NCODH worked with OHE workgroups to ensure the needs of people with disabilities and CYSHCN were addressed.

NCODH provided multiple trainings in FY23 to NCDHHS staff, community-based organizations, and providers to encourage inclusion of people with disabilities and CYSHCN in health equity efforts, recognizing health disparities, and promoting access and inclusion in prevention efforts. The CYSHCN Director contributed to additional health

equity efforts for CYSHCN by serving on the National Resource Center for Patient/Family-Centered Medical Home Health Equity Subcommittee that aimed to ensure that Black CYSHCN and their families have access to services/supports, and receive equitable, culturally competent, and family-centered care from their pediatrician, health care team, and system of care. Furthermore, the CYSHCN Director presented *Catalysts for Change: Advancing Anti-Ableism* as a breakout session for ECAC's first ever leadership summit for racial and ethnic minoritized families.

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 DCFW/WCHS has set an objective to improve this indicator as measured through the NSCH by 30% from the 2018-19 NCHS baseline by 2025. While 2021-22 NSCH results showed 18.7% of YSHCN receiving transition services as compared to 17.8% nationwide. The NC rate is a slight increase from the 2018-19 NSCH baseline of 16.9%, but not close to the goal of a 30% increase. Much 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 FY23, 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 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 DCFW/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 C4NC and Path4NC efforts are included in the earlier medical home section of this domain.

Health Care Transition for Youth in Foster Care

The DCFW SMD continued to co-chair the Transition Age Youth (TAY) Work Group with staff members from Fostering Health NC in FY23. A young adult with lived experience has served as co-chair since March 2022 and continued to help plan for all the bimonthly meetings and participated in meetings. Additional DCFW/WCHS staff members served on the work group, which was established to assist in education, resources development, and outreach to transition age youth who are exiting, or have exited, foster care to help ensure better health outcomes through improved health programming. One main activity was to disseminate widely a one-page flyer entitled *Ensuring Health for Young Adults Formerly in Foster* Care to multiple agencies and professionals working with or interacting with youth formerly in foster care including but not limited to local DSS offices, Guardian ad Litem, school nurses, CCNC, and the NC Foster Parent Association. Through the work group, DCFW/WCHS staff members continued to collaborate with the NC Independent Living Services for Foster Children (LINKS), NC Child, Youth Villages, Life Skills, CCNC, Medicaid, Strong Able Youth Speaking Out, and other partners to discuss needs for additional types of educational resources for transition age youth on transitioning to an adult medical home and applying for Medicaid. NC LINKS is designed to help adolescents aged 13 through 20 who are or were in foster care to become connected with the resources they need to help assure that they will have a well-connected, self-sufficient life. One priority area for this work group was a review of materials for youth and young adults in foster care or formerly in care to help them to choose if they want a health care power of attorney (HCPOA). The TAY Work Group chose *Five Wishes*. NC DSS purchased *Five Wishes* documents to help interested youth discuss HCPOA with their case workers. Fostering Health NC TAY work group staff hosted a training in May 2023 to describe HCPOAs, the requirement to discuss HCPOA, and the use of *Five Wishes* specifically for LINKS DSS case workers to use with youth and young adults. The TAY Work Group also reviewed a HCT training developed for Fostering Health NC staff and helped to give feedback for future trainings and for places to disseminate the current training.

Modifications to Agreement Addenda and Contracts

HCT and self-management of care were able to be formally included into the FY23 AA language as a focus area for child health clinics in LHDs. During FY23, 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 1,848 clients with sickle cell disease, ages 0 to 21, during FY23. 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 FY23, 93 newborns were identified with an abnormal hemoglobin through newborn screening. Approximately eighty-six percent (86%; 353 of 412) 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 having a genotype in which penicillin is not recommended, parent declined treatment, physician decision, lost to follow-up, or 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 penicillin provider webinar was recorded and approval to post on the NCSCSP website is pending.

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. Three virtual meetings were held to discuss improving patient HCT. Committee members reviewed various HCT models presently available. The goal is for the committee to reach a consensus and recommend one HCT model for piloting by the six SC comprehensive medical center partners over the next year. In addition, the community-based organization partner Piedmont Health Services and Sickle Cell Agency planned and hosted several events to educate and empower clients about the importance of preparing for and engaging in HCT efforts. They included:

- Teen Talk Skate Event with a focus on HCT education to teens
- 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.
- Sickle Cell Disease Youth Summit which focused on teaching transitioning age children the importance of taking good care of their health by taking their medications on time, getting proper rest, eating a well-balanced diet and keeping their clinic appointments.
- Game Night for Teens which involved transitioning aged clients and focused on the importance of medication compliance.
- Roadmap to Transition-Life Skills Simulations

The NCSCSP celebrated its 50$^{th}$ Anniversary May 23, 2023, at the NC Museum of Art. The event was well attended by community trailblazers and supporters, NCSCSP staff, comprehensive sickle cell medical center clinicians and staff, individuals and family members living with sickle cell disease, and DHHS and DPH leadership. House Bill 32 created the Council on Sickle Cell Syndrome and the NCSCSP on May 18, 1973. The 50$^{th}$ Anniversary celebration honored individuals that significantly contributed to raising sickle cell awareness through the establishment of programs and services for individuals with sickle cell disease, sickle cell trait and related disorders. The NCSCSP staff received awards for years of exceptional service. Additionally, eight clients with sickle cell disease representing elementary, middle, high school and college ages received Shining Star Awards for excellence in education, service, or the arts, and two adult clients received awards for civic involvement.

**Children with Special Health Care Needs - Application Year**

Priority 7 – Improve Access to Coordinated, Comprehensive, Ongoing Medical Care for CYSHCN

The DCFW/WCHS is committed to improving equitable access to coordinated, comprehensive, ongoing medical care for CYSHCN. Assuring that children with and without special health care needs have a quality medical home in which they receive family-centered and culturally sensitive care is a priority for TA, consultation and/or training for several sections within DCFW and several programs in the WICWS in DPH. To help gauge progress in this area, the DCFW/WCHS will continue to monitor data for NPM#11 (Percent of children with and without special health care needs, ages 0 through 17, who have a medical home) along with the two selected ESMs in FY23.

Education, Training and Support for Providers Regarding Medical Home

In FY25, TA and consultation to support the medical home approach for CYSHCN when LHDs are serving as the child's primary care provider (or medical home) or partnering with a child's medical home will continue to be provided by the RCHNCs, SCHNCs, and SMD to LHDs. Child Health Program live and archived web-based trainings for LHD child health providers will continue to be held at least quarterly to address family-centered and culturally sensitive preventive health care based on the most current Bright Future recommendations; screening, identification and management of mental health concerns; chronic disease prevention and screening, oral health screening and management, special needs related to refugee and immigrant health (i.e., risk for lead exposure, cultural beliefs about disease processes, misinformation), and the need to identify and address SDoH (i.e., food security, transportation, literacy) for all children and especially CYSHCN. The CHNCs will continue to work with DPH Office of the Chief Public Health Nurse (OCPHN) Consultants to develop policy and guidance for child health providers in LHDs to improve screening and billing related to well child care visit components, pre-participation physical evaluations, school health assessments and use of EHR. CHNCs will also promote linkage to NCCARE360 for resources across the state to address SDoH as the child's medical home or with the child's medical home in the NC InCK five pilot counties who are using an alternative payment model to address food security and housing and also kindergarten reading. Additional TA will be provided by CMARC program staff to LHDs participating in the HOP in three areas of the state to address SDoH for all children (including CYSHCN) and their families in partnership with the child's medical homes. NCODH will also continue to offer accessibility reviews for LHDs at their request to enhance the care of CYSHCN and to assist in achieving accreditation requirements.

The SMD will collaborate with the FLS to continue to refine presentation slides to use for health care providers and other professionals about accessible, family-centered, unbiased and culturally sensitive care delivery as part of quality medical home approach and how it relates to the CYSHCN Blueprint for Change. The SMD will use ongoing and new educational and support opportunities with the NCPS, NC Academy of Family Physicians, NC Medical Society Leadership College Program, and other events to include slides related to medical home. The SMD, CMARC program manager, CHNCs and other Title V staff will continue to serve on several advisory committees external to NC DHHS and partner with NC InCK staff and their integration specialists to discuss how to identify and support children eligible for care with family navigators. These NC InCK family navigators will help families partner with the care team (which includes medical home providers) to create a shared action plan across multiple sectors (i.e., early learning, education) in the five pilot counties.

In FY25, the Title V CYSHCN Director will work with the FLS, CYSHCN Outreach Staff, FP and other DCFW/WCHS staff members to review the themes, challenges, and recommendations from Path4CNC convenings and C4CNC advisory group, and learnings from the Consortium regarding NC's participation in the National Center for a System of Services for CYSHCN learning collaborative about the CYSHCN Blueprint for Change to determine a timeline and processes to update the CYSHCN Strategic Plan by 2025 contingent on capacity in relation to staff vacancies.

This process will help to determine the medical home content to use in education, support, and trainings for families in FY25 and planned for FY26 for health care providers and other professionals related to medical home.

Additional efforts by the DCFW/WCHS to increase the percentage of families of CYSHCN who report that their children receive family-centered care in a medical home include continuing several programs and activities during FY24 that were described in the CYSHCN Domain Annual Report. Specific plans for the CMARC program include continued collaboration with other agencies and programs, such as EI and Pregnancy Care Managers, to ensure an effective system of care. The CMARC program, in conjunction with the Prepaid Health Plans (PHPs), will continue to require staff to collaborate with Advance 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 those children engaged in CMARC services, as collaboration with the medical home will ensure the healthiest outcomes for the child. CMARC staff will also continue to partner with DSS to create a system to support a Plan of Safe Care for children identified to be substance affected infants and support staff in the use of the Virtual Health/Care Impact documentation platform system. The CMARC program will continue to provide TA and training per the *NC Medicaid Program Guide for Management of High-Risk Pregnancies and At-Risk Children in Managed Care* to enhance performance assessment and improvement processes to ensure program expectations are met. The CMARC staff will continue to collaborate in FY24 to promote the HOP services and will continue to partner in the care of patients with the NC InCK pilot program in five counties.

With the launch of NC Medicaid Managed Care, CMARC state staff members will continue to work with NC DHB to assure that care management services are maintained and enhanced for children birth to five years of age who meet the program population criteria. Care management services will continue to include general developmental screening using the SWYC tool. The results of the SWYC are communicated to the medical provider for further assessment of any identified needs or concerns and discussed with the parent or caregiver. CMARC care managers will continue to conduct screenings using the Life Skills Progression Assessment tool to assess all children that have experienced toxic stress or adverse life events that reside with their biological, adoptive, or permanent kinship family and share the results with the appropriate medical home practitioners and facilitate EI referrals. CMARC collaborates with the member's medical home to notify the medical home of significant changes made to the Care Plan, and if CMARC services are stopped, including why the services stopped.

The NC Commission on CSHCN will continue to fulfill its legislative charge to monitor the availability and quality of health services for children with special health care needs delivered by medical homes, specialty providers, mental health providers, dental health providers, pharmacists, home health, therapists (i.e., speech, physical therapy, occupational therapy), other community agencies, providers and professionals and make recommendations to key leaders in the state in DHB, DMH/DD/SAS, DSS, and other agencies. This includes having the Commission continue periodic bi-directional communication with the five PHPs that serve Medicaid beneficiaries through managed care. In addition, the Commission will continue to provide feedback and recommendations on the Tailored Plans with plans to host leaders from the four LME/MCOs at meetings in FY25.

The Commission's Behavioral Health Workgroup will continue to specifically review and provide feedback on Medicaid policies and services related to mental health and substance use. While it has been a challenge previously to connect with the state's largest insurer to begin an active dialogue on private insurance coverage of services for CYSHCN, the workgroup will continue to reach out to them and other insurers in the state to explore ways in which families can access these services. The Oral Health Workgroup will continue its outreach efforts to providers and families and will provide training and technical assistance to dental providers and families to ensure that CYSHCN have access to a quality dental home. The Community Alternatives for Children (CAP-C) Workgroup will continue to meet with DHB staff and a representative from the new NC Medicaid Linking Individuals & Families for Long Term Services and Supports (LIFTSS) vendor to report experiences with the referral process and ensure resolution as

quickly as possible for families.

The Commission's Pediatric Home Nursing Workgroup will continue to gather data and meet with DHB leaders to share feedback and recommendations to increase the quantity and quality of home health nurses serving the most vulnerable CYSHCN. In FY25, the group will partner with NC Medicaid and accrediting bodies to define expectations in personal care and supports for nursing agencies addressing gaps that can be scored.

The CYSHCN Help Line Coordinator and SMD plan to reach out to two additional medical homes serving children, ideally those in rural areas, to increase use of the Help Line and conversations about issues coming up for CYSHCN in medical homes in the community.

Education, Training and Support for Families Regarding Medical Home

In FY25, the NC CYSHCN Blueprint Learning Collaborative Team initiated a Medical Home work group comprised of the FLS, CYSHCN Outreach Staff, CYSHCN Access to Care Specialist and FP. The work group will finalize a multi-module medical home training for parents/caregivers. Feedback from pilot training sessions will inform the final draft of the training. The training will focus on the importance of the medical home specifically for families and will be added to the Parent Leadership Training Cadre of resources. An accompanying flyer highlighting the benefits of a medical home will be developed and posted on the DCFW/WCHS CYSHCN webpage.

The former Path4CNC and ongoing C4CNC advisory group efforts will also be used to help to determine additional education, support and trainings planned for FY24 and FY25 for families and youth related to medical home. The DCFW/WCHS will continue to explore how NC can learn from other states about the use of the Family Voices Family Engagement in Systems Checklist or Family Engagement in Systems Assessment Tools. DCFW/WCHS members serving on the C4NC will also discuss the use of PACL training to help practices increase engagement of families and use of family advisors in the processes and policies of medical homes and their agencies.

The DCFW/WCHS will continue to maintain a statewide toll-free Help Line (available Monday through Friday) and email to assist families and providers with services for CYSHCN, including the importance of having and using their medical home and how to access relevant up-to-date resources. The CYSHCN webpage will continue to be updated as needed in FY25 using feedback from the FLS, Access to Care Specialist, FP, and families who visit the website and use the Help Line. Updates will include information regarding the newly developed Medical Home training as well as other Medical Home resources.

The DCFW/WCHS, in collaboration with families, providers and agencies, will continue to review and revise regular communication to families applying for Social Security Disability Insurance which includes linking families to resources to help find a medical home.

