Maternal and Child Health Services Title V Block Grant

North Carolina

FY 2024 Application/ FY 2022 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK BENTON • Deputy Secretary for Health
SUSAN KANSAGRA • Assistant Secretary for Public Health
Division of Public Health

July 19, 2023

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 2024. 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. Gumlon
65A1EE320AD6419...
Kody Kinsley, Secretary

Enclosure: *Maternal and Child Health Services Title V Block Grant FY24 Application/FY22 Annual Report*

cc: Susan Kansagra, 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 F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

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 North Carolina. 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 (formerly the Women's and Children's Health Section [WCHS]) staff members, the NC Title V Director supervises the newly reorganized Women, Infant, and Community Wellness Section (WICWS) which is made up of three branches – Maternal Health, Reproductive Health, and Infant and Community Health – and the Chronic Disease and Injury Section (CDIS). The DCFW/WCHS is made up of six units – Child Behavioral Health, Schools and Health, Best Practices, Childhood Supports, Genetics and Newborn, 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.

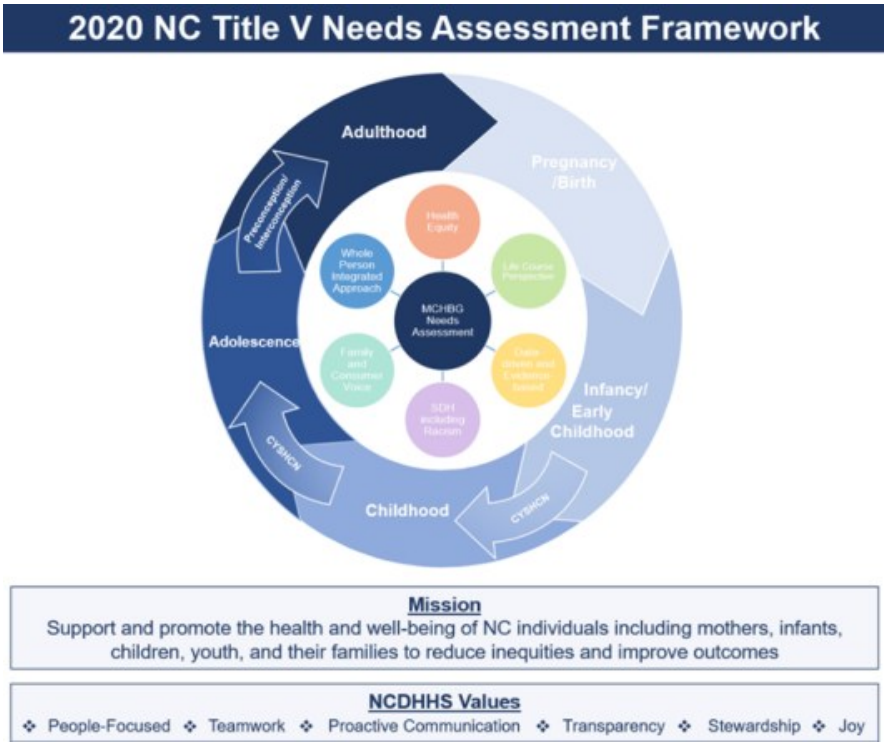
The COVID-19 pandemic highlighted health inequities across the country and we took this as a call to action for NCDHHS to better support North Carolinians. As part of the realignment to bolster whole person health, encourage transparency and accountability, and promote health equity work across the department to create a healthier North Carolina, the DCFW was established to promote cross-program initiatives to support North Carolina'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 access** 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 North Carolina.
5. Achieve **operational excellence** by enabling efficient, effective, and innovative processes and services.

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 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 Division of Child and Family Well-Being (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 the Division of Public Health (DPH), Division of Social Services (DSS), and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) 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 budget expected to be passed by the General Assembly during the current legislative session.

The North Carolina 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 and children's health administered by both DPH and DCFW, as well as DHHS infrastructure to support broader efforts.

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; North Carolina 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), Prevent Child Abuse 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 child with special health care needs to train and support family engagement in DCFW/WCHS programs and partner organizations 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 NC residents between 18 to 44 years old from rural and urban counties who must have children no older than one year of age. As with the Family Partners, 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 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 maternal and child health. 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 funding is also provided to local health departments to offer local care management services to 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 these 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 will also be strengthened 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 will 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

The NC Title V Program has been successful in engaging and empowering young people throughout the state to become active leaders promoting health and wellness in their communities through the Youth Health Advisor Team. Youth Health Advisors serve as advocates and educators for adolescent health promotion and collaborate with the Title V program as experts in their own experience, lending their perspective and leadership to various state and partner agency initiatives.

In addition to providing youth voice to Title V and partner programming in areas such as social and emotional learning, adolescent preventive care and health education, reproductive health care programming, and health equity and access to care, the Youth Health Advisors engaged in research-informed change making within their own communities.

Following the release of their research project titled "*One Year of COVID-19: North Carolina Youth Peer Survey Findings*," Youth Health Advisor team members were energized by the question of "what's next?" Determined to further explore the impact of COVID-19 on the health and well-being of their peers, the Youth Health Advisors began a process of Youth Participatory Action Research (YPAR), a research method rooted in principles of positive youth development social justice.

Guided by the needs and concerns identified from the data and conclusions from their survey report, each Youth Health Advisor created a research question to explore a youth health need in their school or community; they then embarked on a months-long process of data collection, analysis, research, and summarization. Team members researched topics such as mental health care access in schools, pre-teen nutrition education, mental health stigma in Latino communities, youth physical activity and safe places to be active, youth environmental stewardship, and more. Title V supported the facilitation of partnerships and learning throughout this process and guided team members through data collection and analysis, application of health equity principles, and connections to platforms to share their findings. Team members shared their findings in several settings, including state, community, and school meetings.

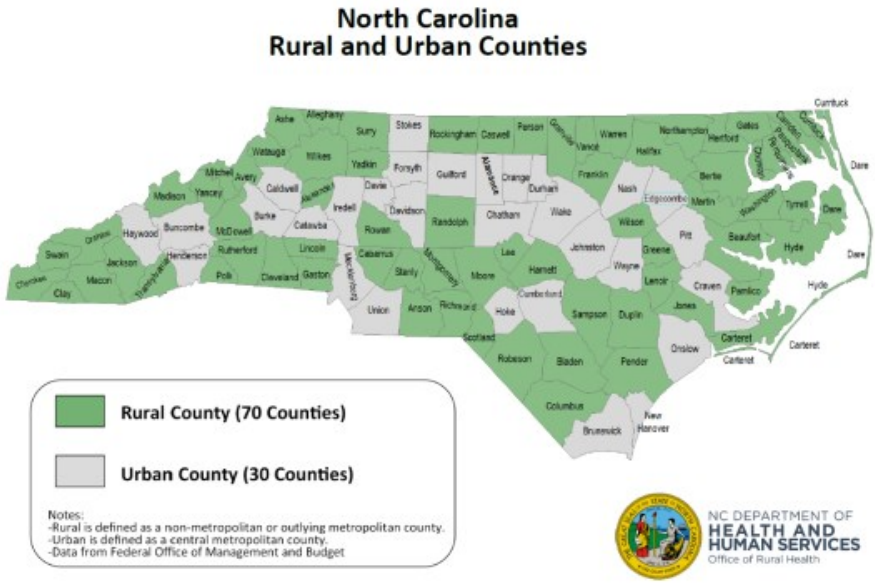
One impactful project explored the mental health needs and help-seeking behaviors of the school population of a local high school. With findings from this project, the Youth Health Advisor responsible for this project was able to partner with her school administration to construct and implement peer-led solutions to student mental health needs. This Youth Health Advisor also developed skills, experience, and insight that allow her to provide guidance to peers throughout the state interested in implementing their own peer-led mental health solutions in schools. Of this process, Youth Health Advisor Amy L. says, "As a YHA, I was immediately exposed to health research, team cooperation, and project management. Because of the team, I saw my dream of making a difference in my community from new angles. Now, I am connecting with leaders from all over to focus on school mental health improvement. It is especially rewarding to know that somewhere out there, another person is being empowered, influenced, or inspired because of my work."

III.B. Overview of the State

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

The state of North Carolina 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, 70 of the 100 NC counties are considered rural. Per data from the Federal Office of Management and Budget, counties are defined as rural if they are non-metropolitan or outlying metropolitan counties and urban if they are central metropolitan counties. The 30 urban counties shown in gray on the map (Figure 1) below have at least one urbanized area that has a population of at least 50,000.

Figure 1



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 2017-2021 American Community Survey (ACS) 5-Year Narrative Profile, NC's official population estimate was 10,367,022.