The SMD will continue to identify and use opportunities in FY25 to promote the need to address prehospital readiness and emergency preparedness for all children including CYSHCN and the implications on mental health during presentations and discussions with a variety of agencies including but not limited to LHDs, Emergency Medical Services, DSS, pediatricians affiliated with Mountain Children's Network (covering the western part of the state), the NC Medical Society (state chapter of the AMA), NC Community Health Center Association, NC Academy of Family Physicians, NC Psychiatric Association, and the NCPS (state chapter of the AAP). This includes the need to prioritize well child care, immunizations (including COVID-19 vaccination), and screening for social drivers and emotional and mental health concerns during times of disasters (such as a pandemic and seasonal hurricanes) and afterwards, especially for CYSHCN.

The NC EHDI program will continue to maintain the ncnewbornhearing.org website with an entire section dedicated to families.

Increasing Family Engagement

The DCFW/WCHS will continue to develop its multi-faceted family engagement activities in FY25. The FP Leadership and Engagement Committee, formerly known as the Steering Committee, including ten diverse FP and the DCFW/WCHS Management Team, will meet quarterly. The focus on less talking, more action and decision making will remain. FP are included in all aspects of program planning, implementation, and evaluation.

The Parent Leadership Training Cadre will continue to deliver the PACL curriculum and the new Teaching Parents of Children with Disabilities About Sexual Health training across the state. Plans for FY25 include adding a multi-module Medical Home training to the Cadre. FP will continue to serve as trainers and provide feedback for training improvements. Seeking out innovative partners in the community to host trainings from the Cadre will be emphasized. FLS will partner with the Outreach Team to share promotional materials about the parent/caregiver trainings during outreach activities with minoritized communities. New FPs from the training participant pool will be explored.

The DCFW/WCHS will continue to partner with ECAC (NC's F2F), holding project-based meetings to determine opportunities for collaboration, share training opportunities, and reduce duplicative efforts. Relevant DCFW/WCHS content will be promoted in ECAC's quarterly disability and health newsletter *Health Online*.

In an effort to educate others using learned and lived knowledge and experience, the DCFW/WCHS will continue to pair staff members with a parent or youth to develop and/or co-present at conferences, workshops, and webinars. These training teams reflect the natural complement of expertise that everyone contributes to the topic.

The NC EHDI program will continue to hire up to two additional parents of children who are D/HH to serve as part-time EHDI Parent Consultants and will continue to engage parent partners in EHDI activities. Additional parent members will be sought for: 1) participation on the EHDI Advisory Committee; 2) participation on EHDI Program committees; 3) review and development of program materials; 4) participation in EHDI learning communities; 5) attendance at PACL Trainings in collaboration with family support groups and agencies; 6) attendance at the National EHDI conference; and, 7) co-presenting with EHDI regional consultants at presentations at local, state, and national meetings. The bilingual (Spanish) Parent Consultant will focus on improving engagement of families of D/HH children in the Hispanic community. The NC EHDI Advisory Committee will continue to have no less than 25% of its membership be parents of children who are D/HH or adults who are themselves D/HH. Three parents will participate in a Common Ground project led by the NC Council for the Deaf and Hard of Hearing for the purpose of reviewing and recommending ways to strengthen existing legislation regarding education of DHH children to include a focus on language acquisition and literacy outcomes.

In conjunction with the NC SLPH, the newborn metabolic screening follow-up program will work to increase family engagement with the NBS program. This will be accomplished, in part, through efforts associated with the newly awarded NBS Propel grant funded by HRSA.

Outreach Efforts

Outreach efforts described in the CYSHCN Domain annual report will continue in FY25. Outreach Staff, consisting of the Access to Care Specialist, Minority Outreach Coordinator, and a newly hired Help Line/Outreach Coordinator,

will continue to refine outreach strategies to promote children's health insurance and programs and supports for CYSHCN in different populations, with an emphasis on Latino, Hmong, Refugee, Tribal, and African American populations. Strategies will include developing state, regional, and local partners to assist in outreach efforts focusing on public and private not-for-profit organizations, minority owned businesses, faith communities and other community-based organizations. Direct outreach will be provided to targeted populations through cultural events and festivals, mobile consulates, and other organizations. DCFW/WCHS efforts to collaborate with Latino and refugee community-based organizations will also include efforts with CHWs (promotores de salud) to ensure an understanding of services for CYSHCN. The Minority Outreach Coordinator will continue work with the Community Health Worker Association team, and with representatives of the Office of Rural Health, CHW master trainers, and other agencies involved with revising and providing the CHW certification training offered through the state's community college system.

Innovative Approaches Initiative

FY25 marks the final year of the three-year (2023-2025) funding cycle for IA. The DCFW/WCHS will continue to support two LHDs to assess and improve the local systems of care for CYSHCN through their IA initiatives. IA sites will continue to work directly with families to implement action plans addressing community systems of care for CYSHCN. Some of the items included in these action plans include:

- Enhance outreach to minoritized populations and equitable engagement among families and caregivers of children with CYSHCN, expanding language access and culturally appropriate services through advocacy and training.
- Continue to expand support for transition activities for CYSHCN by partnering with local schools to integrate additional policies to address transition and increase awareness of health care transition. .
- Explore ways to engage community partners, such as the Children and Family Resource Center, to allow for more continuity and sustainability for the Parent Advisory Committees.
- Work with outdoor recreation partners to increase accessibility and physical activity for CYSHCN through expansion of TRACK Trails project and work to improve accessibility of local parks
- Expand opportunities for CYSHCN with sensory sensitivities to participate in community activities and events with the integration of sensory tents as a part of TRACK Trails and other partnering organizations.
- Partner with organizations serving ages 0-5 years to promote early identification of special health care needs and connections to resources.

A new funding cycle for IA will begin in FY25 which will fund five IA sites that will include up to four surrounding counties. The RFA for the new funding cycle (2025-2028) will be revised to reflect framework and four critical areas outlined in the Blueprint for Change. Under the new RFA, IA funding will be available to FQHCs and non-profits organizations in addition to LHDs.

Oral Health Care for CYSHCN

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 trainings for both families and providers will be offered and ways to expand efforts, including innovative marketing ideas and the addition of a Spanish version of the training, will be explored. In FY25, the revised Dental Home trainings will also include more practical home dental strategies for families and caregivers, which has been a frequent request. Meaningful options for promoting the message that increasing dental home education decreases (dental) emergency room visits continue to be on the FY25 agenda. The Oral Health Workgroup's monitoring of Medicaid Transformation issues will be maintained as oral health remains carved out which is often confusing for parents and caregivers, as well as providers. Messaging to clarify

dental coverage within Medicaid will be shared with families through multiple outlets in FY25.

Additional Strategies to Support CYSHCN

The SCCNC will continue to provide training, TA, and support for 60 local and regional based CCHCs to develop strategies for the inclusion of CSHCN in the state's licensed child care facilities in FY25. The SCCNC will also continue to participate in the statewide efforts of IECMH consultation as part of the EarlyWell Initiative. The SCCNC will continue to evaluate and monitor the impact of care delivered in child care settings to CYSHCN in partnership with medical homes and families from a series of learning collaboratives held for CCHCs across the state in FY24. Archived webinars include the following learning collaborative topics: Inclusive and Accessible Environments; Specialized Enteral Feedings; Diabetes; Seizures; Allergies and Anaphylaxis; Asthma; Responsive Feeding; and Responsive Caregiving and Trauma Informed Practices. Accompanying toolkit resources for each topic are available on the CCHC Resource Portal and accessible to CCHCs to use in supporting child care programs in caring for and including CSHCN in early learning settings in partnership with the child's medical home and specialty providers. The SCCNC in collaboration with NC CCHSRC regional coaches and staff will be responsible for the review and maintenance of the toolkit materials. Additional CCHC learning collaboratives will be developed in FY25. The SCCNC will also collaborate with the NC CCHSRC to continue offering a Medication Administration Training of Trainers to new CCHCs as part of the NC CCHC Course offered two times annually.

The DCFW/WCHS SPHGC will continue to provide additional trainings and TA for multiple audiences, including medical homes, about children and youth with and at risk for genetic conditions in FY25. The SPHGC will explore updating a training which offered NCPD credits to provide guidance on how to take a family history/pedigree for nurses, physicians, and other interested health professionals. The SPHGC will continue to respond to additional requests from providers for other genetic topics and trainings in FY25 as part of ITP in-service trainings for CDSAs. The state GGAC, made up of professionals, families, and other partners with an interest in genetics, will continue to meet monthly to discuss genetic issues and implement components of the 2020 NC Public Health Genetic and Genomics Plan. Sub-committees will continue to meet to focus on actions and goals in each of the three priority areas: Genetic Services and Testing; Education and Communication; and Epidemiology and Surveillance. The GGAC and three Sub-committees will continue to be staffed by the SPHGC.

Following the recent execution of Amendment 1 to the Memorandum of Agreement between the NC Department of Information Technology and NCDHHS Application Support Services Provided by the Government Data Analytics Center, EHDI data from WCSWeb will be incorporated into the NC ECIDS during FY24. Activity for this year will include completion of WCSWeb enhancements in collaboration with the Preschool Development Grant to allow for data integration into ECIDS, requirements building for file structure, layout, and secure file transfer. Transfer of data to and from ECIDS is expected to begin during FY25.

The EHDI Program will enhance collaboration with other early childhood programs and initiatives to develop efficient and effective ways to expand hearing screening beyond the newborn period up to at least age three years. Additionally, the EHDI Program will work with educational programs serving D/HH children to focus on language acquisition and other language and developmental outcomes for D/HH children.

The EHDI Program will work collaboratively with the NC Division of Services for the Deaf and Hard of Hearing to establish and implement a new Deaf Role Model/Mentorship Program in NC. This program is designed to actively involve Deaf adults with families of young D/HH 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. This program aligns with NCGS 143B-216.33, NCGS 130A-125, 42 USC 280g-1, NCDHHS Strategic Goals, NC ECAP, Joint Committee on Infant Hearing recommendations, and NC DHHS Federal

Grants and Cooperative Agreements (HRSA-20-047 and CDC-RFA-DD20-2006).

The “D/HH Heroes” initiative will be expanded in FY25. The goal of D/HH Heroes is to help families build relationships with and learn from the experiences of D/HH adults in the community. The program will include D/HH Hero Trading Cards, where the D/HH adults share their unique superpowers (i.e., SuperReader, SuperFixItAll, etc.). The D/HH Heroes will attend family events for children who are D/HH and their families throughout NC.

NC Office on Disability and Health

In FY25, NCODH will continue to provide TA to LHDs to increase accessibility and inclusion of CYSHCN by providing resources 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 included in state and local disaster planning, response, and recovery through involvement in workgroups and training. NCODH will prioritize the dissemination of emergency preparedness resources through networks to ensure families have access to the information. 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 with the Office of Health Equity and other departments within DHHS to ensure equity efforts are inclusive of CYSHCN and people with disabilities, specifically as it relates to physical access and communication access. In FY25, NCODH will explore how disability data collection can be addressed across NCDHHS Divisions, especially the inclusion of disability status in the collection of demographic data which aligns with the CYSHCN Blueprint for Change.

Ensuring Health Care Transition (HCT) Services

The DCFW/WCHS is committed to helping YSHCN and their families to plan and build the capacity to make successful transitions to adult health care, incorporating input from experienced FP and the YHA Team, and will employ the following strategies, among others, to make that happen. The DCFW/WCHS is still interested but has not had the capacity to explore work related to the development of an Extension for Community Healthcare Outcomes (ECHO) project that includes addressing health care transition and medical home. The plan is to try to explore this further when fully staffed in FY25.

Transition Work Group and CYSHCN Strategic Plan HCT Recommendations

The NC CYSHCN Blueprint Learning Collaborative Team that is focused on medical home began meeting in FY24 to address medical home broadly and include healthcare transition as a significant component of the medical home approach. In addition, the SMD will continue to try to promote communication and collaboration among academic and community providers working on HCT efforts for YSHCN. HCT will be included in at least one training for child health providers in LHDs related to adolescent health. HCT training will continue to be included in the Adolescent Health training of the CHTP. TA and consultation provided by the SCHNC and RCHNCs and SMD to LHDs will continue to include policies that follow administrative rules and examples of strategies and resources about how to address HCT as described in the HCPG. The SMD and state school health nurse consultant will continue to explore how to include specific training opportunities to increase use of HCT strategies with school health nurse case management for chronic health conditions as part of regional meetings for lead school nurses and/or the annual school health nurse conference.

The CYSHCN Help Line will continue to link families to resources related to HCT. The Help Line will collect data about how often transitions are discussed at all ages which includes HCT for adolescents.

HCT for Youth in Foster Care

The Fostering Health NC Program ended on June 30, 2023, but the Transition Age Youth (TAY) Work Group has been restructured with new co-chairs and is being staffed by DSS. The SMD who served as co-chair and the young adult co-chair have both moved out of those roles, although the SMD will continue to participate on the TAY Work Group to help embed the work group into DSS' design team which will bring more efforts to increase engagement, retention, and active and consistent participation from multiple young adults who have been in foster care into the well-being design team efforts. The TAY Work group will continue to work to engage multiple state partners, specifically youth serving agencies (Youth Villages, Life Skills, Strong Able Youth Speaking Out (SAYSO), and Hope Center at Pullen, etc.) to help create educational materials and trainings for youth in foster care, youth exiting care or formerly in foster care, social workers, and foster parents. The TAY work group as directed by DSS will explore creating or promoting additional materials and trainings and share strategies to increase use of shared decision making and informed consent about preventive health, sick care, mental health, oral health services, health care power of attorney for advance care planning, and to ensure that youth have access to care by having continuous comprehensive coverage through Medicaid when eligible, (Medicaid Direct vs Medicaid for Youth Formerly in Foster Care) and access tailored care management when eligible. The SMD, Minority Outreach Coordinator, Access to Care Specialist, and Commission on CSHCN (including the Behavioral Health Work Group) will continue to monitor and assess issues with implementation. They will provide feedback on HCT efforts to be included in NC's Children and Families Specialty Plan from DHB. DCFW will also work with DSS to share information about the Support Act that allows youth who were formerly in foster care in other states to be on Medicaid in NC until age 26. The SMD, RCHNCs, and SCHNC will provide a training to child health providers in LHDs about children and adolescents in foster care that will include strategies to support HCT in partnership with DSS and other agencies.

Modifications to Contracts

The NC CYSHCN Blueprint for Change Learning Collaborative Team will continue to explore the feasibility of incorporating use of one HCT specific recommendation or tool (i.e., HCT policy or checklist) in contracts within the DCFW/WCHS to assist parents, youth, and practitioners in the transition planning process.

Prophylactic Antibiotics for Children with Sickle Cell Disease

The NC Sickle Cell Syndrome Program (NCSCSP) will continue to complete newborn screening follow up efforts to infants that have an abnormal hemoglobin result when tested at birth in FY25. Sickle Cell Educator Counselors and Community-Based Organization (CBO) SC staff will contact and schedule follow up appointments with parents to answer questions and provide one-on-one information to parents and family members about sickle cell disease and its complications. They will also reiterate the importance of attending all pediatric, hematologist and other specialist appointments, getting childhood immunizations on time, giving penicillin to their newborn as prescribed to prevent bacterial infections, and knowing when to seek immediate medical attention. In addition, Sickle Cell Educator Counselors and CBO case managers will, as part of care coordination and follow up protocols, educate parents of newborns on the importance of keeping all SC medical center visits as determined by their newborn/child's hematologist. Sickle Cell staff will regularly check the WCS-Web database for medical center appointment information (i.e., whether appointments were kept and/or missed) and will conduct phone and/or in person follow up as needed. Appointment compliance status and SC staff follow up efforts will be documented in writing and in the WCS-Web database as required.

During FY25, the Sickle Cell Education Consultant, in collaboration with Sickle Cell Educator Counselors and CBO sickle cell case managers, will continue to incorporate the use of the prophylactic antibiotics' toolkit (*North Carolina*

*Sickle Cell Syndrome Program Protocol and Outline for Discussing Penicillin Prophylaxis with Parents)* with parents that includes information about the importance of prophylactic antibiotics for children with sickle cell disease. Sickle Cell Educator Counselors will continue to utilize the toolkit during initial contacts with parents who have a baby with sickle cell disease. The toolkit will also be used during annual assessment visits and as part of ongoing education provided to each family until the child reaches five years of age. Sickle Cell Educator Counselors will continue to document completion of these action steps in writing and in the WCS-Web Database as required. A refresher care coordination and follow up protocols training will be conducted with SC Educator Counselors and CBO SC staff during FY25.

The Sickle Cell Education Consultant will collaborate with key partners in FY25 to host a statewide supportive virtual event for parents of newborns with sickle cell disease by June 30, 2025. Hematologists, primary care providers, social workers, case managers, and other staff will attend and provide clinical and educational information and convene a question-and-answer session for parents and care givers/guardians.

During FY25, the NCSCSP will collaborate with the NC State Laboratory of Public Health to establish a Newborn Screening Hemoglobinopathy Condition Group comprised of NCSCSP and state lab personnel, and pediatric hematologists to provide input and recommendations regarding newborn screening follow up procedures and practices.

CDSA Nutritionist Networking Calls

In FY25, the PNC will continue to share resources through emails and offer networking calls with regional CDSA nutritionists. The PNC will also explore ways to share and collaborate with CDSA nutritionists through exploring SharePoint libraries or perhaps a “CDSA Nutritionist SharePoint Team” in Microsoft Teams. Topics for networking calls will be chosen by the RDNs with a continued focus on integration and coordination with the cadre of health professionals working with this birth to age three population.

**Cross-Cutting/Systems Building**

**State Performance Measures**

**SPM 5 - Ratio of black infant deaths to white infant deaths**

| Measure Status: | Active |
|---|---|

**State Provided Data**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 2.3 | 2.5 | 2.3 |
| Annual Indicator | 2.7 | | 2.7 | 2.4 | 2.7 |
| Numerator | 12.5 | | 12.8 | 12.1 | 12.9 |
| Denominator | 4.7 | | 4.8 | 5.1 | 4.7 |
| Data Source | NC Vital Statistics/SCHS | | NC Vital Statistics/SCHS | NC Vital Statistics/SCHS | NC Vital Statistics/SCHS |
| Data Source Year | 2019 | | 2020 | 2021 | 2022 |
| Provisional or Final ? | Final | | Final | Final | Final |

**Annual Objectives**

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 2.1 | 1.9 |

**State Action Plan Table**

| State Action Plan Table (North Carolina) - Cross-Cutting/Systems Building - Entry 1 |
| --- |
| Priority Need |
| Increase health equity and eliminate disparities and address social determinants of health |
| SPM |
| SPM 5 - Ratio of black infant deaths to white infant deaths |
| Five-Year Objectives |
| CCSB 8A. By 2025, the Title V Program will be working in alignment with the NCDHHS Health Equity Portfolio on health equity and social determinant of health efforts throughout all divisions and sections. |
| CCSB 8B. By 2025, decrease the percent of children living across North Carolina in food insecure homes by 6% from 20.9% to 17.5% according to data provided by Feeding America and cited in the NC Early Childhood Action Plan. |

Strategies

CCSB 8A.1. Provide two trainings for Healthy Beginnings and Reducing Infant Mortality in Communities programs to include a focus on equity and social determinants of health.

CCSB 8A.2. NC Title V Program will identify how they are currently incorporating the NCDHHS Health Equity Framework strategies into their work.

CCSB 8A.3. NC Title V Program will identify additional ways they can incorporate the NCDHHS Health Equity Framework strategies into their work.

CCSB 8A.4. WICWS will continue to require all staff, clinical and non-clinical, from LHDs and other contracted partners, to participate in at least one training annually focused on health equity, health disparities, or social determinants of health to support individual competencies and organizational capacity to promote health equity. This requirement is part of their agreement addenda. LHDs are provided a list of low-cost trainings or continuing education opportunities.

CCSB 8A.5.WICWS will continue to require all staff, clinical and non-clinical, from LHDs and other contracted partners, to participate in at least one training annually focused on health equity, health disparities, or social determinants of health to support individual competencies and organizational capacity to promote health equity. This requirement is part of their agreement addenda. LHDs are provided a list of low-cost trainings or continuing education opportunities.

CCSB 8A.6 Explore ways to address health equity and health disparities among CYSHCN, increasing recognition of intersectionality of CYSHCN and race/ethnicity.

CCSB 8A.7. Promote the use of NCCARE360 within all Title V Programs.

CCSB 8A.8. Explore how Title V Programs can best engage with the Healthy Opportunity Pilots.

CCSB 8B.1. NC Title V Program staff will collaborate across Divisions, Departments, and state plans (ECAP, PHSP, NCDHHS State Action Plan for Nutrition Security, NC State Improvement Plan) to enhance, connect and partner on nutrition/physical activity/food insecurity work at the state and local level using multi-level approaches.

CCSB 8B.2. Increase training to child health staff around nutrition/physical activity/food insecurity and identify audiences in the NC Title V Program and across NCDHHS that would also benefit from these trainings and materials.

## State Action Plan Table (North Carolina) - Cross-Cutting/Systems Building - Entry 2

### Priority Need

Increase health equity and eliminate disparities and address social determinants of health

### SPM

SPM 5 - Ratio of black infant deaths to white infant deaths

### Five-Year Objectives

CCSB 8B. By 2025, decrease the percent of children living across North Carolina in food insecure homes by 6% from 20.9% to 17.5% according to data provided by Feeding America and cited in the NC Early Childhood Action Plan.

### Strategies

CCSB 8B.1. NC Title V Program staff will collaborate across Divisions, Departments, and state plans (ECAP, PHSP, NCDHHS State Action Plan for Nutrition Security, NC State Improvement Plan) to enhance, connect and partner on nutrition/food insecurity work at the state and local level using multi-level approaches.

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CCSB 8B.2. Increase training to child health staff around nutrition/physical activity/food insecurity and identify audiences in the NC Title V Program and across NCDHHS that would also benefit from these trainings and materials.

## State Action Plan Table (North Carolina) - Cross-Cutting/Systems Building - Entry 3

### Priority Need

Increase health equity and eliminate disparities and address social determinants of health

### SPM

SPM 5 - Ratio of black infant deaths to white infant deaths

### Five-Year Objectives

CCSB Objective 8C By 2025, the Title V Program will be working in alignment with the NCDHHS Health Equity Portfolio on health equity and social determinant of health efforts throughout all divisions and sections.

### Strategies

CCSB 8C.1. Promote the use of NCCARE360 within all Title V Programs.

CCSB 8C.2. Explore how Title V Programs can best engage with the Healthy Opportunity Pilots.

**Cross-Cutting/Systems Building - Annual Report**

Priority 8 – Increase Health Equity, Eliminate Disparities, and Address Social Determinants of Health

The NC Title V Program is committed to increasing health equity, eliminating disparities, and addressing social determinants of health as cited in Priority Need 8. In previous MCH Block Grant applications, the NC Title V Program showed this commitment by working to apply an equity lens within each of the priorities related to population domains, but in the 2020 Needs Assessment, it was clear that a separate priority need specific to increasing health equity was required. While there are racial and ethnic 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 2.73 in 2022, up from 2.37 in 2021. 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 Black rate did drop to 12.1 in 2021, but was back up to 12.9 in 2022. 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, ICO4MCH, and the Reducing Infant Mortality in Communities Program) focused on reducing infant mortality and the Black:white disparity ratio as well as inequities between other racial and ethnic groups. Descriptions of these programs and their achievements and plans can be found in the Perinatal/Infant Health Domain.

Health Equity Framework

Promoting health equity remains a key goal for NCDHHS as illustrated by the NCDHHS Health Equity Portfolio, as well "Advance equity" being one of the eight aims of the NCDPH 2023-2025 Strategic Plan released in March 2023. As the Chief Health Equity Officer and Executive Director of the Office of Health Equity worked together with the Assistant Secretary of Equity and Inclusion to determine next steps for NCDHHS with work across Divisions, the NC Title V Program continued to determine its next steps as well. During FY23, the work of the DPH DEI Council, which included members from the NC Title V Program, continued to be enhanced with a growing focus on DPH equity initiatives facilitated by funding through the CDC Public Health Infrastructure grant.

In April 2023, leaders of the NCDHHS Health Equity Portfolio introduced the organizing framework for how the Portfolio approaches health equity and DEI during a lunch and learn open to all NCDHHS employees. The NCDHHS Health Equity Framework is intended to catalyze action and starts 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. Some of the language from the previous DPH Health Equity Framework is included in this new one. Each of the offices within the Health Equity Portfolio (Office of People, Culture and Belonging [formerly DEI]; Office of Rural Health; and Office of Health Equity) continued work on how to best operationalize these different pillars. In addition to the Framework, the Health Equity Portfolio has created a DEI Governance Model which was introduced, but more conversations about the specific roles of Title V Program staff members in this model are needed.

Additional NC Title V Program Health Equity/Social Determinants of Health Plans and Activities

Unconscious Bias training modules continued to be assigned to all Cabinet agency employees, which includes all

 

NCDHHS employees, through the Learning Management System during FY23. The training included 14 e-learning modules totaling 75 minutes in duration. The modules covered a range of topics including: *Why Everyone Has Unconscious Bias*; *Interrupt Your Bias in the Moment*; and *How Unconscious Bias Affects Your Work, Whether You Know It or Not*. All WICWS staff are also required to complete at least eight hours of training annually related to equity and/or social determinants of health.

In order to enhance capacity to advance health equity and reproductive justice, the RHB sent out a Health Equity Training Survey in February 2023 to all North Carolina Title X Family Planning Clinic staff within the LHDs. The survey was used to assess various topics around health equity matters, including knowledge, practices, policies, and training needs. There was an overwhelming response, with 1,177 Family Planning staff responding to the survey from 82 LHDs. Key takeaways from the survey results included a ranked list of equity training topics and modalities LHDs were interested in, such as health needs of people with disabilities, trauma-informed care, and racial health disparities. Additionally, it was found that 45.5% of respondents incorrectly identified individual factors, such as family history and personal health behaviors, as social determinants of health. A summary of statewide results was sent out to all LHDs, and individualized results were sent to all health departments who had at least one respondent. The results will be used by RHB staff to help guide training priorities in FY24.

In FY23, the RHB staff members furthered their health equity journey and how the work is impacted. Staff attended two facilitated meetings in June 2023 with information, discussions and group activities included to enhance understanding of equity within reproductive health, implicit bias, and reproductive justice. In addition, staff also had an opportunity to discuss and have a creative outlet to learn with a discussion-led painting activity around reproductive justice. This session was led by outside facilitators to encourage discussion through hands on expression.

The TPPI staff also focused on equity by offering a sexual violence prevention webinar around the intellectual/developmentally disabled population in August 2022. Twenty-three individuals attended the training from 11 different agencies. Partnering with the NC School Health Training Center at East Carolina University, TPPI also hosted a conference for local agencies called *Supporting Engaging Conversations About Sex & Sexual Health* in May 2023. Attendees learned about supporting youth to have inclusive conversations both inside and outside of the classroom. The conference was held over two days with 62 attendees.

The CMHRP program provides training to newly hired CMHRP Care Managers on health disparities, social determinants of health, and health equity 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 March 2023, the WICWS also transformed its Quality Improvement Council to an Improving Equity and Quality Council to elevate training and ongoing engagement within the WICWS.

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 equity,

health disparities, or social determinants of health to support individual competencies and organizational capacity to promote health equity.

To help the funded partners access good trainings, the WICWS posts a [Health Equity Training Resources document]() on their website annually.

The WICWS also continues to provide opportunities for staff to participate in the Phase I 2-day Racial Equity Institute Foundational Training and Racial Equity Institute Groundwater Training, along with opportunities for small group discussions. 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 diversity, equity, and inclusion topics and situations. In February 2023, the group read and discussed *Pregnant Girl: A Story of Teen Motherhood, College, and Creating a Better Future for Young Families* by Nicole Lewis. This autobiography provided a glimpse into struggles of a young pregnant and parenting woman and how race, economics, and other factors affected her outcomes and career assisting young people. The Reading Circle read *What My Bones Know* by Stephanie Foo in June 2023, which is a memoir chronicling the author's journey of prolonged, repeated trauma. The book reminded us that the impacts of trauma can be long-lasting and difficult to confront. The Reading Circle planned to meet at least three times a year.

Health equity 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 Reproductive Justice 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 a Health Equity Training Survey in February 2023 to all NC Title X Family Planning Clinic staff within the LHDs. The survey, based off the DPH Health Equity Survey, was used to assess various topics around health equity matters, including knowledge, practices, policies, and training needs. There was an overwhelming response, with 1,177 Family Planning staff from 82 LHDs completing the survey. Key takeaways from the survey results included a ranked list of equity training topics and modalities LHDs were interested in, such as health needs of people with disabilities, trauma-informed care, and racial health disparities. Additionally, it was found that 45.5% of respondents incorrectly identified individual factors, such as family history and personal health behaviors, as social determinants of health. A summary of statewide results was sent out to all LHDs, and individualized results were sent to all LHDs who had at least one respondent. The results will be used by RHB staff to help guide training priorities in FY24.

LHDs funded for the first time under the ICO4MCH Program are required to conduct a Health Equity 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 and health inequities. The tool allows a team to think outside the box and consider all factors that could potentially impact the health of populations at risk. The HEIA helps facilitate conversations about factors that support or weaken health, including the root causes of disparities and inequities. 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 and inequities within the impacted population(s). #impactEQUITYNC continued to promote use of the HEIA across DPH and DCFW and with their partners during FY23 and held a HEIA Chat webinar to introduce the tool which drew 40 participants.