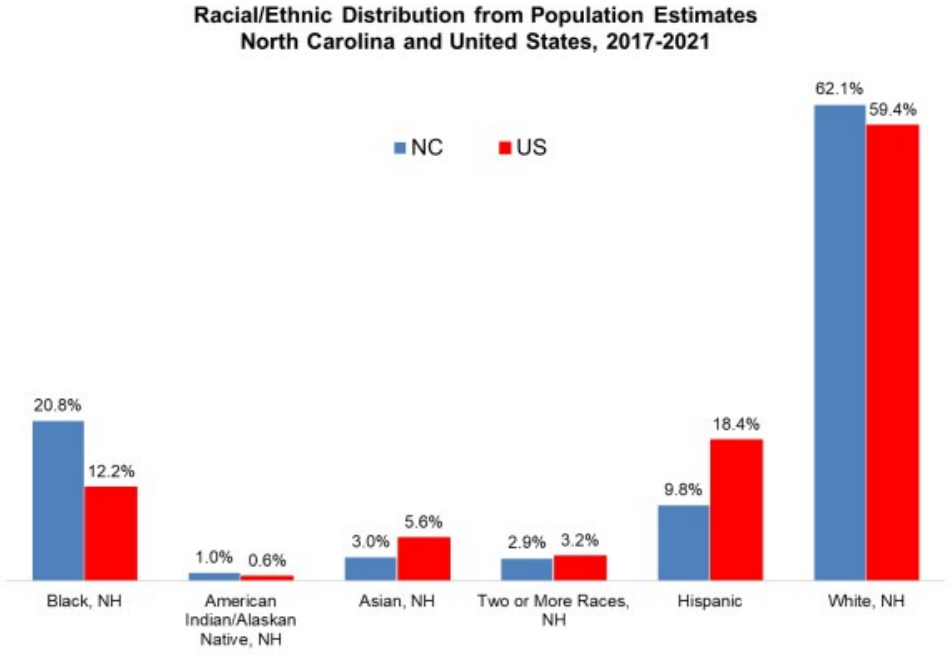
Per the 2017-2021 ACS, the age distribution of the female population of NC mirrors that of the nation. Females in

NC and in the US are also aging at approximately the same rate. The median age in NC is 39 years; for women, it is 40.3 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 120,501 in 2021, 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. Based on 2017-2021 ACS population estimates, children under five years make up 5.7% of NC's population, while children under 18 years comprise 22.2%. These percentages are similar to those for the US (5.9% and 22.5% respectively).

2017-2021 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 20.8% of the population. The combined other minority groups – Hispanic (9.8%), American Indian and Alaska Native, NH (1.1%), Asian, NH (3.0%) and those reporting two or more races, NH (2.9%) – 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

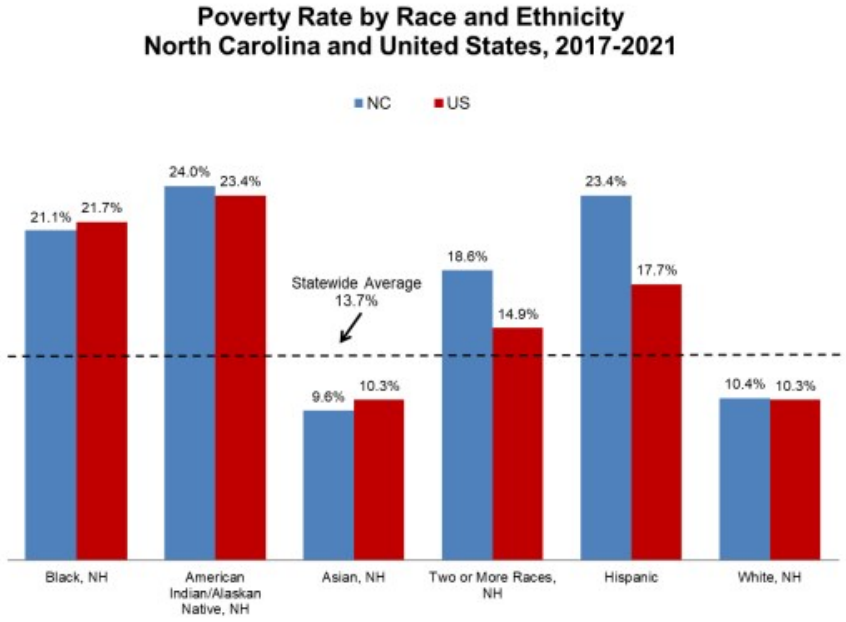


Source: U.S. Census Bureau: 2017-2021 American Community Survey 5-Year Estimates

According to single-year ACS data, 1.4 million North Carolinians (13.4%) lived in poverty in 2021, making NC the state with the 16th highest poverty rate (tied with Ohio). Poverty rates by race and ethnicity in NC from ACS 2017-2021 data are similar to national rates in all categories, except NC rates are higher for people of two or more races, NH, American Indian/Alaskan Native, NH and for those of Hispanic/Latino ethnicity (Figure 3). Poverty rates for non-

Hispanic Black, non-Hispanic American Indian, and Hispanic North Carolinians are more than twice the rates for non-Hispanic whites and non-Hispanic Asians. Women in NC are more likely to be in poverty (15%) than men (12.3%), and children under 18 in NC are at a higher rate of poverty (19.3%) than for the nation as a whole (17%).

Figure 3



Source: U.S. Census Bureau: 2017-2021 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 2017-2021 ACS data, the median household income level for North Carolinians was $61,972 as compared to $69,717 for the US. which does 2007-2011 ACS data shows the NC level at $46,291 and the US level at $52,762.

Per the *State of North Carolina Economic Overview* report published by the NC Department of Commerce in July 2021, "when comparing April 2021 to February 2020, the state has 159,667 fewer employed people and 67,371 more unemployed people" but that while "the declining rate of labor force participation is a concern and accelerated during the heights of the pandemic, North Carolina's decline in participation long preceded 2020." The report goes on to discuss that even though the state's economic conditions have improved considerably (at least in July 2021), the recovery has not been equitable as Black non-Hispanic employment was still down more than 20 percent from February 2020 although white non-Hispanic employment had returned to its February 2020 level, and "those with low-wage and middle-wage employment pre-pandemic were significantly less likely to be employed in North Carolina in the 4th quarter of 2020." According to the NC Budget and Tax Center, while the statewide unemployment rate for December 2021 (3.7%) was low, nearly 75% of NC counties still had fewer people working than before the pandemic arrived. (Blog by Patrick McHugh published February 2, 2022 and accessed April 2022). According to data from the Economic Policy Institute's analysis of Bureau of Labor Statistics Local Area Unemployment Statistics and Current Population Survey data, unemployment rates changed from 2020 Q1 to 2022 Q4 by the following percentage points for these racial/ethnic population groups: Overall +0.1; White -0.1; Black +1.5; and Hispanic -2.2. Black/white and Hispanic/white state unemployment rate ratios were 2.4 and 1.1, respectively. (State unemployment by race and ethnicity Economic Policy Institute updated March 2023 and accessed May 5, 2023)

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 NCDPH 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. Follow up materials were submitted, and PHAB awarded national accreditation status to NCDPH 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 with planning underway for the future.

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 North Carolina. 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, two new departmental agencies were established: an Office of Emergency Preparedness, Response, and Recovery and a Division of Child and Family Well-Being (DCFW). The DCFW will promote cross-program initiatives to support North Carolina'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 Division of Public Health, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and Division of Social Services to increase access and enrollment in services and to improve outcomes for children and their families. This includes nutrition programs (Food and Nutrition Services/Supplemental Nutrition Assistance Program (FNS/SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the Child and Adult Care Food Program (CACFP)), health & prevention services for children and youth (including those with special health care needs), 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 Medicaid Director for Health Promotion for the NC DPH. In this new role, she supervises the WICWS, the CDIS, the Oral Health Section, and the NC Title V Office and works closely with the Assistant Secretary for Public Health on division-wide projects. 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. 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 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; Human Resources; Oral Health; State Center for Health Statistics; State Laboratory; WICWS, and Title V Office. 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 DPH-DCFW 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 health people and communities; 3) enable North Carolina'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). The operational transition to the new DCFW is still underway during the time of this reporting period and therefore these numbers will change for future reporting. 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 budget expecting to be passed 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 provides 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 or Health Choice (NC Child Health Insurance Program) 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. Recommendations from the Summit included:

- Increasing the percent of CYSHCN that have access to behavioral, mental, and oral health services
- Increasing the number of counties implementing Innovative Approaches (Improving Systems of Care for CYSHCN)
- Increasing the capacity of health professionals to improve quality care for people with disabilities and CYSHCN through partnerships with major medical centers
- Increasing the number of CYSHCN that have access to patient and family centered care by training parents in Parents and Collaborative Leaders
- Increasing parent access to information by creating a CYSHCN webpage with info and links to credible source
- Increasing information on transitioning from pediatric to adult health services

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.
- 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 Division of Mental Health/DD/SAS.
- 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, appointed by the Governor and supported by the DCFW/WCHS 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 a learning collaborative with MCHB and family led state teams 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 North Carolina 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, 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. NC Title V continues to support implementation of these goals as part of the NCDHHS priority areas.

Along the maternal and child health continuum with these initiatives, implementation of the Perinatal Health Strategic Plan (PHSP): 2016-2020 continued. A new PHSP Program Consultant position was hired in June 2021 after a temporary staff member had been in that position since July 2020. 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. 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.

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 FY22, RRT staffed more than 250 referrals.

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 North Carolina had HFW services available to their residents. By June 2022, 66% of counties had HFW services available to families in their area. NCDHHS has supported the expansion of HFW services by funding a university partner to administer a statewide training and technical assistance program and by funding Medicaid payers and private providers to develop and expand services to more communities across the state.

According to data from the interactive NC Health Professions Data System, in 2021, for NC as a whole, there was an average of 8 physicians with a primary care practice per 10,000 individuals. However, 28 counties have relatively few primary care physicians (less than 4 per 10,000 people) and one county did not have any primary care physicians. NC also has an increasing shortage of health care professionals performing deliveries, and there have been seven rural hospital closures since 2010 in NC.

Per the NC Health Professions Data System, in 2021 there was an average of 1.66 physicians whose specialty was general pediatrics per 10,000 population, but twenty counties did not have any pediatricians. NC has several children's hospitals nationally ranked in pediatric specialties (i.e., UNC Children's Hospital; Duke Children's Hospital and Health Center; and Levine Children's Hospital), 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 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 (SMM). 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.