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 as 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 launch 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 right direction as the percentage decreased to 18.2% in 2019 and 15.4% in 2021. According to the new Food Sufficiency NPM, NC (70.5%) is similar to the nation (71.2%) in the percent of children, ages 0 through 11, whose households were food sufficient per the 2021-22 NSCH. More CYSHCN in NC (70.6%) indicated that they were food sufficient than nationally (61.0). 2021-22 NCHS results also indicate that in the 6 to 11 year age range, only 24.2% of parents in NC and 26.3% nationally reported that their children were active at least 60 minutes per day. Almost 12% of respondents to the 2021 NC BRFSS 2021 stated that it was often or sometimes true that they worried whether their food would run out before they got money to buy more, and 11% said 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 healthy equity and access to healthy food 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 so much 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 P-EBT. One purpose of creating the DCFW was to bring together most of the federal nutrition assistance programs administered by NCDHHS which includes 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 FY23, many collaborative projects were continued or started including data

sharing agreements between SNAP/FNS, WIC, and Medicaid to increase cross-program referral and enrollment.

In March 2023, the NC Food and Nutrition Summit was held by staff within DCFW and specifically the FNS program. The 3-hour virtual summit objectives were to: showcase food insecurity data and programs; use collaborative strengths to determine the food security resources in seven geographic regions of NC; develop and implement creative solutions to close the gaps for food security in each region; and identify food security programs available within each region. Over 350 participants, facilitators and speakers attended the event, with the PNC serving as one of the facilitators.

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 included in the plan including:

- Increase cross-enrollment across FNS, WIC, and Medicaid
- Improve the participant experience in FNS (SNAP ARPA initiatives)
- Improve the participant experience in WIC (Tufts Telehealth grant)
- Implement Healthy Opportunities Pilot
- Grow NCCARE360 network
- Provide breastfeeding training for WIC staff
- Launch a statewide breastfeeding hotline

In FY23, the PNC co-led the HOP Food Services Operational Guidelines and Best Practices Working Group and also serves 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. During FY23, the PNC also proactively shared 2021 NC BRFSS web tables including food insecurity data for NC adults with WCHS leaders. The PNC was also actively involved in the NC State Nutrition Action Coalition and contributed to improving a Food Insecurity survey that was developed in FY23 and implemented in NC in FY24 with lower resource people/families.

The PNC co-leads (and helped form) 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, Steering Work Group/Farm to Early Care and Education (ECE) Implementation Grant (FIG) Leadership Team; Resources Workgroup, Systems Change Workgroup, etc.) and the Coalition (Steering Committee, Retention and Recruitment Workgroup Lead and Strategic Planning Workgroup). The NCF2PN was competitively awarded an Association of State Public Health Nutritionists (ASPHN) FIG for FY20-23, and the PNC was one of the lead grant writers and served on the leadership and implementation team. In FY23, the PNC recruited and onboarded two nutrition consultants from the Child and Adult Care Food Program (CACFP) in DCFW and CDIS to serve on the Steering Workgroup/FIG Leadership Team for the Network. This allowed the CDIS

to have greater connections with Farm to ECE which likely contributed to their SPAN Grant competitive RFA application and in turn will further support funding and resources going towards Farm to ECE in NC. The NCF2PN was partially supported by the FIG. 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 June 2023, the Network submitted its final Year 3 report which was then summarized in this infographic. During the 3-year FIG grant, the Network impacted an estimated 4,924 children, 111 ECE's and 593 ECE educators. Highlighted Network outcomes included: creating seven online Farm to ECE trainings, all of which provide educators with professional development from DCDEE, the state licensing agency; developed a NC Farm to ECE survey which collected information current Farm to ECE practices from 656 ECE's in NC; supported 48 ECE's with mini-grants which resulted in a variety of policy, systems and environmental changes, including garden creation; and developed a NC Farm to ECE video series to highlight success stories in Farm to ECE, including one Cherokee Nation ECE and a Developmental Day Care ECE. Another outcome achieved in FY23 included the creation of the North Carolina Farm to Early Care and Education Policy Strategic Plan (2023-2026). Goals in this plan include 1) Increase local food procurement opportunities by increasing, funding, local infrastructure, and resources available to NC ECE sites; and 2) Integrate the Recognizing ECE's Advancing Children's Healthy Habits (REACH) designation into the NC ECE licensing system. Successful FIG implementation and resources including a passionate Network Advisory Committee/Leadership Team will continue to foster positive benefits such as increasing children's consumption of fruits and vegetables daily and other outcomes that have been documented.

During FY23, the PNC co-initiated and led the DCFW NC Crunch which included creating a presentation, DCFW leadership speaker notes, and an evaluation report. The NC Crunch is an annual event to celebrate NC agriculture, local farmers and farm workers and nutrition in school, ECE and other sites across NC. Additionally, the PNC assisted with development of the Governor's National Farm to School and ECE Month Proclamation for October.

During FY23, the PNC continued to serve on a variety of statewide workgroups that support nutrition and/or physical activity with children, families, and communities. One example includes serving on the Eat Smart, Move More NC (ESMMNC) Partner Engagement Workgroup which planned and implemented 4 statewide virtual and in-person trainings. The PNC also co-presented at one of those trainings, on "Weighty" Matters: Inclusive & Compassionate Approaches to Whole Person, Whole Community Health which was well received via evaluations and webinar participation. One hundred percent of the participants who completed the webinar evaluation reported that participation in the meeting helped them learn something new; allowed them to share information, strategies, or resources; and helped them connect with others or deepen their network. Several highlighted write-in comments included...." I will strive to be more inclusive in my language. Wonderful presentations and networking today!"; "When creating content for pediatricians to share with their patients, I will definitely refer to this presentation and the resources shared to make sure my language is inclusive."

**Cross-Cutting/Systems Building - Application Year**

Priority 8 – Increase Health Equity, Eliminate Disparities, and Address Social Determinants of Health

The NC Title V Program remains committed to increasing health equity, eliminating disparities, and addressing social determinants of health as cited in Priority Need 8. With all the transitions occurring in NCDHHS over the past three years, including the creation of a Chief Health Equity Officer, a revitalized Office of Health Equity, and the new DCFW, several planned activities for Title V programs have had to be reassessed for alignment and implementation but will carry over into FY25. In FY25, NCODH will continue to build on this collaboration to promote the needs of CYSHCN through partnership with the Office of Health Equity and ongoing work to address communication and physical access needs of people with disabilities, CYSHCN and their families.

Health Equity Framework

Work on integrating the pillars of the NCDHHS Health Equity Framework into the work of the Title V Program is ongoing. Two primary strategies identified for FY25 are to ensure that all Title V Program staff members are aware of the Framework and to help staff members identify how they can incorporate the Framework strategies more fully into their work. In addition, the Health Equity Framework and the recently released *NCDHHS Community and Partner Engagement Guide* will be guiding resources for the FY25 Needs Assessment and incorporated into the work of Title V Program staff members.

Additional NC Title V Program Health Equity/Social Determinants of Health Plans and Activities

The WICWS will continue to require staff and contracted partners to attend at least eight hours of racial equity and/or social determinants of health trainings. All new staff will be required to attend 16 hours of foundational training by the Racial Equity Institute.

Members of WICWS and the Title V Office will continue to serve on the DPH DEI Council in FY25. DCFW is also committed to centering equity in programming and service delivery as well. DCFW leadership is currently working on expanding Early Intervention's DEI Council to all of DCFW.

The WICWS plans to continue the Reading Circle in FY25. 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 a wide range of topics to help staff better understand their work and diverse communities. The Reading Circle plans to read two to three books a year on a variety of topics to continue learning opportunities.

Healthy Beginnings will continue to be implemented through ten contracted partners. This program's focus is to improve the Black/white gap in birth outcomes in selected communities. The current funded sites received additional funds to support staff travel, increase participant engagement with incentives, and staff development to support program implementation. Plans are also underway to conduct an external evaluation of the program also. Several ICO4MCH and Reducing Infant Mortality in Communities (RIMC) sites plan to participate in introductory trainings to learn more about the Health Equity Impact Assessment (HEIA) tool and implementation framework. In addition, ICO4MCH sites that are awarded new funding beginning in FY25 are required to implement at least one HEIA examining an evidence-based strategy.

Health equity continues to be a priority area of Title X (Federal Family Planning program). In FY25, the Reproductive Health Branch (RHB) plans to release a quarterly Equity Newsletter for LHDs to share information, highlight local success stories, and offer resources and trainings. Every newsletter will have a specific theme or topic to cover with

information on why it is significant to reproductive health services, what projects agencies have been implementing, and what resources can assist in moving this work forward. The Reproductive Justice (RJ) Coordinator will lead this newsletter development. In addition, the RJ Coordinator, along with other RHB staff, will review state family planning policies and update them with equitable language. This will include reviewing the policies to be more inclusive, embrace diversity, recognize historical impacts to the work, and are clear on who and how individuals are impacted. Once the state completes this review, the goal is to assist local health departments in completing this work for their own policies as well.

In FY25, the NC MHI Program will continue to create and distribute the Maternal Health Innovation Roundup newsletter quarterly. The newsletter is designed for the State Provider Support Network and the MHI contracted partners and highlights health equity resources in the various formats, like journal articles, podcasts, videos, news articles, toolkits, websites, and other materials.

Food Insecurity and Nutrition/Physical Activity

Decreasing food insecurity with a focus on health equity and access to healthier, affordable, and culturally appropriate food remains a priority for the NC Title V Program and as a NCDHHS priority for FY25. There are many plans for work to continue in FY25 under revised strategy CCSB 8B.1 (NC Title V Program staff will collaborate across Divisions, Departments, and state plans [ECAP, PHSP, etc.] to enhance, connect and partner on nutrition/food insecurity work at the state and local level using multi-level approaches). The PNC will continue to co-lead the HOP Food Services Operational Guidelines Working Group. The purpose of this group, which formed in FY23, is to develop operational guidelines and best practices (Version 1.0) for the HOP Food Services that can be used by all internal and external HOP partners. In this co-lead capacity, the PNC works closely with HOP leadership in DHB/Medicaid and a co-coordinator to plan meetings, draft documents, provide outreach and communication with HOP working group members and staff within DCFW and DPH. Once the HOP Food Service Guidelines document has been completed, the guidelines will be used by Network Leads and Human Service Organizations in all three pilot regions across NC and will be used to provide both consistency and flexibility across HOP. Version 1.0 of the HOP Food Service Guidelines document(s) is expected to be finished in the Summer of 2024 and shared via a collaborative meeting with Network Leads, MCO's and other internal HOP partners. The PNC will plan with HOP partners other trainings or other communication channels to share the Guidance documents with external partners. If NC Medicaid's 1115 waiver request for statewide expansion of HOP is granted for FFY24-29, then internal HOP partners and the PNC will need to determine training needs for new partners interested in participating in HOP Food/Nutrition Services.

The PNC will continually work to explore and advance nutrition/food security activities into programs within the DCFW/WCHS, NC Title V Program, and other DCFW and DPH programs as staff and programs have greater capacity and interest in addressing this area and as direct COVID-related responsibilities and threats continue to decrease. Sensitivity and awareness around racial equity issues and systems that affect food insecurity will also be incorporated into plans developed by the PNC and other team members. These food insecurity strategies can also be aligned through work under the NCDHHS Health Equity Framework where feasible and reasonable. One planned activity for FY25 is to update and disseminate an NC Federal Nutrition Food Assistance Program resource that the PNC developed in 2019. In FY25, the PNC will continue to lead and support multiple food insecurity projects and programs working to address food insecurity. This includes involvement in the SHIP Food Access Workgroup, the Feeding the Carolinas and State Nutrition Action Coalition's Food Insecurity survey and findings project, plus multiple other food insecurity projects. Another activity is that the PNC will continue to identify and partner internally with DCFW staff as appropriate to support food insecurity work being led by the CNSS and the FNSS. For example, the FNSS, in partnership with the NCDPI, received approval in December 2023 to administer the U.S. Department of Agriculture's new Summer Electronic Benefits Transfer (S-EBT) Program (known as SUN Bucks). The NC SUN

Bucks program will begin in the summer 2024 and will provide grocery-buying benefits during the summer months to qualifying families with school-aged children throughout NC. FNSS staff estimate that 1 million children will be eligible for Sun Bucks in Summer 2024.
SUN Bucks will be delivered to eligible families on debit-like EBT cards for families to purchase groceries at retailers that accept EBT, including most major grocery stores. Qualifying families can expect to receive a one-time payment of $120 per eligible child.

Strategy CCSB 8B.2. (Increase training to child health staff around nutrition/food insecurity and identify audiences in the NC Title V Program and across NCDHHS that would also benefit from these trainings and materials) has become more important because of the rise in food insecurity due to COVID-19, the decrease in nutrition assistance benefits now that this public health emergency is over, and inflation. As part of this strategy for FY25, the PNC and SMD will continue to integrate food insecurity trainings into trainings and webinars for child health, CMARC, and in the CHTP for CHERRNs. The PNC and SMD will also continue to share these nutrition/food insecurity and growth and development trainings and resources with other programs in NCDHHS that would benefit from them.

The COVID-19 pandemic caused so much stress and hardship for individuals, children, and families in North Carolina, with a disproportionate burden on HMPs. Food insecurity has increased, especially among children. NCDHHS has worked for years on data linkages that will provide the opportunity for tailored outreach to increase enrollment of eligible families in WIC and FNS. The NC Title V Program will continue to work with multiple partners to ensure innovative ways to provide nutritious and culturally appropriate foods to children and families during this pandemic and afterward. The NC Title V Program will continue to include information as part of outreach and/or presentations to LHDs, providers and other professionals across the state information about the changes or new programs that have been implemented to increase access to food such as NC 211, SNAP, WIC, and SUN Bucks. In addition, the SMD and PNC will explore how to share resources as they become available through the HOP and other efforts (i.e., Legal Aid of NC) to address increased needs for housing, transportation, and other SDoH to health care providers and child health serving professionals.

The SMD will continue to work on revising the national AAP policy statements about food security and homelessness and housing security for children and families in partnership with pediatricians across the country.

Lastly, the SMD will continue to work with the SCHNC and RCHNCs on training and TA for CHERRNs and current staff in the child health clinics in LHDs to increase screening, assessment, and referral for SDoH which include food, housing, interpersonal violence, and transportation. The SMD will also continue to work with partner agencies (i.e., DSS, CCNC, LINKS, SAYSO, Life Skills) who serve youth in foster care and those who were in care to increase awareness of resources for youth in and transitioning out of foster care to address SDoH.