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 2020, Medicaid paid for 62,435 births, or 53.5% of all births in NC. In NC, as of July 1, 2022, income eligibility standards for selected coverage groups that use Modified Adjusted Gross Income (MAGI) rules in Medicaid and the Child Health Insurance Program (CHIP) are as follows:

NC Medicaid Income Eligibility Standards – 7/1/2021	
Coverage Group	**Percentage of the Federal Poverty Level**
Children Medicaid Ages 0-1	210
Children Medicaid Ages 1-5	210
Children Medicaid Ages 6-18	133
Children Separate CHIP	211 (6 up to 19)
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 Centers for Medicare & Medicaid Services. 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. The Behavioral Health and Intellectual/Developmental Disability Tailored Plan was scheduled to be launched on October 1, 2023, but will now go forward at a date still to be determined to ensure that beneficiaries can seamlessly receive care on day one.

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 and Health Choice 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 2024 Application/FY 2022 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. DCFW is also leading a group across NCDHHS to pull together a child mental health dashboard. 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 FY22 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 three 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 2021 Behavioral Risk Factor Surveillance System (BRFSS) in the FAD, 75.9%% of women ages 18 to 44 surveyed had received a preventive medical visit in the past year which is higher than the national rate

(69.7%) and is a bit lower than the 2018 NC rate of 77% (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 year 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 2021 and for NH Black women and for the total respondents. There does seem to be an increase in those women who were overweight or obese.

Characteristics of Women of Childbearing Age by Race/Ethnicity
North Carolina, 2018 & 2021

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
	2021	76.3	72.4-79.8	76.4	70.8-81.1	84.6	77.5-89.8	67.9	57.8-76.6
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
	2021	86.9	84.2-89.3	93.6	90.2-95.9	94.5	90.0-97.1	52.1	42.6-61.5
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
	2021	63.3	58.9-67.4	55.5	49.5-61.4	79.9	71.5-86.3	67.8	56.3-77.6
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
	2021	11.4	9.1-14.2	12.6	9.4-16.6	12.2	7.6-18.9	5.4	2.6-11.0
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
	2021	18.6	15.7-22	22.6	18.4-27.5	14.1	8.9-21.7	13.8	8.3-22.1

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 2021 show that 73.9% 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 2021, North Carolina's infant mortality rate returned to a historic low of 6.8 infant deaths per 1,000 live births from a rate of 6.9 in 2020, but that means that 820 infants (a figure equal to about 11 school buses of 72 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 decreased slightly from 2014 to 2021, from 2.51 to 2.37, but this disparity ratio fluctuated from a low of 2.29 in 2015 to a high of 2.83 in 2020. Fetal death rates per 1,000 deliveries continue to tell the same story, as in 2021, the non-Hispanic Black rate (9.7) was 1.9 times that of the non-Hispanic white rate (5.1) with a total state rate of 6.0.

The latest data from the National Immunization Survey (NIS) show that 83.4% of infants born in NC in 2019 were ever breastfed which is slight decrease from the previous year and is almost the same as the national rate of 83.2%. Breastfeeding initiation data obtained from birth certificates for infants born in 2021 indicate that 80.8% of all infants were breastfed at hospital discharge. However, Hispanic infants (86.7%) and non-Hispanic Asian infants (89.1%) were more likely to be breastfeeding than non-Hispanic Black (69.9%), non-Hispanic white (83.7%), or non-Hispanic American Indian (52.2%) infants. While birth certificate data on mothers who reported smoking during pregnancy continues to trend down (5.6% of all live births in 2021 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 2020-21 National Survey of Children's Health (NSCH), 89% of NC parents surveyed responded that their child was in excellent or very good health, which is approximately the same as the 2018-19 result of 91.1%. 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 as well as those who were receiving care which met the criteria for a medical home. Percentages were higher for non-Hispanic white (94.2%) children than Hispanic (86.3%) and non-Hispanic Black (80.1%) 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] ≥ 85th 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 and 2021 because heights and weights data were not consistently collected and measured using a standardized method because of remote WIC services in agencies during the pandemic. Additional data from the 2020-21 NSCH show that 39.5% of children in NC between 9-35 months had received appropriate developmental screening which is about the same as the rate of 43% in the 2017-18 NSCH, but lower than the rate of 55.8% in the 2019-20 NSCH and higher than the national average of 34.8%. It should be noted that the percentage for NC should be interpreted with caution as the estimate has a 95% confidence interval width exceeding 20 percentage points and may not be reliable. While the percentage of children with ≥2ACEs decreased from the 2017-18 to 2020-21 NSCH, 19.2 % down to 17.8%, the decrease is likely not significant. 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 75.9% per the 2018-20 NIS. There was a slight increase to 76.5% in the 2019-21 NIS, although with fairly wide confidence intervals this increase was not significant. NC rates did continue to be higher than the national 2019-21 NIS rate of 70.1%. 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 NSCH data, the percentage of adolescents (ages 12 through 17) with a preventive visit decreased from 2016-17 (81%) to 2020-21 (72.4%), and this decrease was probably due to the COVID-19 pandemic, particularly with School Health Centers being closed for much of SY20-21. Teen immunization rates from the 2021 NIS – Teen showed continued increase over 2019 reports for teens receiving the human papillomavirus series (60.4%), and the

rates for teens receiving meningococcal conjugate vaccine (95.6%) and one or more doses of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (96.2%) remained about the same. According to 2020-21 NSCH data, 21% of parents in NC responded that their child (age 10 to 17) was obese with a BMI ≥95th percentile (BMI is based on parents' recollection of the selected child's height and weight). This is an increase from 13.5% in the 2017-18 survey. Children and youth whose parents reported that they had experienced two or more adverse childhood experiences or who were low-income (<200% of the federal poverty level) 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 22.1% of CYSHCN in NC per the 2020-21 NSCH, which is almost identical to the 2017-18 NSCH results of 21.2%. The 2020-21 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 (69.7% for CYSHCN v. 94.5% for non-CYSHCN), and this difference appears to be statistically significant. CYSHCN in NC age 10-17 years were more likely to be obese (34.6%) than children and youth without special health care needs (15.7%) according to the same survey. The percentage of CYSHCN in NC receiving care in a medical home decreased from 41% in the 2017-18 NSCH to 36.3% in the 2019-20 NSCH, with the majority of CYSHCN not receiving care within a medical home.

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

During FY21 and FY22, the Title V Program Director continued to lead COVID-19 pandemic response efforts, particularly in the areas of nutrition and vaccine rollout, serving on multiple NCDHHS teams to ensure that vaccine was made available quickly to all eligible populations in an equitable manner. She worked with teams across NCDHHS to elevate MCH work, while continuing to monitor work on the Title V State Action Plan.

Two significant changes in the MCH systems of care in NC, the transformation to NC Medicaid Managed Care and the planned creation of the new NCDHHS Division of Child & Family Well-Being, are still 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. Some beneficiaries, including those people with significant behavioral health needs, intellectual/developmental disabilities, and traumatic brain injury, are not required to choose a health plan at this time, as the Behavioral Health and Intellectual/Developmental Disability Tailored Plan is now set to launch on October 1, 2023, after a couple of delayed launch dates. Other beneficiaries, such as those receiving Family Planning Medicaid or children in foster care or receiving Community Alternatives Program for Children (CAP/C) services will remain in traditional Medicaid, which is called NC Medicaid Direct.

All pregnant women enrolled in managed care through pre-paid health plans (PHPs) will continue to receive a coordinated set of high-quality maternity services through the Pregnancy Medical Program (PMP), which will be

administered as a partnership between PHPs and local perinatal service providers. Birthing people will 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, will continue 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 five 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. Establishment of an Office of Emergency, Preparedness, Response, and Recovery to bring together teams from across NCDHHS to prepare for, respond to, and recover from disasters and health emergencies affecting North Carolina, strengthening the Department's partnership with the Division of Emergency Management at the Department of Public Safety.
5. 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 will bring 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.

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 have been immense and have strengthened relationships both with other state agencies and non-governmental partners. As mentioned above, the transformation to NC Medicaid Managed Care 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 FY23 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 was only one major leadership change in FY22. In March 2022, Dr. Anne Odusanya assumed the role of Assistant Director for the DCFW/WCHS and serves as the NC CYSHCN Director. Before taking this position, she was the CYSCHN Director/Unit Supervisor for Title V at the Wisconsin Department of Health Services. She received her DrPH from Georgia Southern University in Community Health Behavior and Education.

Emerging Public Health Issues

In addition to the ongoing COVID-19 pandemic and Medicaid Transformation, 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 38.5 deaths per 100,000 residents in 2021. 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 are the NC Institute of Medicaid Task Force on the Future of Public Health, NC Association of Local Health Directors ongoing initiatives, and North Carolina's participation in the cross-state 21st Century Learning Collaborative on public health system change. In addition, the new DPH Director plans to focus on the following three goals:

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

The health insurance coverage gap coupled with insufficient access to affordable care disproportionately impacts Historically Marginalized Populations who have also experienced worse outcomes than others with the COVID-19 pandemic. Expanding Medicaid has been a key priority of NCDHHS for the past several years as an unprecedented opportunity to increase access to health care across the state, particularly in rural communities. Governor Cooper signed House Bill 76, Access to Healthcare Options into law on March 27, 2023, which will expand Medicaid and is expected to provide health coverage to over 600,000 people. While we are still waiting on the state budget to pass which is needed to become effective and determine the specific dates for eligibility rules, Medicaid Expansion is a powerful tool to improve the health and well-being of North Carolinians and their families.

On March 14, 2023, Governor Cooper announced the creation of a statewide Office of Violence Prevention which will be located in the NC Department of Public Safety. The Office will focus on reducing 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 Chronic Disease and Injury Section.

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

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

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$17,424,544	$18,812,551	$18,806,308	$16,804,521
State Funds	$41,861,408	$38,249,324	$34,195,972	$35,228,731
Local Funds	$0	$0	$0	$0
Other Funds	$66,078,190	$52,819,279	$66,371,749	$57,078,391
Program Funds	$70,779,201	$73,859,576	$69,967,790	$67,155,895
SubTotal	$196,143,343	$183,740,730	$189,341,819	$176,267,538
Other Federal Funds	$403,362,999	$281,671,839	$393,826,669	$291,783,688
Total	$599,506,342	$465,412,569	$583,168,488	$468,051,226

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$18,806,308	$16,451,537	$18,871,732	
State Funds	$37,169,426	$45,802,293	$45,189,526	
Local Funds	$0	$0	$0	
Other Funds	$65,371,749	$57,707,314	$65,311,808	
Program Funds	$73,859,576	$70,327,753	$67,155,895	
SubTotal	$195,207,059	$190,288,897	$196,528,961	
Other Federal Funds	$456,342,218	$390,961,113	$413,861,107	
Total	$651,549,277	$581,250,010	$610,390,068	

	2024	
	Budgeted	Expended
Federal Allocation	$18,871,732	
State Funds	$46,722,582	
Local Funds	$0	
Other Funds	$65,322,845	
Program Funds	$70,327,754	
SubTotal	$201,244,913	
Other Federal Funds	$435,531,229	
Total	$636,776,142	

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 FY22, federal Maternal and Child Health Block Grant expenditures were $16,451,537, which is a slight decrease of $352,984 from the previous year. There was some delay in contracting which led to a decrease in expenditures in some areas. Since we have two years to spend, we do not leave funds unexpended.

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 (~81%) went to enabling services, with a smaller proportion (~19%) 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. Three more significant variations were noted and documented in the Field Notes section of the report Form 2.

- Federal Allocation FY 2022 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.
- There was in increase in State MCH Funds FY 2022 Expended compared to the Budget, which was mostly due to newly appropriated state funds totaling $7.2 million.
- 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% (Other Funds Expended).

We have covered our process below on our procedures 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 FY 24 Application Budget for the MCHBG is $18,871,732, a majority (87%) 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 (10%) 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 ~3% 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 (~79% of budget), with the remainder (21% 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 FY24 as shown in Form 2 is $46,722,582. This includes state funds used for matching Title V funds, which for the FY24 application is $182,373,181.

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 recognize 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 some time now, the NC Home Visiting Consortium has been working on developing a set of standard core competencies for home visitors and parent educators. The goal is to professionalize the field across NC by standardizing the knowledge, skills, and abilities of home visitors and parenting educators. At the 2019 NC Home Visiting Summit, a workshop was held to discuss the need for core competencies. As a result of the workshop, a

number of stakeholders were recruited to participate in a Core Competency Committee which drafted a set of competencies. A second workshop to review the draft core competencies was held at the 2020 NC Home Visiting Summit. The MIECHV Program Manager, HFA State Consultant, and NFP State Consultant are members of the Committee. The Core Competency Committee has finalized the competencies, and they will be reviewed soon by the Home Visiting and Parenting Education Collaborative Board to align with the NC Home Visiting and Parenting Education System Action Plan. Once approved, the plan is to recommend that home visiting and parenting education professionals adopt them for use.

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 Teen Pregnancy Prevention Conference was held in May 2023 for current partners and other youth-serving agencies.

The WICWS has held a regular Reading Circle focused on cultural awareness for many years. The Reading Circle, a completely voluntary group, 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

Recent books read by the reading circle include *Pregnant Girl: A Story of Teen Motherhood, College, and Creating a Better Future for Young Families* by Nicole Lynn Lewis and *What My Bones Know: A Memoir of Healing from Complex* Trauma by Stephanie Foo.

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 creating a community engagement survey which launched in April 2023.

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 Steering 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 Steering 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 FY22 and FY23, 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 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 attend community events with t-shirts and trading cards. 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.

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 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 Risk Assessment Monitoring System.

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 death prevention. Title V funding fully supports the 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 will update 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 21st Annual EET Poster Day in June 2022, with participants able to share posters created for local, state, and national conferences with DPH staff members. Prior to 2020, Poster Day was held in a conference room on the DPH campus with more than 100 people attending. Moving it to a virtual platform in 2020 due to the COVID-19 pandemic has limited the number of presentations, but perhaps helped EET attract a wider audience as participants can view the recording of the presentations at their convenience. The 2023 EET Poster Day will be held on August 11, 2023, and will be an in-person event only.

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 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 state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which includes questions identical to the 2020 PRAMS survey.

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 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 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. The SSDI Project Coordinator is also one of the co-chairs of the DPH Epidemiology and Evaluation Team which was described earlier.

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.

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 2022 State Health Improvement Plan 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. Work to develop a HNC 2030 indicator database is ongoing.

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 Data Dashboard tracks progress toward the targets and sub-targets of the 2025 goals of the NC ECAP. ECAP County Data Reports are also available. Efforts to create a revised Early Childhood Action Plan Data Dashboard are underway. 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 is leading an effort to establish a data dashboard with child behavioral health measures. Effectively and equitably addressing the child and youth behavioral health crisis requires being able to quickly gain insights into where we are making progress and where we must do more. The dashboard will include prioritized measures to inform data-driven decision making for policy and service development and care delivery. Currently, data related to children's behavioral health in North Carolina exist in siloes and must often be pulled and analyzed manually. The dashboard will facilitate more timely data transparency and shared accountability within NCDHHS and with our partners, including providers, payers, schools, child welfare system, and policymakers. The data dashboard will tentatively be released internally during summer 2023 and be publicly available in late 2023 or early 2024. The Perinatal Epidemiologist was a member of the initial planning team.

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 Title V Program is also working with NCDHHS to refine our 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) 2022 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 2022. 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 2021 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.

NCDHHS strives to build upon our strengths and the lessons learned from the pandemic to craft an even stronger, more integrated Department and is working to establish an Office of Emergency Preparedness, Response, and Recovery to bring together teams from across the Department to prepare for, respond to, and recover from disasters and health emergencies affecting North Carolina. The intent of this new office will strengthen and streamline our coordination and partnership with the Division of Emergency Management at the Department of Public Safety. The planning for this new office is still underway.

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. 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 DPH/DCFW 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
- 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 between the state's Medicaid agency and the Title V program is included in this application with an updated version as a three-way agreement between DHB, DPH and DCFW going through the approval process. 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, including a specific one focused on MCH issues that arise as part of the Medicaid transformation. NCDHHS anticipates an evolving agreement as we more fully transition to Medicaid managed care and with the development of the new DCFW.

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.

There are fourteen 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 with its Department of MCH, but also with the Departments of Public Health at UNC-Greensboro and East Carolina University and 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 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 and DPH. A full revision to this IAA/MOA is underway, so the current IAA/MOA has been extended by NC Medicaid for another year (until July 1, 2024) in order to finalize the revisions. It is anticipated that the new MOA, which will be between DHB, DPH, and DCFW, will be completed by September 2023.

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 and NC Health Choice Annual Report for State Fiscal Year 2022, in SFY22, NC Medicaid provided access to care and services to nearly 2.9. million people in the state, with many served through outreach and enrollment efforts of Title V programs and partners. According to the 2020 NC Composite Linked Birth File, 53% of all resident births were to women receiving Medicaid. The NC SCHS has yet to release the 2021 data.

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, thus enrollment and implementation for the transition to managed care was suspended on November 19, 2019. With Medicaid Managed Care suspended, NC Medicaid continued to operate under the current fee-for-service model administered by NCDHHS, although providers continued to negotiate contracts with the Medicaid Managed Care health plan which also continued to prepare reporting data and update systems. 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. Despite the suspension and the additional burden placed on NCDHHS and providers to respond to the COVID-19 pandemic, NC Medicaid Managed Care launched on schedule. 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 Behavioral Health Intellectual/Developmental Disability (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 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.

The BH I/DD Tailored Plan was scheduled to be launched October 1, 2023, but will now go forward at a date still to be determined as NCDHHS works to ensure a smooth transition. The BH I/DD Tailored Plan will serve individuals with more serious behavioral health disorders (serious mental illness, serious emotional disturbance, and/or substance use disorders), I/DDs, and traumatic brain injuries. NCDHHS is investing in the Tailored Care Management model in which BH I/DD Tailored Plan beneficiaries will have a single designated care manager supported by a multidisciplinary care team to provide integrated care management that addresses physical health, behavioral health, I/DD, traumatic brain injuries, pharmacy, and long-term services and supports along with addressing their unmet health-related resource needs. The following six organizations will serve as regional BH I/DD Tailored Plans: Alliance Health; Eastpointe; Partners Health Management; Sandhills Center; 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. The goals of the pilots are to:

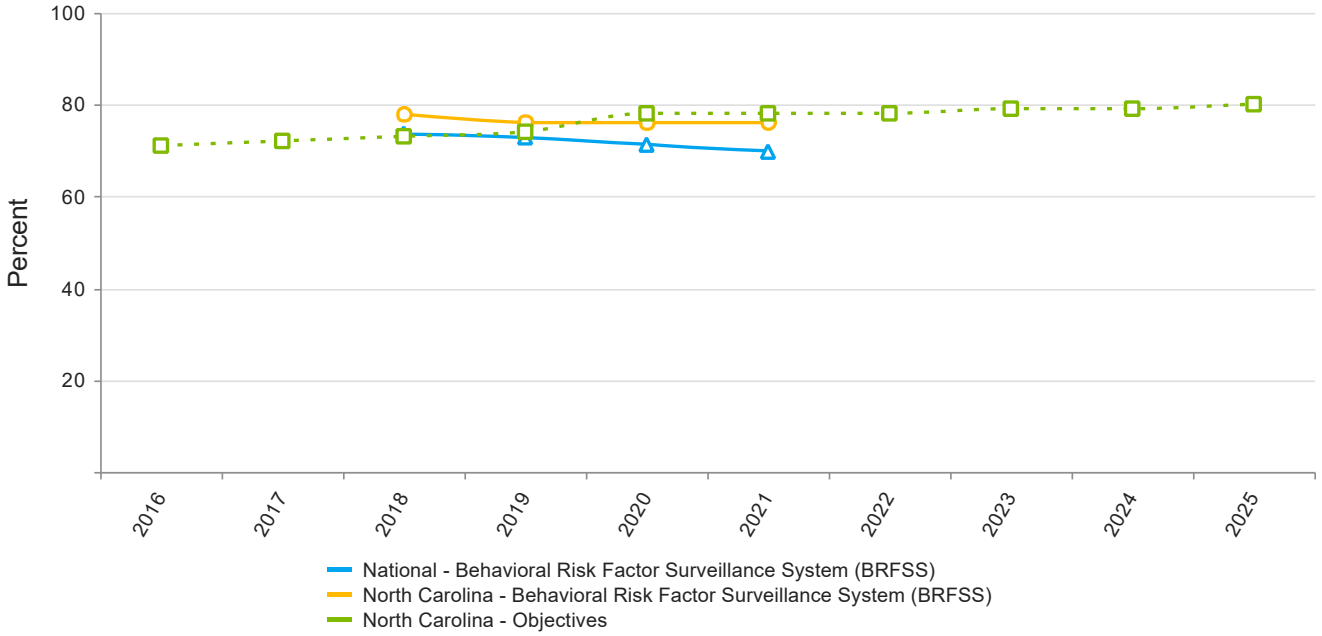
- evaluate the effectiveness of select, evidence-based, non-medical interventions and the role of the Network Leads in improving health outcomes and reducing health care costs for high-risk NC Medicaid Managed Care members
- leverage evaluation findings to embed cost-effective interventions that improve health outcomes into the Medicaid program statewide, furthering the department's goals for a sustainable Medicaid program, and
- support the sustainability of delivering non-medical services identified as effective through the evaluation, including by strengthening the capabilities of Human Service Organizations and partnerships with health care payers and providers.

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

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			78	78	78
Annual Indicator		77.6	76.1	75.8	75.9
Numerator		1,412,575	1,386,809	1,385,665	1,383,829
Denominator		1,820,993	1,823,266	1,827,713	1,822,669
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	2024	2025
Annual Objective	79.0	79.0	80.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Number of LHDs that offer extended hours for FP services.

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	16.0	16.5	17.0

ESM 1.2 - Percent of WICWS programs that utilize the PCH Outreach and Education Toolkit

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	10.0	15.0	20.0

ESM 1.3 - 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
Annual Objective			30	40
Annual Indicator			32.9	82.1
Numerator			28	69
Denominator			85	84
Data Source			WICWS Internal Log	WICWS Internal Log
Data Source Year			FY20-21	FY21-22
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	75.0	75.0	75.0

ESM 1.4 - 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
Annual Objective			74	85
Annual Indicator			84.5	73.7
Numerator			82	73
Denominator			97	99
Data Source			NC FP LHD Clinical Practice Survey	NC FP LHD Clinical Practice Survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	86.0	86.0	87.0

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
Annual Objective			59.7	60
Annual Indicator	55.9		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
Data Source Year	2019		2020	2020
Provisional or Final ?	Final		Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	60.3	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 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
WMH 1A. By 2025, increase by 10% from 15 (Baseline May 2018) to 17 the number of LHDs that offer extended hours for FP services.	
WMH 1B.1 Create the PCH Outreach and Education Toolkit by June 30, 2023.	
WMH 1.B.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 1.1 - Number of LHDs that offer extended hours for FP services.	Active
ESM 1.2 - Percent of WICWS programs that utilize the PCH Outreach and Education Toolkit	Active
ESM 1.3 - Percent of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and reproductive life planning (RLP).	Active
ESM 1.4 - Percent of LHDs offering same day insertion of both contraceptive implants and intrauterine devices (IUDs)	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Increase pregnancy intendedness within reproductive justice framework

SPM

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

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.

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.

NPM#1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Increasing the percentage of women with a past year preventive medical visit (NPM#1) is a critical piece of the work of the WICWS. Per FAD data from the 2021 BRFSS, 75.9%% of women ages 18 to 44 surveyed had received such a service which is higher than the national rate (69.7%) and is consistent with the 2019 NC rate of 76.1%. Of the women who responded to the 2021 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 (84.6%) were more likely to have had a visit than Hispanic women (67.8%) or non-Hispanic white women (76.4%). 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 NPM#1. 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 disease 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, state, and local funding, was allocated to 84 LHDs for the delivery of family planning services in FY22. According to the 2022 Family Planning Annual Report, 60,541 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. Funding supported four local teen parenting programs. In addition, the WICWS continued to partner with Sexual Health Initiatives For Teens NC (SHIFT NC) as they nurtured a

youth leadership council for NC. During FY22, the youth council had nine participating young adults. Twelve meetings were held throughout the year, and the youth attended seven different workshops on various adolescent health topics including contraception, minor's rights, healthy relationships and consent, LGBTQ+ inclusion, and mental health. The Council was interviewed and recorded by staff about how adults can effectively work with youth in virtual environments, and the recording was shared an as easily accessible training for adults on YouTube. Council members also created infographics about various topics important to them, and the infographics were shared on Instagram to reach more young people. The topics included consent, menstruation, infections, sexual assault, and relationships. In June 2022, SHIFT NC decided to dissolve and close their doors. The agency went through a lot of leadership transitions over the last few years and ultimately determined this was the best course of action for their agency.

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

Throughout FY22, the WICWS Regional Nurse Consultants (RNCs) provided LHDs monitoring and technical assistance to assure that the family planning clinical services offered met the needs of their community. RNCs routinely reviewed LHD policies/procedures/protocols 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.

The Reproductive Health Branch (RHB) developed and released a six-part archived webinar series about the community engagement, community education and awareness, and quality improvement project required of LHD family planning clinics annually. These webinars were developed to assist LHDs gain a thorough understanding of community engagement and community awareness, suggestions on ways to reach out to their communities, and tools to practice quality improvement. The webinar series broke the process down into smaller components, allowing LHDs to review the specific information needed. This was an initial step in the process of developing the skills of LHDs to connect with their community to determine what services are provided. LHDs also started submitting their plans to the state office staff to review prior to implementation to receive feedback and tips to ensure successful outcomes.

Extended Hours for Family Planning Services

WICWS created ESM 1.1 (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. The number of LHDs offering extended hours has stayed consistent. In May 2018, there were 15 agencies that did so. This number dropped to ten in 2021, and then increased to eleven LHDs in 2022. Agencies shared that many LHDs do not offer extended hours due to staff turnover and lack of interest from the community. During FY22, a survey was created for those health departments offering extended hours to determine the process they utilized to set up extended hours, what challenges they had, who they needed to include in the conversations, how they advertised services, and overall lessons learned. Agencies were also asked if they would be interested in sharing their experiences with the LHD network through a webinar or partnering with an agency to assist through this process.

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. It was submitted to the ICHB Head for review in September 2022. The toolkit will be used with LHDs, other providers, and community and faith-based organizations to increase knowledge about preconception health in FY23 (ESM 1.2), but development was delayed due to staff vacancies and COVID-19 priorities. Internal review of the toolkit is anticipated by April 2023, 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 the National Office of Minority Health Resource Center. PPE program efforts continue to take place at 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 twenty two- and four-year colleges remain on the NC PPE roster. Albemarle Regional Health Services-Hertford County, in collaboration with the ICHB, hosted a virtual (Zoom) PPE training on February 3-5, 2022. More than twenty-eight students from Elizabeth City State University, East Carolina University, Johnson C. Smith University, University of North Carolina at Greensboro, and Pembroke campuses along with students affiliated with Hertford County 4-H Program University 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 FY22, 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 women and men. Mecklenburg and Sandhills Collaboratives conducted a combined total of 97 outreach events (66-Sandhills and 31-Mecklenburg) on preconception and interconception health, reaching 2,021 women (1481-
Sandhills and 540-Mecklenburg) of reproductive age. Mecklenburg hosted workshops throughout FY22 that received positive feedback with pre and post-test results noting planned behavior change. In addition, the Mecklenburg Collaborative served young adults ages 16-24 in workshops focused on helping them become healthy, productive, engaged members of the community. Mecklenburg hosted nine hybrid events for Black Maternal Health Week including mindfulness workshops, an awareness walk, and roundtable discussions in collaboration with their local Community Resource Center. Both Mecklenburg and Sandhills Collaboratives were active on social media, with Mecklenburg running a Healthy Now For Later social media campaign on
Facebook and Instagram. Sandhills had 1,871 views during one quarter on preconception content alone across all their social media outlets.

Thirteen staff members from both grantee sites were trained (two from Sandhills and 11 from the Mecklenburg Collaborative) to facilitate the Mothers & Babies (MB) Program. They delivered ten group and 42 individual sessions of the program to 88 women (20 from Sandhills and 68 from the Mecklenburg Collaborative) and one man. Attendees received 18 referrals and 13 of those were completed (72% connection rate). Sandhills Collaborative experienced barriers in implementation due to COVID-19 response needs in LHDs, but worked to introduce MB Program to new staff and community members through CHWs. They began delivering the MB Program with other health education classes to reach expecting or new mothers. Montgomery and Hoke County added MB onto their health education classes on childbirth and safe sleep to improve utilization in

their service areas. Mecklenburg Collaborative encountered challenges with
retention and lost contact with participants after they transferred out of partner organizations. They are working together to develop a plan to better retain participants.

The Mecklenburg Collaborative established an active partnership with Upstream. They collaborated with their Community Resource Center to facilitate online workshops and provided individual information packets for community health fairs through contactless pickup by making them available for drive through pickup. Planning discussions with the Preconception Health and Wellness Program Manager and Guilford and Mecklenburg ICO4MCH leadership began in June 2022 to determine logistics and related details for PPE trainings held in fall 2022.