## 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 2021-25 Priority Needs and is currently providing input into the 2026-2030 Priority Needs, the NC Title V Program seeks public input on the MCH Block Grant Application/Annual Report in several ways. The Application/Annual Report is posted on the DPH 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 Early Childhood Action Plan, 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 DCFW/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 understanding (MOU) 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 MOU will be 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 turnover.

The NC Title V Program has been engaged in multiple technical assistance and training opportunities related to MCH in the last few years Various examples include:

- Leadership Exchange for Adolescent Health Promotion (LEAHP)
- Title X Peer Learning on monitoring
- ASPHN/HRSA Children's Healthy Weight Collaborative Improvement & Innovation Network (CoIIN) – Technical Assistance
- National MCH Workforce Development Center (UNC) – Children & Youth Opioid Action Team and Accelerating Equity Learning Community
- Maternal Health Learning and Innovation Center as part of the Maternal Health Innovation effort
- National Center for Hearing Assessment and Management at Utah State University (NCHAM) – EHDI and Newborn Hearing Screening
- Zero to Three Infant and Early Childhood Mental Health Financing and Policy Project
- SAMHSA/ Center of Excellence Early Childhood Mental Health Consultation TA Support
- National Center for Children in Poverty – Promoting Research-Informed State IECMH Policies and Scaled Initiative (PRiSM) TA
- Medicaid Innovation Accelerator Program (IAP) to Strengthen Partnerships While Developing Data Analytic Capacity to Support Reduction of Maternal Mortality (MM) and Severe Maternal Morbidity (SMM) in Medicaid
- ASTHVI – Association of State and Territorial Home Visiting Initiatives – Multiple training and technical assistance from applications to best practices.
- NASHP Contraceptive Care Access
- National Center for a System of services for CYSHCN Blueprint for Change Learning Collaborative (ends June 2025)
- Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Technical Assistance Resource Center (TARC) offers MIECHV awardees the opportunity to participate in Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) annually
- National Academy of State Health Policy (NASHP) Child Behavioral Health Policy Academy
- Comprehensive School Mental Health State Policy Academy
- National Family Planning and Reproductive Health Association's Racism Affinity Group
- National MCH Workforce Development Center (UNC) – Maternal Health Institute

Potential future areas of needed technical assistance for the NC Title V Program are:

1. Measuring impact of reproductive health policy changes
2. Successful examples and tools of programs and policies addressing institutional racism and its effect on MCH populations
3. Fetal and Infant Mortality Review and other ways to strengthen child fatality prevention systems
4. Measuring change while implementing equity work

### 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.pdf

 Created on 7/12/2024 at 2:15 PM

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Glossary of Acronyms Used in the FY25 NC MCHBG Application.pdf

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FY25 NC MCH Block Grant Application O-Chart .pdf

## VII. Appendix

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## Form 2
## MCH Budget/Expenditure Details

**State: North Carolina**

| | FY 25 Application Budgeted | |
|---|---|---|
| 1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 18,871,732 | |
| A. Preventive and Primary Care for Children | $ 6,939,578 | (36.7%) |
| B. Children with Special Health Care Needs | $ 7,139,538 | (37.8%) |
| C. Title V Administrative Costs | $ 337,436 | (1.8%) |
| 2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others) | $ 14,416,552 | |
| 3. STATE MCH FUNDS (Item 18c of SF-424) | $ 54,811,949 | |
| 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) | $ 75,179,067 | |
| 7. TOTAL STATE MATCH (Lines 3 through 6) | $ 129,991,016 | |
| 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) | $ 148,862,748 | |
| 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) | $ 69,890,335 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 218,753,083 | |

| OTHER FEDERAL FUNDS | FY 25 Application Budgeted |
|---|---|
| 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) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF) | $ 5,037,327 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs | $ 156,000 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood | $ 400,000 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees | $ 772,730 |
| Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs | $ 3,299,076 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start | $ 2,354,464 |
| 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 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention | $ 235,000 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 100,000 |
| Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning | $ 7,800,000 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program | $ 100,427 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program | $ 2,541,743 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program | $ 750,000 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 1,568,237 |

| OTHER FEDERAL FUNDS | FY 25 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) > Positive Parenting Program | $ 150,000 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > American Rescue Plan Act Public Health Workforce | $ 40,151,096 |

| | FY 23 Annual Report Budgeted | | FY 23 Annual Report Expended | |
|---|---|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 18,871,732<br>(FY 23 Federal Award:<br>$ 18,607,695) | | $ 16,711,237 | |
| A. Preventive and Primary Care for Children | $ 6,600,923 | (35%) | $ 6,015,902 | (35.9%) |
| B. Children with Special Health Care Needs | $ 7,509,113 | (39.8%) | $ 6,719,517 | (40.2%) |
| C. Title V Administrative Costs | $ 215,441 | (1.1%) | $ 377,883 | (2.3%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 14,325,477 | | $ 13,113,302 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 45,189,526 | | $ 49,684,655 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | | $ 0 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 65,311,808 | | $ 186,253,574 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 67,155,895 | | $ 75,179,067 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 177,657,229 | | $ 311,117,296 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 29,063,379 | | | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 196,528,961 | | $ 327,828,533 | |
| 9. OTHER FEDERAL FUNDS<br>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) | $ 413,861,107 | | $ 337,108,529 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 610,390,068 | | $ 664,937,062 | |

| OTHER FEDERAL FUNDS | FY 23 Annual Report Budgeted | FY 23 Annual Report Expended |
|---|---|---|
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 124,785 | $ 96,252 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start | $ 2,000,743 | $ 1,239,090 |
| US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC) | $ 237,874,865 | $ 196,238,439 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood | $ 446,213 | $ 259,977 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs | $ 247,216 | $ 79,323 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations | $ 12,148,898 | $ 1,492,902 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants | $ 3,969,646 | $ 2,706,936 |
| Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning | $ 6,355,692 | $ 7,398,382 |
| 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 | $ 2,932,008 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF) | $ 3,522,996 | $ 2,995,186 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention | $ 239,466 | $ 232,282 |
| Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Children's Health Insurance Program Reauthorization Act (CHIPRA) | $ 264,035 | $ 13,779 |
| US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP) | $ 136,477,230 | $ 105,551,824 |

| OTHER FEDERAL FUNDS | FY 23 Annual Report Budgeted | FY 23 Annual Report Expended |
|---|---|---|
| Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens | $ 935,407 | $ 0 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 1,746,589 | $ 1,001,865 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees | $ 428,779 | $ 642,075 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program | $ 2,816,048 | $ 2,633,828 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sickle Cell Funding | $ 395,668 | $ 760,849 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > COVID Immunization Funding | $ 882,335 | $ 10,833,532 |

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **1.FEDERAL ALLOCATION** |
| | **Fiscal Year:** | **2023** |
| | **Column Name:** | **Annual Report Expended** |

**Field Note:**
The NC General Assembly 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 MCHBG award to the state. All budget and expenditure actions relating to the Title V funds occur within the approved state plan. 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. These funds will be expended completely within the two year spent period.

| | | |
|---|---|---|
| 2. | **Field Name:** | **Federal Allocation, B. Children with Special Health Care Needs:** |
| | **Fiscal Year:** | **2023** |
| | **Column Name:** | **Annual Report Expended** |

**Field Note:**
The amount spent for Children with Special Healthcare Needs was approximately $789,000 less than budgeted for FY23. This was mostly due to extended position vacancies and contract delays for several CSHCN programs.

| | | |
|---|---|---|
| 3. | **Field Name:** | **Federal Allocation, C. Title V Administrative Costs:** |
| | **Fiscal Year:** | **2023** |
| | **Column Name:** | **Annual Report Expended** |

**Field Note:**
The variance is due to pay and benefit increases passed by the NC General Assembly.

| | | |
|---|---|---|
| 4. | **Field Name:** | **5. OTHER FUNDS** |
| | **Fiscal Year:** | **2023** |
| | **Column Name:** | **Annual Report Expended** |

**Field Note:**
Per the Office of State Budget and Management, programs are encouraged to budget based on a three-year average of receipts; therefore, since rebates are based on participation rates, differences between budget and expenditures can fluctuate greater than 10%. Specific for the WIC program, additional funding associated with the COVID-19 pandemic resulted in an increase in expenditures.

| | | |
|---|---|---|
| 5. | **Field Name:** | **6. PROGRAM INCOME** |

| | |
|---|---|
| **Fiscal Year:** | **2023** |
| **Column Name:** | **Annual Report Expended** |

**Field Note:**
The methodology used to track this information has changed since the budgeting process. We previously relied on a Division report but are now asking local health departments to directly report their program income.

**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 25 Application Budgeted | FY 23 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 1,464,634 | $ 1,096,201 |
| 2. Infants < 1 year | $ 1,540,140 | $ 1,168,915 |
| 3. Children 1 through 21 Years | $ 6,939,578 | $ 6,015,902 |
| 4. CSHCN | $ 7,139,538 | $ 6,719,517 |
| 5. All Others | $ 1,572,710 | $ 1,332,819 |
| Federal Total of Individuals Served | $ 18,656,600 | $ 16,333,354 |

| IB. Non-Federal MCH Block Grant | FY 25 Application Budgeted | FY 23 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 14,118,297 | $ 15,101,718 |
| 2. Infants < 1 year | $ 4,203,851 | $ 16,003,664 |
| 3. Children 1 through 21 Years | $ 15,841,266 | $ 40,378,339 |
| 4. CSHCN | $ 10,157,096 | $ 9,286,761 |
| 5. All Others | $ 10,109,901 | $ 17,224,028 |
| Non-Federal Total of Individuals Served | $ 54,430,411 | $ 97,994,510 |
| Federal State MCH Block Grant Partnership Total | $ 73,087,011 | $ 114,327,864 |

 

**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 25 Application Budgeted | FY 23 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 | $ 16,203,933 | $ 13,713,014 |
| 3. Public Health Services and Systems | $ 2,667,799 | $ 2,998,223 |
| 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** | $ 18,871,732 | $ 16,711,237 |

| IIB. Non-Federal MCH Block Grant | FY 25 Application Budgeted | FY 23 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 1,746,307 | $ 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 | $ 13,831 | $ 797,825 |
| 2. Enabling Services | $ 41,658,112 | $ 52,358,641 |
| 3. Public Health Services and Systems | $ 8,287,585 | $ 44,043,895 |
| 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** | $ 51,692,004 | $ 97,200,361 |

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

| 1. | **Field Name:** | **IIB. - Other - Other** |
|---|---|---|
| | **Fiscal Year:** | **2025** |
| | **Column Name:** | **Annual Report Expended** |

**Field Note:**
The majority of these dollars go to local health departments for MCH services. With the current system, we do not have the ability to differentiate local services provided within the larger categories of child health, maternal health, and family planning.

## Form 4
## Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

**State: North Carolina**

**Total Births by Occurrence: 123,772** **Data Source Year: 2022**

**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 | 123,183 (99.5%) | 2,272 | 254 | 244 (96.1%) |

| Program Name(s) | | | | |
|---|---|---|---|---|
| 3-Hydroxy-3-Methylglutaric 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) | Hearing Loss | 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 | 122,571 (99.0%) | 4,861 | 245 | 243 (99.2%) |

#### 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 Referred For Treatment** |
| | **Fiscal Year:** | **2023** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:**<br>Infants not referred for treatment: 1 deceased and 9 XALD carrier females. | |
| 2. | **Field Name:** | **Newborn Hearing - Total Number Referred For Treatment** |
| | **Fiscal Year:** | **2023** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:**<br>2 infants died. | |

**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 2023**

### 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 | 20,324 | 54.2 | 0.0 | 0.7 | 3.1 | 42.0 |
| 2. Infants < 1 Year of Age | 6,354 | 75.8 | 0.0 | 0.0 | 1.5 | 22.7 |
| 3. Children 1 through 21 Years of Age | 65,325 | 70.1 | 0.0 | 0.6 | 9.5 | 19.8 |
| 3a. Children with Special Health Care Needs 0 through 21 years of age^ | 31,300 | 81.3 | 0.0 | 0.2 | 18.2 | 0.3 |
| 4. Others | 8,609 | 33.0 | 0.0 | 17.0 | 0.2 | 49.8 |
| Total | 100,612 | | | | | |

### 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 | 121,562 | No | 117,985 | 90.0 | 106,187 | 20,324 |
| 2. Infants < 1 Year of Age | 123,714 | No | 122,060 | 99.0 | 120,839 | 6,354 |
| 3. Children 1 through 21 Years of Age | 2,772,598 | Yes | 2,772,598 | 14.8 | 410,345 | 65,325 |
| 3a. Children with Special Health Care Needs 0 through 21 years of age^ | 645,396 | Yes | 645,396 | 8.5 | 54,859 | 31,300 |
| 4. Others | 7,804,821 | Yes | 7,804,821 | 0.8 | 62,439 | 8,609 |

^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 included in this report about 2023, but these data will change in future reporting years once operational transition is complete.