During FY22, 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 60 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. 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 FY22, 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 rolled out a state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which includes questions identical to the 2020 PRAMS survey, so data for 2023 is forthcoming.

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 1.3 (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 FY22, 82% of LHDs have had staff complete a training.

During FY22, the WICWS sponsored several trainings for LHD staff. In fall 2021, the RHB sponsored a webinar for LHDs around normalizing conversations around condom use. The webinar provided information on condoms, including how they are manufactured and their overall function. LHD staff were also able to discuss common questions and concerns that arise when discussing condoms with patients. The webinar had 56 attendees, and the RHB sponsored a follow up webinar in June 2022 to provide techniques to LHDs on starting conversations on condom use and troubleshooting challenges LHDs find when discussing condoms. That webinar had 38 attendees join.

During fall 2021, the WICWS hosted five regional virtual meetings for the LHD Family Planning and Maternal Health programs. These meetings provided an opportunity for LHDs to express non-COVID-19 related challenges they were facing, express training needs, address telehealth concerns, and provide networking opportunities between LHD agencies. These meetings combined had 110 attendees from over 50 different LHDs.

In March 2022, the WICWS offered LHDs an opportunity to attend a webinar to highlight trauma informed care in Family Planning Clinics, an important topic in providing inclusive, equitable reproductive health services. This webinar was delivered by Dr. Amina White, an OB/GYN with UNC Chapel Hill. The objectives of this webinar were to describe universal trauma precautions involving communication and behaviors to adopt and avoid and to view a clinical space and identify environmental considerations to create a trauma-informed space. Over 280 participants attended this webinar, representing 68% of the LHDs.

Lastly, in continuing the partnership WICWS has with the NC DMH/DD/SAS, a training about Reproductive Life Planning for Substance Use Disorders (RLP SUD) programs was held for LHDs along with opioid treatment programs in their communities in May 2022. Fifty-four individuals attended with 21 of those attending from LHDs. The training provided reproductive health information, including reproductive life planning, to staff that work at opioid treatment programs, and information around working with individuals in substance use treatment and different treatment regimens for the LHD clinic staff.

In FY22, the RHB staff members furthered their understanding of reproductive justice by reading the book *Killing the Black Body* by Dorothy Roberts. After reading the book, staff members were able to process the information through several facilitated discussions. Staff were given several months to read the book and were paired with a colleague to have monthly debriefing discussions. Staff enjoyed the opportunity to read this challenging book together and to continue the work in learning more about reproductive justice and how programs and outcomes can be improved.

The Teen Pregnancy Prevention Initiatives (TPPI) staff also focused on equity by identifying more equitable and inclusive primary prevention curricula implementation options and offering various training opportunities. They were able to offer overview sessions on two different curricula (Rights, Respect and Responsibility [3Rs] and FLASH). These curricula choices were a product of the workgroups created in FY21 across the TPPI network. The workgroups offered feedback on these alternative curricula choices. TPPI decided to only list 3Rs and FLASH as the curricula choices in the Request for Applications (RFA) process in summer of 2022.

In addition, funds were contracted with the School Health Training Center at East Carolina University to provide trainings for TPPI sites. These trainings included: Racial Equity Institute's Groundwater Training in December 2021 (41 attendees); Disability Justice 102 Training in October 2021 (12 attendees); Creating Safe Spaces in August 2021 (34 attendees), and Sexuality for Communities of Color in May 2022 (35 attendees). A Racial Equity Institute Phase I training was also offered in January 2022 with 21 attendees. These trainings provided opportunities to focus on the intersection of reproductive health and race and to increase inclusivity of other frequently marginalized groups as well. Equity continued to be a focus in all aspects of the work happening within our reproductive health programs.

Another objective is to increase access to highly effective contraceptive methods. During FY22, the WICWS partnered with professional societies to provide information on the latest evidence around all contraceptive methods and the value of offering all to patients. The WICWS helps lead the North Carolina Reproductive Life Planning Stakeholders Workgroup which has representation from 16 different agencies all focused on Reproductive Life Planning for all North Carolinians. Agencies represent state government, Title X subrecipients, FQHCs, nonprofits, private funders, hospital systems, universities, consumers, Medicaid, and substance use disorder treatment programs. The group met in August 2021 (15 attendees); November 2021 (16 attendees); February 2022 (17 attendees); and June 2022 (12 attendees). The topics during these meetings included health equity, expanding access to contraceptives through pharmacies and primary care, Medicaid expansion of postpartum services, and overall access to reproductive health services with all the changes in policy. The group was able to learn specifically about the health equity work of DPH and about the Health Equity Impact Assessment (HEIA) tool. Agencies also learned from one another on how their agency is addressing health equity within their agency missions. On the access to contraceptives topic, there was much discussion around the new Pharmacy Bill that passed in NC allowing pharmacists to prescribe oral and transdermal contraceptives and administer Depo Provera under a doctor's prescription. This work evolved over the year to learn more about the training of pharmacists, supporting a grant application for UNC to create pharmacy champions to focus on this movement, and discussing how to encourage this program throughout the state.

In October 2021, the RHB hosted a webinar for LHDs on the changes to the federal Title X program requirements. These changes revoked the 2019 regulations and readopted the 2000 regulations with several revisions to ensure access to equitable, affordable, client-centered, quality family planning services for all clients. Specific changes included the ability of clinics to offer nondirective pregnancy counseling regarding all options, ability to provide a referral, upon request, for any pregnancy option the patient requests, and that all Title X funded clinics must provide a prescription or referral for any contraceptive method that is not available onsite. The webinar allowed agencies to ask questions about changes and hear from one another on suggestions on how to transition to the new requirements. Over 160 individuals attended the webinar representing 59 LHDs. Additional agencies reviewed the archived webinar.

NCDHHS continued to partner with the nonprofit Upstream USA, which is working 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 FY22, Upstream started to re-engage with agencies that were paused during COVID-19. Some agencies started over the process with all new staff, while others continued to pause or consider the partnership. Upstream hosted a webinar on their program and services for LHDs on March 18, 2022. This provided an opportunity for Upstream to

re/introduce their services to everyone and start the collaboration conversation. During the webinar, one LHD shared information on their experiences with Upstream including training and technical assistance. Upstream also created a document to specifically address how their work builds equity and reproductive justice into their program.

During FY22, the WICWS RNCs assisted agencies in understanding Medicaid billing rules around same-day insertion 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 1.4) according to results of the 2022 FPAR Survey remained at 73.7%, almost the same as the 2019 baseline of 74%. This decline can be attributed to the staff turnover within LHDs, including providers. An increase of LHDs have reached out asking about LARC training resources for providers. The number of requests reached a level that the National Clinical Training Center for Family Planning decided to set up a training in North Carolina to be held in 2023. Due to the staff turnovers, agencies have not been at a place to make solid changes in this area.

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 are able to 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 FY24.

Provide Guidance and Support to Offer Family Friendly Clinical Services

Collecting feedback from the communities served within clinical spaces is critical to ensuring healthy outcomes within that community. In FY24, the RHB will continue to work with LHDs to ensure they are planning, executing, and evaluating robust community engagement projects for their family planning clinics. RHB staff will review plans, provide feedback, and ensure LHDs have the resources to carry out their plans. A key demographic to ensure has input in the reproductive health services available are adolescents. Adolescents must be part of the community voice in determining appropriate, inclusive, safe, family friendly services.

Additionally, the RHB will continue to develop a youth friendly services toolkit to assist local projects in creating adolescent friendly environments and services. The toolkit has evolved into a webpage where detailed information is housed on a variety of topics related to adolescent health services. During the next year, this information will be fleshed out and available for review and input from LHDs on the existing and missing resources needed.

Extended Hours for FP Services

Offering clinical services at convenient times for the community reduces barriers to accessing care. In FY24, the RHB will provide TA to the thirteen identified LHDs interested in extending clinic hours for patients. This TA will involve determining what challenges each LHD has and connecting agencies to work with one another and receive support from existing LHDs currently offering extended hours. Providing tailored TA with support from peers will improve the likelihood of an agency addressing challenges and barriers and finding ways to implement new hours that work for all involved.

Improving Preconception Health and Creation of Outreach and Education Toolkit

The PCH Team, in collaboration with at least one RNC, has finalized content of 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. Content for webinars on preconception health and birth spacing will be developed and, along with the PCH toolkit, will undergo review by the NCDHHS Office of Communications by December 31, 2023 (ESM 1.2). The toolkit will include 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 webinar will define preconception health and explain its importance to women's health, maternal health, and family planning services. The priority audience for the webinar will be newly hired and seasoned nurses, social workers, community health workers, and health educators who work in LHD settings. The webinar will be presented live, recorded, and posted on the WICWS website, and will be integrated into new staff orientation and annual training. The PCH Team will work with key WICWS staff members to develop educational materials focused

on birth spacing messages for pregnant and postpartum women receiving care management services under the CMHRP program. In addition, to promote the use of the brochure, a webinar defining birth spacing and related messages will be created and hosted for CMHRP care managers to increase their understanding and awareness around this topic. The RSP Toolkit, which has been used by the WICWS for many years and was recently updated, contains preconception and interconception health and reproductive life planning materials, activities, and family planning flash cards that can be used in one-on-one patient contacts or small group settings.

The Preconception Health Outreach and Education Toolkit will be posted on the WICWS website by December 31, 2023. Once it is posted, the PCH Team will engage and collaborate with other WICWS programs including NC BLP, ICO4MCH, Adolescent Pregnancy Prevention, Adolescent Parenting, and Healthy Beginnings to make them aware of it and provide technical assistance and training on its use.

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

Additional FY24 efforts supporting this priority need, NPM#1, and ESM#2 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. Two 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- 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.

The federally funded Healthy Start program, NC BLP, will continue to provide case management services using evidence-based tools for risk assessment and screening, provide education on pregnancy intendedness using the RSP toolkit, and facilitate access to health services for preconception women in FY24 as described in the WMH Domain Annual Report.

Priority 2 – Increase Pregnancy Intendedness Within a Reproductive Justice Framework

The RHB provides ongoing training opportunities for LHDs on a variety of topics. These trainings include expanding local staff's understanding and capacity to provide inclusive reproductive health services, utilizing the reproductive justice framework. Trainings planned for FY24 include an introduction to utilizing community health workers to expand access to family planning services; offering family planning services through mobile units; and utilizing media to increase family planning services. These opportunities will promote inclusive clinical services in reaching the community through a variety of methods.

Additional training opportunities will be offered based on results from the Health Equity Survey that LHDs completed. Trainings specifically noted from this survey that are planned for FY24 include social determinants of health and working with LGBTQ+ populations (Lesbian, Gay, Bisexual, Transgender, Queer, plus).

Beyond training opportunities for the LHDs, the RHB plans to release two toolkits for LHDs. One is around trauma-informed care with the toolkit including trainings, checklists, and resources to review protocols and procedures to ensure trauma-informed services. The second toolkit provides resources and guidance for creating equitable hiring practices within family planning clinics at LHDs. Many clinics are facing high staff turnover, and this toolkit will provide tips as they work to build a strong, inclusive team of staff.

The WICWS TPPI provides ongoing training and technical assistance to ensure local agencies are providing equitable reproductive health programs to young people. TPPI identified training and competency development as focus areas for sites implementing teen pregnancy primary prevention programs. This need was ushered in by the transition to curricula designated in the last RFA cycle and a wave of new staff at the agency level due to post-pandemic staff turnover. TPPI will continue our longstanding partnership with the North Carolina School Health Training Center at East Carolina University to provide reproductive health training, technical assistance, and resources to TPPI funded sites utilizing the *Rights, Respect and Responsibility (3Rs)* and *Family Life and Sexual Health (FLASH)* curricula. In FY24, TPPI will provide facilitator curriculum training and in-depth instructional resources to all primary prevention sites. Training will span a wide range of essential topics such as introduction to teaching reproductive health, adolescent brain development, trauma informed facilitation, and positive youth development. During this time, TPPI will also focus on issuing a RFA for secondary prevention sites offering home visiting and support services to adolescent parents. This step will fully transition programs to offering the *Parents as Teachers* home visiting curriculum at the affiliate level. Additionally, secondary pregnancy prevention sites will continue to focus on applying a reproductive justice framework to program implementation. In FY24, program coordinators that previously participated in a series of reproductive justice workgroup meetings will report learning and key takeaways to all local agency staff. They will identify strategies and develop best practices to be implemented across all secondary prevention sites.

To further advance teen pregnancy prevention, the RHB will begin working with a new partner to continue initiatives that SHIFT NC started. These initiatives include re-energizing a youth leadership council (YLC) for North Carolina. At least ten youth leaders will serve on the council with the opportunity to develop their leadership skills, deepen knowledge of pregnancy prevention, and strengthen teamwork. The YLC will be part of a planning team for an Annual Conference that will be held for professionals working in the field of adolescent pregnancy prevention. Additionally, at least two other training opportunities will be offered in conjunction with the TPPI team for professionals working in teen pregnancy prevention.

The RHB continues to move forward on the objective to increase access to highly effective contraceptive methods. In FY24, a training will be provided around the importance of a variety contraceptive methods in tandem with a resource from the Reproductive Health National Training Center. The WICWS continues to collaborate with Upstream NC to increase access to contraceptive methods and same day access to method of choice. In the coming year, Upstream will provide an opportunity for all LHDs to hear some lessons learned from their work in North Carolina and tips to making same day access work within the clinic space. The RHB plans to hold virtual “office hours” for LHDs looking to make policy changes to encourage clinic flow to provide same day contraceptive access for their local community.

Perinatal/Infant Health

National Performance Measures

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

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

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	90	90	90	90	90
Annual Indicator	77.3	76.7	80.1	75.1	73.9
Numerator	1,560	1,269	1,375	1,253	1,266
Denominator	2,017	1,654	1,717	1,668	1,714
Data Source	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	90.0	90.0	90.0

Evidence-Based or –Informed Strategy Measures

ESM 3.1 - Percent of birth facilities with level of care documented using the CDC LOCATe tool.

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

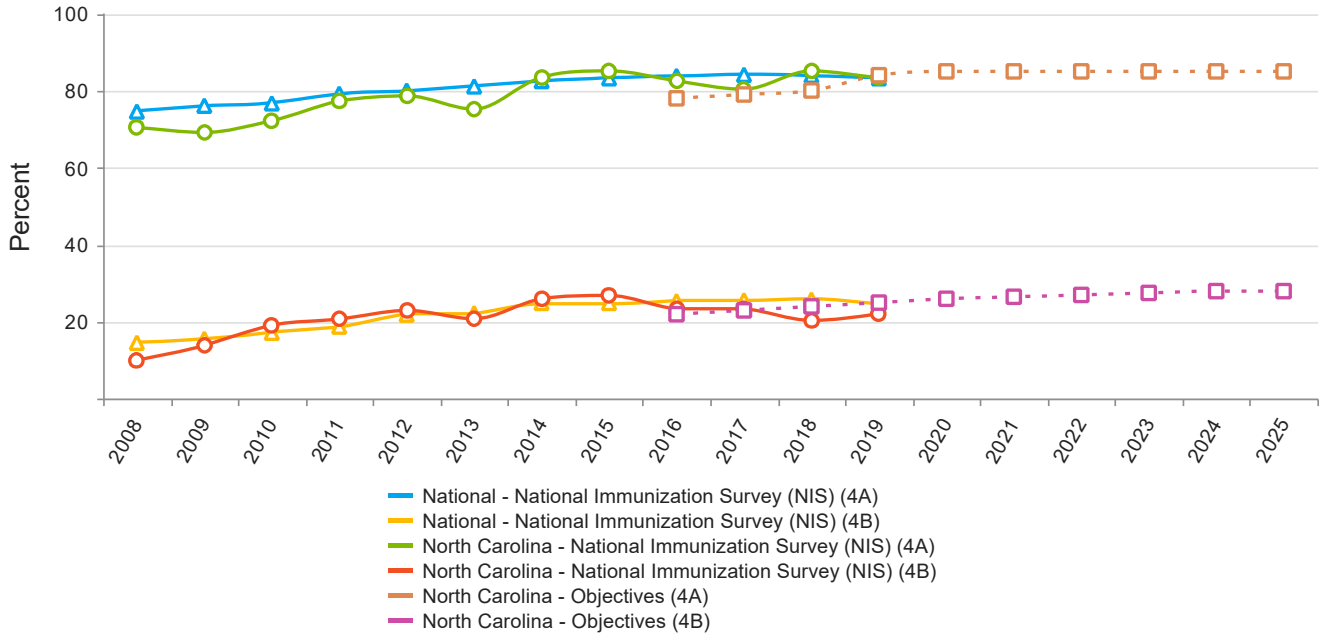
ESM 3.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL)

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			25	25
Annual Indicator		1.2	2.4	16.5
Numerator		1	2	14
Denominator		85	85	85
Data Source		WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	40.0	60.0	75.0

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80	84	85	85	85
Annual Indicator	84.9	82.5	80.3	85.0	83.4
Numerator	103,683	88,249	90,222	91,471	92,086
Denominator	122,165	106,953	112,365	107,553	110,468
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	85.0	85.0	85.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	24	25	26	26.5	27
Annual Indicator	27.0	23.4	23.3	20.2	22.1
Numerator	31,775	24,051	25,865	21,416	24,009
Denominator	117,705	102,887	111,143	106,047	108,844
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	27.5	28.0	28.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Number of eligible WIC participants who receive breastfeeding peer counselor services

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			28,350	29,120
Annual Indicator	27,587	25,020	22,263	22,599
Numerator				
Denominator				
Data Source	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
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	29,900.0	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
Annual Objective			8.1	7
Annual Indicator	7.6		6.8	5.6
Numerator	8,991		7,923	6,756
Denominator	118,725		116,755	120,501
Data Source	NC Vital Statistics/SCHS		NC Vital Statistics/SCHS	NC Vital Statistics/SCHS
Data Source Year	2019		2020	2021
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	6.8	6.7	6.5

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 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
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. Develop/strengthen relationships with LMEs related to WICWS programs.
PIH 1B.4. Expand the MATTERS Leadership Team to include local LMEs.
PIH 1B.5. WICWS RNC will provide orientation and TA for LHDs inclusive of behavioral health.
PIH 1B.6. 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 3.1 - Percent of birth facilities with level of care documented using the CDC LOCATe tool.	Active
ESM 3.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL)	Active

NOMs
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births

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

Priority Need

Prevent infant/fetal deaths and premature births

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

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 4.1 - Number of eligible WIC participants who receive breastfeeding peer counselor services	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

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

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

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.

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 FY22, to sustain the work of the Maternal Health Task Force (MHTF) and keep momentum with implementing strategies to improve maternal health, the work of the MHTF was merged within the Perinatal Health Equity Collective (PHEC). Within the PHEC, there is an ongoing group of stakeholders interested in maternal health specifically called the Maternal Health Work Group (MHWG). This workgroup functions in the same way as the MHTF and will be responsible for moving maternal health related efforts forward. The MHWG deployed Action Teams – small, strategic and time specific groups – designed to achieve measurable results. Currently, there are three action teams: Maternal Levels of Care, Neonatal Levels of Care, and Equity into Action. The Equity into Action team will focus on promoting training and system changes necessary to achieve maternal health equity.