**Field Level Notes for Form 5a:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women Total Served** |
| | **Fiscal Year:** | **2023** |
| | **Field Note:**<br>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:** | **2023** |
| | **Field Note:**<br>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:** | **2023** |
| | **Field Note:**<br>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:** | **2023** |
| | **Field Note:**<br>This is based on FY23 CMARC data from the CareImpact database and FY23 CYSHCN Help Line calls. The CMARC data are only available by Medicaid or non-Medicaid status (which are counted as unknown). The insurance status of people making Help Line calls is not known for all callers, but does not change the overall status due to such small numbers. | |
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2023** |
| | **Field Note:**<br>This is a prorated count of women served in local health department Family Planning clinics through Title V funding taken from the Family Planning Annual Report. | |

**Field Level Notes for Form 5b:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women Total % Served** |
| | **Fiscal Year:** | **2023** |
| | **Field Note:**<br>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:** | **2023** |
| | **Field Note:**<br>Data source is 2023 State Center for Health Statistics Provisional Birth Files for Resident live births as of February 19, 2024. | |
| 3. | **Field Name:** | **Infants Less Than One Year Total % Served** |
| | **Fiscal Year:** | **2023** |
| | **Field Note:**<br>99% of all infants received newborn hearing screening. | |
| 4. | **Field Name:** | **Infants Less Than One Year Denominator** |
| | **Fiscal Year:** | **2023** |
| | **Field Note:**<br>Data source is 2023 State Center for Health Statistics Provisional Birth Files for Occurrent live births as of February 19, 2024. | |
| 5. | **Field Name:** | **Children 1 through 21 Years of Age Total % Served** |
| | **Fiscal Year:** | **2023** |
| | **Field Note:**<br>Includes: 5 year-olds in 2023 per Census Bureau Population Estimates as all have received kindergarten health assessments and immunizations histories have been reviewed (124879); Average monthly participation count of children being served by WIC (1146,023) in FY23 - preliminary data as of 6/14/24; the number of 12 year-olds in 2023 per Census Bureau Population Estimates as all are required by law to have received immunizations for school (130,525); the number of newborn visiting infants/children seen in FFY23 (2049); and number of children served by Triple P in FY23 (7170). | |
| 6. | **Field Name:** | **Children with Special Health Care Needs 0 through 21 Years of Age Total % Served** |
| | **Fiscal Year:** | **2023** |
| | **Field Note:**<br>Includes: CMARC, CYSHCN Help Line, Early Intervention Infant Toddler Program, and Help Line Outreach. | |
| 7. | **Field Name:** | **Others Total % Served** |
| | **Fiscal Year:** | **2023** |
| | **Field Note:**<br>Includes Preconception Health Campaign community ambassadors trained and those trained by them; 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; and people served by NCQuitline who are 25 and older. | |

**Data Alerts: None**

**Form 6**
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: North Carolina**

**Annual Report Year 2023**

### 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 | 120,501 | 63,161 | 26,898 | 20,613 | 1,458 | 4,705 | 137 | 3,236 | 293 |
| Title V Served | 119,417 | 62,593 | 26,656 | 20,427 | 1,445 | 4,663 | 136 | 3,207 | 290 |
| Eligible for Title XIX | 62,387 | 22,494 | 20,274 | 14,967 | 1,142 | 1,245 | 82 | 2,031 | 152 |
| 2. Total Infants in State | 116,056 | 55,164 | 26,445 | 22,086 | 1,417 | 4,397 | 88 | 6,459 | 0 |
| Title V Served | 115,011 | 54,668 | 26,207 | 21,887 | 1,404 | 4,357 | 87 | 6,401 | 0 |
| Eligible for Title XIX | 65,832 | 24,023 | 21,144 | 15,797 | 1,150 | 1,386 | 85 | 2,089 | 158 |

**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 2021 NC Composite Linked Birth File. The number of infants in the state is from the US Census Bureau (State Characteristics Datasets: 2021 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 2021 (99.1%) by the total number of deliveries and infants.

**Field Level Notes for Form 6:**

None

# Form 7
## Title V Program Workforce

### State: North Carolina

Reporting on Form 7 in the 2025 Application/2023 Annual Report is optional. The state has opted-out of providing Form 7 data. Reporting on Form 7 is mandatory for 2026 Application/2024 Annual Report.

**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**

| 1. Title V Maternal and Child Health (MCH) Director | |
|---|---|
| Name | Kelly Kimple |
| Title | NC Title V Director/Senior Medical Director for Health Promotion |
| Address 1 | 1931 Mail Service Center |
| Address 2 | |
| City/State/Zip | Raleigh / NC / 27699 |
| Telephone | (919) 641-9301 |
| Extension | |
| Email | kelly.kimple@dhhs.nc.gov |

| 2. Title V Children with Special Health Care Needs (CSHCN) Director | |
|---|---|
| Name | Anne Odusanya |
| Title | NC CYSCHN Director/Assistant Director, DCFW, Whole Child Health Section |
| Address 1 | 1928 Mail Service Center |
| Address 2 | |
| City/State/Zip | Raleigh / NC / 27699 |
| Telephone | (919) 704-0456 |
| Extension | |
| Email | anne.odusanya@dhhs.nc.gov |

| 3. State Family Leader (Optional) | |
| --- | --- |
| Name | Mahala Turner |
| Title | Family Liaison Specialist |
| Address 1 | 1928 Mail Service Center |
| Address 2 | |
| City/State/Zip | Raleigh / NC / 27699 |
| Telephone | (919) 707-5607 |
| Extension | |
| Email | mahala.turner@dhhs.nc.gov |

| 4. State Youth Leader (Optional) | |
| --- | --- |
| Name | |
| Title | |
| Address 1 | |
| Address 2 | |
| City/State/Zip | |
| Telephone | |
| Extension | |
| Email | |

| 5. SSDI Project Director | |
|---|---|
| Name | Sarah McCracken |
| Title | SSDI Project Coordinator |
| Address 1 | 1931 Mail Service Center |
| Address 2 | |
| City/State/Zip | Raleigh / NC / 27699 |
| Telephone | (919) 707-5515 |
| Extension | |
| Email | sarah.mccracken@dhhs.nc.gov |

| 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 MCH Priority Needs

**State: North Carolina**

**Application Year 2025**

| No. | Priority Need |
|---|---|
| 1. | Improve access to high quality integrated health care services |
| 2. | Increase pregnancy intendedness within reproductive justice framework |
| 3. | Prevent infant/fetal deaths and premature births |
| 4. | Promote safe, stable, and nurturing relationships |
| 5. | Improve immunization rates to prevent vaccine-preventable diseases |
| 6. | Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN |
| 7. | Improve access to mental/behavioral health services |
| 8. | Increase health equity and eliminate disparities and address social determinants of health |

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 9 State Priorities – Needs Assessment Year – Application Year 2021**

| No. | Priority Need | Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period) |
|---|---|---|
| 1. | Improve access to high quality integrated health care services | New |
| 2. | Increase pregnancy intendedness within reproductive justice framework | New |
| 3. | Prevent infant/fetal deaths and premature births | New |
| 4. | Promote safe, stable, and nurturing relationships | New |
| 5. | Improve immunization rates to prevent vaccine-preventable diseases | New |
| 6. | Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN | New |
| 7. | Improve access to mental/behavioral health services | New |
| 8. | Increase health equity and eliminate disparities and address social determinants of health | New |

## Form 10
## National Outcome Measures (NOMs)

**State: North Carolina**

**Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

**NOM - Percent of pregnant women who receive prenatal care beginning in the first trimester (Early Prenatal Care, Formerly NOM 1) - PNC**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 72.4 % | 0.1 % | 87,421 | 120,784 |
| 2021 | 74.5 % | 0.1 % | 88,934 | 119,437 |
| 2020 | 74.0 % | 0.1 % | 85,578 | 115,589 |
| 2019 | 74.2 % | 0.1 % | 87,311 | 117,730 |
| 2018 | 74.7 % | 0.1 % | 88,123 | 118,033 |
| 2017 | 74.8 % | 0.1 % | 89,198 | 119,326 |
| 2016 | 74.9 % | 0.1 % | 89,983 | 120,088 |
| 2015 | 73.7 % | 0.1 % | 88,307 | 119,752 |
| 2014 | 74.1 % | 0.1 % | 88,579 | 119,583 |
| 2013 | 72.0 % | 0.1 % | 84,444 | 117,290 |
| 2012 | 72.7 % | 0.1 % | 85,679 | 117,860 |
| 2011 | 72.3 % | 0.1 % | 85,784 | 118,593 |

**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 PNC - Notes:**

None

**Data Alerts: None**

**NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 (Maternal Mortality, Formerly NOM 3) - MM**

**Data Source: National Vital Statistics System (NVSS)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW**

**Data Source: National Vital Statistics System (NVSS)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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) (Preterm Birth, Formerly NOM 5) - PTB**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 29.5 % | 0.1 % | 35,903 | 121,503 |
| 2021 | 29.3 % | 0.1 % | 35,262 | 120,418 |
| 2020 | 27.8 % | 0.1 % | 32,404 | 116,691 |
| 2019 | 27.3 % | 0.1 % | 32,452 | 118,688 |
| 2018 | 26.2 % | 0.1 % | 31,121 | 118,888 |
| 2017 | 25.4 % | 0.1 % | 30,534 | 120,070 |
| 2016 | 24.6 % | 0.1 % | 29,727 | 120,729 |
| 2015 | 24.2 % | 0.1 % | 29,188 | 120,789 |
| 2014 | 24.0 % | 0.1 % | 28,978 | 120,907 |
| 2013 | 23.7 % | 0.1 % | 28,139 | 118,896 |
| 2012 | 24.1 % | 0.1 % | 28,834 | 119,723 |
| 2011 | 24.4 % | 0.1 % | 29,315 | 120,264 |
| 2010 | 24.9 % | 0.1 % | 30,503 | 122,302 |
| 2009 | 25.8 % | 0.1 % | 32,679 | 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 ETB - Notes:**

None

**Data Alerts: None**

**NOM - Percent of non-medically indicated early elective deliveries (Early Elective Delivery, Formerly NOM 7) - EED**

**Data Source: CMS Hospital Compare**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022/Q1-2022/Q4 | 2.0 % | | | |
| 2021/Q4-2022/Q3 | 2.0 % | | | |
| 2021/Q3-2022/Q2 | 2.0 % | | | |
| 2021/Q2-2022/Q1 | 1.0 % | | | |
| 2021/Q1-2021/Q4 | 2.0 % | | | |
| 2020/Q4-2021/Q3 | 2.0 % | | | |
| 2020/Q3-2021/Q1 | 2.0 % | | | |
| 2019/Q4-2020/Q3 | 1.0 % | | | |
| 2019/Q1-2019/Q4 | 1.0 % | | | |
| 2018/Q4-2019/Q3 | 1.0 % | | | |
| 2018/Q3-2019/Q2 | 1.0 % | | | |
| 2018/Q2-2019/Q1 | 1.0 % | | | |
| 2018/Q1-2018/Q4 | 1.0 % | | | |
| 2017/Q4-2018/Q3 | 1.0 % | | | |
| 2017/Q3-2018/Q2 | 1.0 % | | | |
| 2017/Q2-2018/Q1 | 1.0 % | | | |
| 2017/Q1-2017/Q4 | 1.0 % | | | |
| 2016/Q4-2017/Q3 | 1.0 % | | | |
| 2016/Q3-2017/Q2 | 2.0 % | | | |
| 2016/Q2-2017/Q1 | 2.0 % | | | |
| 2016/Q1-2016/Q4 | 2.0 % | | | |
| 2015/Q4-2016/Q3 | 1.0 % | | | |
| 2015/Q3-2016/Q2 | 1.0 % | | | |

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2015/Q2-2016/Q1 | 1.0 % | | | |
| 2015/Q1-2015/Q4 | 1.0 % | | | |
| 2014/Q4-2015/Q3 | 2.0 % | | | |
| 2014/Q3-2015/Q2 | 2.0 % | | | |
| 2014/Q2-2015/Q1 | 2.0 % | | | |
| 2014/Q1-2014/Q4 | 2.0 % | | | |
| 2013/Q4-2014/Q3 | 2.0 % | | | |
| 2013/Q3-2014/Q2 | 3.0 % | | | |
| 2013/Q2-2014/Q1 | 3.0 % | | | |

**Legends:**

**NOM EED - Notes:**

None

**Data Alerts: None**

**NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM**

**Data Source: National Vital Statistics System (NVSS)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 (Infant Mortality, Formerly NOM 9.1) - IM**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal**

**Data Source: National Vital Statistics System (NVSS)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 (SUID Mortality, Formerly NOM 9.5) - IM-SUID**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 7.9 % | 1.1 % | 9,064 | 114,306 |
| 2018 | 9.0 % | 1.1 % | 10,270 | 113,829 |
| 2017 | 9.5 % | 1.1 % | 10,925 | 114,833 |
| 2008 | 8.2 % | 0.8 % | 10,279 | 125,506 |
| 2007 | 5.8 % | 0.7 % | 7,316 | 125,511 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM DP - Notes:**

None

**Data Alerts: None**

**NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL) (Newborn Screening Timely Follow-Up, Formerly NOM 12) - NBS**

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

**NOM NBS - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR**

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

**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 (Tooth decay or cavities, Formerly NOM 14) - TDC**

**Data Source: National Survey of Children's Health (NSCH)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 (Child Mortality, Formerly NOM 15) - CM**

**Data Source: National Vital Statistics System (NVSS)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 (Adolescent Mortality, Formerly NOM 16.1) - AM**

**Data Source: National Vital Statistics System (NVSS)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 - Percent of children with special health care needs (CSHCN), ages 0 through 17 (CSHCN, Formerly NOM 17.1) - CSHCN**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021_2022 | 22.3 % | 1.4 % | 512,437 | 2,296,195 |
| 2020_2021 | 22.4 % | 1.5 % | 513,419 | 2,291,531 |
| 2019_2020 | 23.4 % | 1.6 % | 535,013 | 2,287,070 |
| 2018_2019 | 22.5 % | 1.5 % | 516,354 | 2,292,865 |
| 2017_2018 | 20.7 % | 1.7 % | 475,844 | 2,293,973 |
| 2016_2017 | 21.3 % | 1.7 % | 487,173 | 2,285,822 |

**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 CSHCN - 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 (CSHCN Systems of Care, Formerly NOM 17.2) - SOC**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021_2022 | 11.1 % | 1.8 % | 56,829 | 512,437 |
| 2020_2021 | 11.8 % | 2.0 % | 60,354 | 513,419 |
| 2019_2020 | 17.0 % | 2.7 % | 91,086 | 535,013 |
| 2018_2019 | 18.6 % | 2.7 % | 96,295 | 516,354 |
| 2017_2018 | 14.8 % | 2.5 % | 70,649 | 475,844 |
| 2016_2017 | 16.5 % | 3.0 % | 80,232 | 487,173 |

**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 3 through 17, diagnosed with an autism spectrum disorder (Autism, Formerly NOM 17.3) - ASD**

**Data Source: National Survey of Children's Health (NSCH)**

### Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021_2022 | 1.7 % | 0.4 % | 33,649 | 1,941,056 |
| 2020_2021 | 2.2 % | 0.4 % | 42,706 | 1,944,964 |
| 2019_2020 | 3.3 % | 0.7 % | 65,422 | 1,957,093 |
| 2018_2019 | 3.4 % | 0.7 % | 65,203 | 1,931,493 |
| 2017_2018 | 1.7 % | 0.4 % | 32,925 | 1,942,951 |
| 2016_2017 | 1.6 % | 0.4 % | 31,579 | 1,957,399 |

**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 ASD - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) (ADD or ADHD, Formerly NOM 17.4) - ADHD**

**Data Source: National Survey of Children's Health (NSCH)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021_2022 | 10.9 % | 1.1 % | 210,548 | 1,934,061 |
| 2020_2021 | 12.4 % | 1.3 % | 240,041 | 1,932,244 |
| 2019_2020 | 13.7 % | 1.5 % | 267,267 | 1,946,178 |
| 2018_2019 | 12.5 % | 1.3 % | 239,494 | 1,918,507 |
| 2017_2018 | 10.2 % | 1.4 % | 196,694 | 1,931,435 |
| 2016_2017 | 10.4 % | 1.4 % | 202,195 | 1,946,944 |

**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 ADHD - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021_2022 | 55.4 % | 4.6 % | 175,515 | 316,616 |
| 2020_2021 | 51.6 % | 5.0 % | 161,709 | 313,363 |
| 2019_2020 | 49.6 % ϟ | 5.3 % ϟ | 142,704 ϟ | 287,882 ϟ |
| 2018_2019 | 53.1 % | 4.9 % | 142,345 | 267,871 |
| 2017_2018 | 47.6 % ϟ | 6.3 % ϟ | 114,694 ϟ | 240,922 ϟ |
| 2016_2017 | 40.9 % ϟ | 6.4 % ϟ | 90,926 ϟ | 222,240 ϟ |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

ϟ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM MHTX - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - 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: Youth Risk Behavior Surveillance System (YRBSS)

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021 | 19.0 % | 1.8 % | 77,004 | 404,846 |
| 2019 | 15.4 % | 1.4 % | 63,235 | 410,622 |
| 2017 | 15.4 % | 1.1 % | 66,425 | 432,035 |
| 2015 | 16.4 % | 1.4 % | 68,596 | 417,208 |
| 2013 | 12.5 % | 0.9 % | 52,783 | 421,815 |
| 2011 | 12.9 % | 1.5 % | 53,533 | 415,433 |
| 2009 | 13.2 % | 1.2 % | 53,695 | 406,168 |
| 2007 | 12.7 % | 1.2 % | 46,593 | 367,524 |
| 2005 | 13.4 % | 1.2 % | 50,885 | 380,019 |

**Legends:**

Indicator has an unweighted denominator <100 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 |
|---|---|---|---|---|
| 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 children, ages 0 through 17, without health insurance (Uninsured, Formerly NOM 21) - UI**

**Data Source: American Community Survey (ACS)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 4.7 % | 0.2 % | 107,933 | 2,292,917 |
| 2021 | 5.1 % | 0.3 % | 118,236 | 2,298,294 |
| 2019 | 5.5 % | 0.3 % | 127,033 | 2,293,400 |
| 2018 | 4.9 % | 0.3 % | 113,604 | 2,297,795 |
| 2017 | 4.5 % | 0.2 % | 103,784 | 2,300,781 |
| 2016 | 4.3 % | 0.2 % | 98,271 | 2,294,158 |
| 2015 | 4.6 % | 0.2 % | 104,590 | 2,286,419 |
| 2014 | 5.3 % | 0.3 % | 121,516 | 2,289,345 |
| 2013 | 5.9 % | 0.3 % | 135,699 | 2,283,544 |
| 2012 | 7.3 % | 0.3 % | 167,287 | 2,282,478 |
| 2011 | 7.8 % | 0.4 % | 177,990 | 2,290,269 |
| 2010 | 8.1 % | 0.3 % | 184,881 | 2,283,103 |
| 2009 | 7.9 % | 0.3 % | 179,093 | 2,271,639 |

**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 UI - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child**

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 67.9 % | 4.4 % | 82,000 | 121,000 |
| 2017 | 80.3 % | 3.6 % | 99,000 | 124,000 |
| 2016 | 77.9 % | 3.1 % | 95,000 | 122,000 |
| 2015 | 73.0 % | 3.4 % | 91,000 | 124,000 |
| 2014 | 69.9 % | 4.0 % | 87,000 | 124,000 |
| 2013 | 71.2 % | 3.8 % | 88,000 | 123,000 |
| 2012 | 76.5 % | 3.8 % | 95,000 | 124,000 |
| 2011 | 72.0 % | 4.1 % | 90,000 | 125,000 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

**NOM VAX-Child - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu**

**Data Source: National Immunization Survey (NIS) – Flu**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 55.6 % | 1.6 % | 1,207,479 | 2,171,724 |
| 2021_2022 | 55.4 % | 1.6 % | 1,205,925 | 2,175,687 |
| 2020_2021 | 59.3 % | 1.9 % | 1,289,349 | 2,174,282 |
| 2019_2020 | 64.4 % | 1.6 % | 1,395,814 | 2,167,413 |
| 2018_2019 | 65.4 % | 1.5 % | 1,413,403 | 2,160,176 |
| 2017_2018 | 59.3 % | 1.7 % | 1,280,587 | 2,159,969 |
| 2016_2017 | 60.6 % | 1.7 % | 1,306,872 | 2,156,911 |
| 2015_2016 | 60.6 % | 1.9 % | 1,297,209 | 2,141,316 |
| 2014_2015 | 60.7 % | 2.1 % | 1,285,333 | 2,118,216 |
| 2013_2014 | 61.4 % | 1.8 % | 1,321,283 | 2,153,730 |
| 2012_2013 | 57.6 % | 2.0 % | 1,244,218 | 2,161,520 |
| 2011_2012 | 55.7 % | 3.1 % | 1,188,294 | 2,134,601 |
| 2010_2011 | 51.7 % | 2.7 % | 1,095,627 | 2,119,202 |
| 2009_2010 | 47.3 % | 3.9 % | 1,071,779 | 2,265,918 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM VAX-Flu - Notes:**

None

**Data Alerts: None**

**NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV**

**Data Source: National Immunization Survey (NIS) - Teen**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 73.1 % | 3.2 % | 508,382 | 695,009 |
| 2021 | 85.0 % | 3.0 % | 576,155 | 677,682 |
| 2020 | 80.3 % | 2.9 % | 536,943 | 668,515 |
| 2019 | 71.3 % | 3.3 % | 471,579 | 661,756 |
| 2018 | 68.6 % | 3.2 % | 453,863 | 661,238 |
| 2017 | 66.8 % | 3.1 % | 441,771 | 661,313 |
| 2016 | 57.5 % | 3.3 % | 377,126 | 655,800 |
| 2015 | 56.7 % | 3.1 % | 369,417 | 651,689 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM VAX-HPV - Notes:**

None

**Data Alerts: None**

**NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP**

**Data Source: National Immunization Survey (NIS) - Teen**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 91.2 % | 2.1 % | 633,967 | 695,009 |
| 2021 | 94.5 % | 2.0 % | 640,628 | 677,682 |
| 2020 | 92.5 % | 2.1 % | 618,570 | 668,515 |
| 2019 | 92.0 % | 2.1 % | 608,684 | 661,756 |
| 2018 | 89.1 % | 2.1 % | 589,099 | 661,238 |
| 2017 | 91.9 % | 1.7 % | 607,771 | 661,313 |
| 2016 | 89.2 % | 2.0 % | 584,642 | 655,800 |
| 2015 | 93.4 % | 1.5 % | 608,666 | 651,689 |
| 2014 | 92.3 % | 1.9 % | 598,117 | 647,948 |
| 2013 | 89.4 % | 2.0 % | 573,089 | 641,084 |
| 2012 | 87.9 % | 2.3 % | 557,002 | 633,720 |
| 2011 | 77.8 % | 2.9 % | 491,003 | 631,495 |
| 2010 | 67.7 % | 2.9 % | 411,306 | 607,904 |
| 2009 | 54.8 % | 3.3 % | 333,405 | 608,979 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM VAX-TDAP - Notes:**

None

**Data Alerts: None**

**NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN**

**Data Source: National Immunization Survey (NIS) - Teen**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 92.8 % | 2.0 % | 644,788 | 695,009 |
| 2021 | 93.3 % | 2.2 % | 632,548 | 677,682 |
| 2020 | 94.4 % | 1.7 % | 630,765 | 668,515 |
| 2019 | 93.2 % | 1.9 % | 616,510 | 661,756 |
| 2018 | 86.1 % | 2.4 % | 569,365 | 661,238 |
| 2017 | 84.8 % | 2.4 % | 561,007 | 661,313 |
| 2016 | 75.7 % | 2.9 % | 496,468 | 655,800 |
| 2015 | 78.5 % | 2.6 % | 511,648 | 651,689 |
| 2014 | 74.1 % | 2.9 % | 480,407 | 647,948 |
| 2013 | 72.4 % | 2.9 % | 464,207 | 641,084 |
| 2012 | 68.2 % | 3.2 % | 432,326 | 633,720 |
| 2011 | 65.9 % | 3.2 % | 416,429 | 631,495 |
| 2010 | 52.4 % | 3.1 % | 318,321 | 607,904 |
| 2009 | 46.8 % | 3.3 % | 284,930 | 608,979 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM VAX-MEN - Notes:**

None

**Data Alerts: None**

**NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB**

**Data Source: National Vital Statistics System (NVSS)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC**

**Data Source: National Survey of Children's Health (NSCH)**

## Multi-Year Trend

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021_2022 | 3.4 % | 0.7 % | 77,812 | 2,286,570 |
| 2020_2021 | 3.9 % | 0.8 % | 90,069 | 2,286,958 |
| 2019_2020 | 2.7 % | 0.6 % | 61,518 | 2,281,581 |
| 2018_2019 | 2.7 % | 0.5 % | 61,619 | 2,279,339 |
| 2017_2018 | 3.6 % | 0.9 % | 82,205 | 2,264,166 |
| 2016_2017 | 3.1 % | 0.9 % | 70,159 | 2,264,881 |

**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 FHC - Notes:**

None

**Data Alerts: None**

## Form 10
## National Performance Measures (NPMs)

### State: North Carolina

**NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| Data Source: Behavioral Risk Factor Surveillance System (BRFSS) | | | | | |
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | 78 | 78 | 78 | 79 |
| Annual Indicator | 77.6 | 76.1 | 75.9 | 75.9 | 73.4 |
| Numerator | 1,412,575 | 1,386,809 | 1,383,829 | 1,383,829 | 1,360,288 |
| Denominator | 1,820,993 | 1,823,266 | 1,822,669 | 1,822,669 | 1,853,350 |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2018 | 2019 | 2021 | 2021 | 2022 |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 79.0 | 80.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC**

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

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | 90 | 90 | 90 | 90 | 90 |
| Annual Indicator | 76.7 | 80.1 | 75.1 | 73.9 | 74.1 |
| Numerator | 1,269 | 1,375 | 1,253 | 1,266 | 1,210 |
| Denominator | 1,654 | 1,717 | 1,668 | 1,714 | 1,632 |
| Data Source | NC Vital Statistics | NC Vital Statistics | NC Vital Statistics | NC Vital Statistics | NC Vital Statistics |
| Data Source Year | 2018 | 2019 | 2020 | 2021 | 2022 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 90.0 | 90.0 |

**Field Level Notes for Form 10 NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **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:** | **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.

| | | |
|---|---|---|
| 3. | **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.

| | | |
|---|---|---|
| 4. | **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.

| | | |
|---|---|---|
| 5. | **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.

**NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| Data Source: National Immunization Survey (NIS) | | | | | |
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | 84 | 85 | 85 | 85 | 85 |
| Annual Indicator | 82.5 | 80.3 | 83.4 | 83.4 | 81.4 |
| Numerator | 88,249 | 90,222 | 92,086 | 92,086 | 92,139 |
| Denominator | 106,953 | 112,365 | 110,468 | 110,468 | 113,239 |
| Data Source | NIS | NIS | NIS | NIS | NIS |
| Data Source Year | 2016 | 2017 | 2019 | 2019 | 2020 |

| Federally Available Data | |
|---|---|
| Data Source: National Vital Statistics System (NVSS) | |
| | 2023 |
| Annual Objective | 85 |
| Annual Indicator | 82.1 |
| Numerator | 98,631 |
| Denominator | 120,143 |
| Data Source | NVSS |
| Data Source Year | 2022 |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 85.0 | 85.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** |
| Annual Objective | 25 | 26 | 27 | 27 | 27.5 |
| Annual Indicator | 23.4 | 23.3 | 22.1 | 22.1 | 23.1 |
| Numerator | 24,051 | 25,865 | 24,009 | 24,009 | 25,017 |
| Denominator | 102,887 | 111,143 | 108,844 | 108,844 | 108,429 |
| Data Source | NIS | NIS | NIS | NIS | NIS |
| Data Source Year | 2016 | 2017 | 2019 | 2019 | 2020 |

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | |
| | **2023** |
| Annual Objective | 27.5 |
| Annual Indicator | 30.8 |
| Numerator | 84,259 |
| Denominator | 273,537 |
| Data Source | NSCH |
| Data Source Year | 2021_2022 |

| Annual Objectives | | |
|---|---|---|
| | **2024** | **2025** |
| Annual Objective | 28.0 | 28.0 |

**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 (Developmental Screening, Formerly NPM 6) - DS**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| Data Source: National Survey of Children's Health (NSCH) | | | | | |
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | 50 | 50 | 50 | 50 | 50 |
| Annual Indicator | 43.0 | 48.1 | 39.5 | 39.5 | 37.1 |
| Numerator | 112,720 | 119,658 | 94,883 | 94,883 | 92,922 |
| Denominator | 261,906 | 249,001 | 240,161 | 240,161 | 250,771 |
| Data Source | NSCH | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2017_2018 | 2018_2019 | 2020_2021 | 2020_2021 | 2021_2022 |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 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 (Adolescent Well-Visit, Formerly NPM 10) - AWV**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| Data Source: National Survey of Children's Health (NSCH) | | | | | |
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | 83 | 83 | 83 | 83 | 83 |
| Annual Indicator | 81.0 | 87.3 | 72.4 | 72.4 | 76.3 |
| Numerator | 638,902 | 786,182 | 588,143 | 588,143 | 619,903 |
| Denominator | 788,733 | 900,582 | 812,116 | 812,116 | 812,165 |
| Data Source | NSCH | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2016_2017 | 2019 | 2020_2021 | 2020_2021 | 2021_2022 |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 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 (Medical Home, Formerly NPM 11) - MH - Children with Special Health Care Needs**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** |
| Annual Objective | 50 | 45 | 48.5 | 48.5 | 49 |
| Annual Indicator | 41.0 | 48.4 | 36.3 | 36.3 | 41.2 |
| Numerator | 199,181 | 241,421 | 184,239 | 184,239 | 211,221 |
| Denominator | 485,743 | 498,468 | 507,316 | 507,316 | 512,437 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2017_2018 | 2018_2019 | 2020_2021 | 2020_2021 | 2021_2022 |

| Annual Objectives | | |
|---|---|---|
| | **2024** | **2025** |
| Annual Objective | 49.0 | 50.0 |

**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 (Medical Home, Formerly NPM 11) - MH - Child Health - All Children**

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - All Children** | |
| | **2023** |
| Annual Objective | |
| Annual Indicator | 48.9 |
| Numerator | 1,120,042 |
| Denominator | 2,292,452 |
| Data Source | NSCH-All Children |
| Data Source Year | 2021_2022 |

**Field Level Notes for Form 10 NPMs:**

None

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

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

**Field Level Notes for Form 10 NPMs:**

None

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

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

**Field Level Notes for Form 10 NPMs:**

None

 Created on 7/12/2024 at 2:15 PM

## Form 10
## State Performance Measures (SPMs)

**State: North Carolina**

**SPM 1 - Percent of PRAMS respondents who reported that their pregnancy was intended**

| Measure Status: | Active |
|---|---|

**State Provided Data**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 59.7 | 60 | 60.3 |
| Annual Indicator | 55.9 | | 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 | 2019 | | 2020 | 2020 | 2020 |
| Provisional or Final ? | Final | | Final | Provisional | Provisional |

**Annual Objectives**

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 60.6 | 61.0 |

**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.

### SPM 2 - Percent of women who smoke during pregnancy

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 8.1 | 7 | 6.8 |
| Annual Indicator | 7.6 | | 6.8 | 5.6 | 4.5 |
| Numerator | 8,991 | | 7,923 | 6,756 | 5,425 |
| Denominator | 118,725 | | 116,755 | 120,501 | 121,557 |
| Data Source | NC Vital Statistics/SCHS | | NC Vital Statistics/SCHS | NC Vital Statistics/SCHS | NC Vital Statistics/SCHS |
| Data Source Year | 2019 | | 2020 | 2021 | 2022 |
| Provisional or Final ? | Final | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 5.0 | 5.0 |

**Field Level Notes for Form 10 SPMs:**

None

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 15 | 15 | 15 |
| Annual Indicator | 15.3 | | 16.6 | 17.8 | 18.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | 2018-19 NSCH | | 2019-20 NSCH | 2020-21 NSCH | 2021-22 NSCH |
| Data Source Year | 2018-19 | | 2019-20 | 2020-21 | 2021-22 |
| Provisional or Final ? | Final | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 14.0 | 14.0 |

**Field Level Notes for Form 10 SPMs:**

None

**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 | | | | | |
|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** |
| Annual Objective | | | 90 | 90 | 90 |
| Annual Indicator | 80.1 | | 75.9 | 76.5 | 72.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | 2017-19 National Immunization Survey | | 2018-20 National Immunization Survey | 2019-2021 National Immunization Survey | 2020-2022 National Immunization Survey |
| Data Source Year | 2019 | | 2020 | 2021 | 2022 |
| Provisional or Final ? | Final | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | **2024** | **2025** |
| Annual Objective | 90.0 | 90.0 |

**Field Level Notes for Form 10 SPMs:**

None

**SPM 5 - Ratio of black infant deaths to white infant deaths**

| Measure Status: | Active |
|---|---|

**State Provided Data**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 2.3 | 2.5 | 2.3 |
| Annual Indicator | 2.7 | | 2.7 | 2.4 | 2.7 |
| Numerator | 12.5 | | 12.8 | 12.1 | 12.9 |
| Denominator | 4.7 | | 4.8 | 5.1 | 4.7 |
| Data Source | NC Vital Statistics/SCHS | | NC Vital Statistics/SCHS | NC Vital Statistics/SCHS | NC Vital Statistics/SCHS |
| Data Source Year | 2019 | | 2020 | 2021 | 2022 |
| Provisional or Final ? | Final | | Final | Final | Final |

**Annual Objectives**

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 2.1 | 1.9 |

**Field Level Notes for Form 10 SPMs:**

None

## Form 10
## Evidence-Based or –Informed Strategy Measures (ESMs)

**State: North Carolina**

**ESM WWV.1 - Number of LHDs that offer extended hours for FP services.**

| **Measure Status:** | **Inactive - Replaced** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** |
| Annual Objective | | | 15 | 15.5 | 16 |
| Annual Indicator | 15 | | 10 | 11 | 24 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | NC FP Program Service Site Information | | NC FP Program Service Site Information | NC FP Program Service Site Information | NC FP Program Service Site Information |
| Data Source Year | 2020 | | 2021 | 2022 | 2023 |
| Provisional or Final ? | Final | | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 0 | 0 | 10 |
| Annual Indicator | | | 0 | 0 | 0 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log |
| Data Source Year | | | 2021 | 2022 | 2023 |
| Provisional or Final ? | | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 15.0 | 20.0 |

**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.

**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 | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 30 | 40 | 75 |
| Annual Indicator | | | 32.9 | 82.1 | 95.2 |
| Numerator | | | 28 | 69 | 80 |
| Denominator | | | 85 | 84 | 84 |
| Data Source | | | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log |
| Data Source Year | | | FY20-21 | FY21-22 | FY22-23 |
| Provisional or Final ? | | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 95.0 | 95.0 |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 74 | 85 | 86 |
| Annual Indicator | | | 84.5 | 73.7 | 59.2 |
| Numerator | | | 82 | 73 | 58 |
| Denominator | | | 97 | 99 | 98 |
| Data Source | | | NC FP LHD Clinical Practice Survey | NC FP LHD Clinical Practice Survey | NC FP LHD Clinical Practice Survey |
| Data Source Year | | | 2021 | 2022 | 2023 |
| Provisional or Final ? | | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 86.0 | 87.0 |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2023 |
| Annual Objective | |
| Annual Indicator | 28.6 |
| Numerator | 24 |
| Denominator | 84 |
| Data Source | NC Family Planning Program Service Site Informatio |
| Data Source Year | 2023 |
| Provisional or Final ? | Final |

| Annual Objectives | |
|---|---|
| | 2025 |
| Annual Objective | 31.5 |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | Active |
|---|---|

**State Provided Data**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 50 | 75 | 100 |
| Annual Indicator | 33.7 | 37.2 | 70.9 | 78.8 | 80.2 |
| Numerator | 29 | 32 | 61 | 67 | 65 |
| Denominator | 86 | 86 | 86 | 85 | 81 |
| Data Source | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log |
| Data Source Year | FY18-19 | FY19-20 | FY20-21 | FY21-22 | FY22-23 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

**Annual Objectives**

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 100.0 | 100.0 |

**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.

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

| Measure Status: | Active |
|---|---|

State Provided Data

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 25 | 25 | 40 |
| Annual Indicator | | 1.2 | 2.4 | 16.5 | 15.3 |
| Numerator | | 1 | 2 | 14 | 13 |
| Denominator | | 85 | 85 | 85 | 85 |
| Data Source | | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log | WICWS Internal Log |
| Data Source Year | | 2020 | 2021 | 2022 | 2023 |
| Provisional or Final ? | | Final | Final | Final | Final |

Annual Objectives

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 60.0 | 75.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM BF.1 - Number of eligible WIC participants who receive breastfeeding peer counselor services**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 28,350 | 29,120 | 29,900 |
| Annual Indicator | 27,587 | 25,020 | 22,263 | 22,599 | 22,987 |
| 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 | SFY18-19 | SFY19-20 | SFY20-21 | SFY21-22 | SFY22-23 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 30,660.0 | 31,425.0 |

**Field Level Notes for Form 10 ESMs:**

None

 

**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**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 80 | 85 | 90 |
| Annual Indicator | | 75 | 80.9 | 75.4 | 80 |
| Numerator | | 51 | 55 | 49 | 52 |
| Denominator | | 68 | 68 | 65 | 65 |
| Data Source | | 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 |
| Provisional or Final ? | | Final | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 95.0 | 100.0 |

**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**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Annual Objective | | | 24,225 | 8,000 | 17,000 |
| Annual Indicator | | 16,676 | 7,656 | 16,169 | 18,265 |
| 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 |
| Data Source Year | | 2020 | 2021 | 2022 | 2023 |
| Provisional or Final ? | | Provisional | Final | Final | Final |

**Annual Objectives**

| | 2024 | 2025 |
|---|---|---|
| Annual Objective | 20,000.0 | 26,222.0 |

**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.

**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 | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 66.3 | 75 | 77 |
| Annual Indicator | | | 71.6 | 71.2 | 51.8 |
| Numerator | | | 4,334 | 5,073 | 5,207 |
| Denominator | | | 6,054 | 7,122 | 10,045 |
| Data Source | | | LHD/HSA | LHD/HSA | LHD/HSA |
| Data Source Year | | | SFY20-21 | SFY21-22 | SFY22-23 |
| Provisional or Final ? | | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 80.0 | 82.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM MH.1 - Percent of children with special health care needs who received family-centered care**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 88.7 | 85 | 87 |
| Annual Indicator | 85 | | 80.8 | 80.3 | 84.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | 2018-19 NSCH | | 2019-20 NSCH | 2020-21 NSCH | 2021-22 NSCH |
| Data Source Year | 2018-19 | | 2019-20 | 2020-21 | 2021-22 |
| Provisional or Final ? | Final | | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 90.0 | 90.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM MH.2 - 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: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | | | 10 | 12 | 18 |
| Annual Indicator | | 8 | 9 | 17 | 13 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | 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 |
| Provisional or Final ? | | Final | Final | Final | Final |

| Annual Objectives | | |
|---|---|---|
| | 2024 | 2025 |
| Annual Objective | 15.0 | 16.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data are for State Fiscal Year (July 1 - June 30). | |
| 2. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data are for State Fiscal Year (July 1 - June 30). | |
| 3. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data are for State Fiscal Year (July 1 - June 30). | |
| 4. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data are for State Fiscal Year (July 1 - June 30). | |

## Form 10
## State Performance Measure (SPM) Detail Sheets

### State: North Carolina

**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<br>**Unit Number:** 100<br>**Numerator:** Number of PRAMS respondents who reported that they wanted to be pregnant then or sooner<br>**Denominator:** Number of PRAMS respondents |
| **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. |

**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<br>**Unit Number:** 100<br>**Numerator:** Number of women who report smoking during pregnancy<br>**Denominator:** Number of live births |
| **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.<br><br>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 |

**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<br>**Unit Number:** 100<br>**Numerator:** Number of children with 2 or more adverse childhood experiences as reported by their parents<br>**Denominator:** Number of children age 0-17 years |
| **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) |

**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<br>**Unit Number:** 100<br>**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)<br>**Denominator:** Number of NC children sampled, ages 19 through 35 months |
| **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) |

**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<br>**Unit Number:** 1<br>**Numerator:** Black, non-Hispanic infant mortality rate<br>**Denominator:** White, non-Hsipanic infant mortalit rate |
| **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 WWV.1 - Number of LHDs that offer extended hours for FP services.**
**NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV**

| | |
|---|---|
| **Measure Status:** | Inactive - Replaced |
| **Goal:** | To increase the number of LHDs that offer extended hours for FP services tby 10% (from 15 to 17) by 2025 in order to increase access to preventive medical visits. |
| **Definition:** | **Unit Type:** Count<br>**Unit Number:** 100<br>**Numerator:** Number of LHDs that offer extended hours for FP services.<br>**Denominator:** |
| **Data Sources and Data Issues:** | NC Family Planning Program Service Site Information |
| **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. |

**ESM WWV.2 - Percent of WICWS programs that utilize the PCH Outreach and Education Toolkit**
**NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - 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<br>**Unit Number:** 100<br>**Numerator:** Number of WHB programs that utilize the PCH Outreach and Education Toolkit<br>**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 |

**ESM WWV.3 - Percent of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and reproductive life planning (RLP).**
**NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - 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<br>**Unit Number:** 100<br>**Numerator:** Number of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and RLP<br>**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. |

**ESM WWV.4 - Percent of LHDs offering same day insertion of both contraceptive implants and intrauterine devices (IUDs)**
**NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - 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<br>**Unit Number:** 100<br>**Numerator:** Number of LHDs that offer same day insertion of contraceptive methods. (IUDs & implants)<br>**Denominator:** 99 counties |
| **Data Sources and Data Issues:** | NC Family Planning Local Health Department Clinical Practice Survey<br>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. |

**ESM WWV.5 - Percent of LHDs that offer extended hours for Family Planning services.**
**NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - 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<br>**Unit Number:** 100<br>**Numerator:** Number of LHDs that offer extended hours for FP services.<br>**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. |

**ESM RAC.1 - Percent of birth facilities with level of care documented using the CDC LOCATe tool.**
**NPM – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - 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>

**ESM RAC.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL)**
**NPM – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - 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<br>**Unit Number:** 100<br>**Numerator:** Number of LHDs who are utilizing the NC-PAL<br>**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. |

**ESM BF.1 - Number of eligible WIC participants who receive breastfeeding peer counselor services**
**NPM – A) Percent of infants who are ever breastfed B) Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months (Breastfeeding, Formerly NPM 4) - BF**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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).</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100,000</td></tr>
<tr><td>Numerator:</td><td>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)</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>NC Crossroads WIC System</td></tr>
<tr><td>Significance:</td><td>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<br>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.</td></tr>
</table>

**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**
**NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS**

| | |
|---|---|
| **Measure Status:** | Active |
| **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<br>**Unit Number:** 100<br>**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<br>**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:<br>- prevent or reduce the impact of developmental delays<br>- identify, build and reinforce developmental strengths in the child and family<br>- prevent fully developed developmental conditions or disorders; and<br>- 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 (Adolescent Well-Visit, Formerly NPM 10) - AWV**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | By 2025, at least 26,222 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<br>**Unit Number:** 100,000<br>**Numerator:** Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center<br>**Denominator:** |
| **Data Sources and Data Issues:** | Local Health Department - Health Systems Analysis (LHD-HSA) and School Health Center Annual Report |
| **Significance:** | While adolescents are generally healthy, preventive medical visits are important in order to address unique health care needs as early as possible and to promote behaviors that will improve long term health. |

**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 (Adolescent Well-Visit, Formerly NPM 10) - AWV**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | By 2025, the percent of adolescents who had a behavioral health screening at time of preventive care visit will increase by 2 percent each year |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** # of adolescents who had a behavioral health screening at time of preventive care visit in LHD<br>**Denominator:** # of adolescents who had a preventive care visit |
| **Data Sources and Data Issues:** | Local Health Department - Health Systems Analysis (LHD-HSA) |
| **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 - Percent of children with special health care needs who received family-centered care**
**NPM – Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling (Medical Home, Formerly NPM 11) - MH**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | By 2025, increase the percent of CSHCN who received family-centered care to 90% |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** Number of CSHCN ages 0 through 17 that received family-centered care<br>**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<br>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.2 - 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 adolescents, ages 12 through 17, who receive needed mental health treatment or counseling (Medical Home, Formerly NPM 11) - MH**

| | |
|---|---|
| **Measure Status:** | Active |
| **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<br>**Unit Number:** 100<br>**Numerator:** Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by MCH staff with an agenda item related to medical home promotion<br>**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 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 2023**

| | 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:**<br>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 state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which included questions identical to the 2020 PRAMS survey and is using Phase 9 PRAMS questions in 2024. |

## Form 12
## Part 2 – Products and Publications (Optional)

**State: North Carolina**

**Annual Report Year 2023**

Products and Publications information has not been provided by the State.