NPM#3 – 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 NPM#3 are based on the current self-designated levels of care which do not align with the AAP guidelines. Data for 2021 show that 73.9% of VLBW infants received care at currently designated Level III+ NICUs, which is similar to data for the past three years. 2021 rates were higher for NH Black (76%) and NH Asian/PI (75.4%) births than for Hispanic (73.7%) and white, non-Hispanic (72.1%) births.

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

DPH has continued its partnership with their sister Division, Health Services Regulation (DHSR), to review and discuss the process for developing maternal levels of care for the state. This has included a review of the NC Administrative Code 10A NCAC 13B .4301-04 (maternal services) to reflect the uniform, nationally recognized, and evidence-based guidelines for regionalized and risk-appropriate maternal levels of care offered by ACOG/SMFM and the NC Administrative Code 10A NCAC 13B .4305-08 (neonatal services) to reflect the uniform, nationally recognized, and evidence-based guidelines for regionalized and risk-appropriate neonatal levels of care offered by the AAP. DHSR has worked with DPH in developing a list of stakeholders to gather interest and feedback in order to move the work further along. Unfortunately, COVID-19 delayed some of the process as providers have needed to prioritize other efforts. This work is being prioritized as part of the PHEC moving forward.

The mission of the Perinatal Nurse Champion Program, formerly the Perinatal/Neonatal Outreach Coordination Program, is to improve the state's maternal and neonatal morbidity and mortality rates by ensuring that all pregnant women and high-risk infants have access to the appropriate level of care through a well-established regional perinatal system. To achieve this mission, along with provision of training and TA, birthing facilities were engaged to complete the CDC Level of Care Assessment Tool (LOCATe^{SM}) to determine risk appropriate levels of maternal and neonatal care. The Perinatal Nurse Champion program was first implemented in FY18 in PCRs 4 and 6. In FY19, Perinatal Nurse Champion program was expanded to include all six PCRs with a combination of MCHBG and Maternal Health Innovation funding. During FY22, the Perinatal Nurse Champions assessed six additional hospitals using the LOCATe^{SM} tool. By the end of FY22 reporting period, 78.8% of birthing facilities have been assessed at least once (ESM 3.1), which included 16 birthing facilities completing a reassessment. The Perinatal Nurse Champions are on track to complete a LOCATe^{SM} tool with all birthing facilities in NC by June 2023.

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. One component of the NC MATTERS program is the NC Psychiatry Access Line (NC-PAL), 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. ESM 3.2 (Percent of LHDs who are utilizing NC-PAL) was created to help monitor this strategy. The NC MATTERS team continues to enhance relationships with NC LHD staff. Currently, the NC MATTERS team is collaborating with the Alamance County Health Department maternity care team by providing a perinatal psychiatrist and social worker to participate in monthly consultations. Plans to replicate this service to other NC LHDs began in FY22. The NC MATTERS team supports the NC BLP program by offering monthly consultations with the BLP Licensed Clinical Social Worker (LCSW). All BLP participants are screened for maternal depression and other related behavioral disorders. If the screening tool indicates further assessment is needed, the BLP LCSW is connected to NC MATTERS resources and staff to aid in any assessments conducted and referral resources.

In FY22, the NC MATTERS program provided training to the Alliance Local Management Entity (LME) and Sandhills LME providers along with LHD staff in the catchment areas of the LME. A total of 110 behavioral health providers were reached through both training events. Topics covered in the trainings included understanding perinatal mood and anxiety disorders (PMAD) basics, screening and assessing risk, role of medication and other treatment in PMADs, addressing perinatal substance use and co-occurring disorders, collaborating with local resources to support care, and referral and treatment within scope of practice.

In FY22, the WICWS maintained a recorded webinar titled *Perinatal Mental Health for Local Health Departments: Awareness, Assessment, Action, for LHD Staff*. During the FY22 reporting period, 59 persons completed the webinar training and received 1.25 nursing continuing professional development contact hours. The webinar was facilitated 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 addresses 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 covers 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 will remain 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 FY22:

- Four New Hire Orientations were held with 69 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.

Also, in FY22, four statewide required webinars were held for all CMHRP care managers and supervisors. The webinars, which are archived for future reference, included topics such as Medicaid Managed Care and its impact on CMHRP, data, caseload management, timeliness of outreach and care management services, and member outreach.

During FY22, the RSWC team updated existing and created new programmatic guidance documents, as needed. The guidance documents included information on the standardized method of providing care management services including the prioritization of members experiencing behavioral health concerns and appropriate referrals and closing the loop on the referrals. The CMHRP Toolkit also includes a series of Pathways including appropriate patient education and services to be provided during the prenatal and postpartum periods. The Pathways include requirements to refer for behavioral health services, as appropriate.

Behavioral health is addressed in following CMHRP Programmatic documents:

- Pregnancy Risk Screening Form, which is used statewide by prenatal care providers and CMHRP Care Managers
- CMHRP Resources and References Document
- CMHRP Common Pathway
- CMHRP Patient Education Pathway

The RSWC team provided technical assistance, support, and one-on-one programmatic and patient consultation with CMHRP supervisors. Consultation included general programmatic oversight, but it also included encouragement for the supervisors to discuss resource deserts with each prepaid health plan in their region. From these consultative conversations, the supervisors have advocated to the prepaid health plans on behalf of member needs in their county, which is inclusive of behavioral health services.

The WICWS RNCs maintain close contact with LHDs through regional meetings with Nurse Administrators, emails, and phone calls. The Nurse Administrators rely on their RNCs to provide technical assistance and training for their agencies' Women's Health staff. When staff turnover occurs, the Nurse Administrator informs the RNC of the staff change and requests a face-to-face or virtual orientation for the new Women's Health staff member. The RNC will schedule the orientation at the convenience of the local staff, reviewing information appropriate to the staff person's role within the agency. For Maternal Health Nurse Administrators, Maternal Health Program Coordinators, and Maternal Health Providers, this includes a review of required behavioral health screenings and referrals.

Newborn Screening Follow-Up Team

Universal newborn screening 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 newborn screening (NBS) expansion to include Pompe disease, Mucopolysaccharidosis Type I (MPS I), and X-Linked Adrenoleukodystrophy (X-ALD), and for the Commission for Public Health to "amend the rules as necessary to ensure that each condition listed on the Recommended Uniform Screening Panel…is included in the Newborn Screening Program."

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 FY22, the NBS Follow-Up Team provided services for 848 infants with abnormal NBS results for CH, CAH, galactosemia, biotinidase deficiency, SCID, SMA and CF, 203 of whom were confirmed to be affected and are receiving treatment as determined by the appropriate subspecialist. The NBS Follow-Up Team completed follow-up protocols and educational materials to coincide with the launch of X-ALD screening in 2022. The NBS Follow-Up Team began similar work for MPS I and Pompe disease, which are the next two screens slated for addition to the NBS panel.

The DCFW/WCHS maintains a contract with UNC-Chapel Hill for follow-up and management of infants identified by tandem mass spectrometry (MS/MS). They also follow up on positive screens for SMA when the family is referred to UNC and follow up for X-ALD began in February 2022. 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 2,200 newborns and patients with a potential diagnosis for an inborn error of metabolism identified through MS/MS through the DHHS. UNC provided expertise and consultation to the SLPH on follow-up care for approximately 651 infants identified through NBS and consultation to referring healthcare providers regarding patient diagnosis, care, and management. There were 29 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 NCSLPH Newborn Screening (NBS) Program completed first-tier method verification of C26:0-LPC measurement via FDA-Cleared NeoBase™2 MS/MS kit assay and second-tier validation of a Laboratory Developed Test (LDT) via Liquid Chromatography-Tandem Mass Spectrometry (LC-MS/MS) for X-Linked Adrenoleukodystrophy (X-ALD). The NBS Follow-Up Team at the UNC Division of Genetics and Metabolism began receiving notification of potential X-ALD cases and began providing timely interpretation, confirmation of suspected diagnoses, and coordination of care. Since the launch of X-ALD screening on February 14, 2022, at least 2 confirmed-positive X-ALD cases have been identified. The NCSLPH NBS Lab also migrated from STARLIMS Version 9.0 to STARLIMS Version 12.0 on February 14, 2022. This migration resulted in an updated reporting format of the NBS report, which includes descriptive comments about specimen referrals to follow-up and re-collection requests. The NBS MS/MS Lab developed a first-tier method verification plan for the FDA-Cleared NeoLSD™ MSMS Kit to screen for Mucopolysaccharidosis Type I (MPS I) and Glycogen Storage Disease Type II (Pompe).

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 in FY22. 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 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 2021, a total of 121,678 (99.1% of 122,733 occurrent live births) were screened for hearing, with 118,775 (96.8% 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. The PHSP is making an impact by 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 we are doing 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, which is Goal 1 of the NC Early Childhood Action Plan and the underlying framework of the PHSP continued in FY21 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 new 2022-2026 PHSP, released in 2022, 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 (60% of the 1,360 child deaths in 2021), 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 517 minority pregnant and postpartum/interconception women and their children in FY22. During FY22, there were 475 live births with one infant death (2.1 infant death rate). Among all pregnant program participants, 81.5% received prenatal care within the first trimester. 90.5% 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 Collaborative for Maternal and Infant Health'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 FY22 BLP continued to focus its efforts in four counties with higher infant mortality rates within the state and enrolled 214 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 13 health departments) in FY22. 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. Two ICO4MCH sites (Durham and Wake) conducted reproductive justice training in FY22 reaching a combined total of 59 providers. High Country Collaborative (HCC) and Wake provided administrative training related to reproductive life

planning to a total of 15 providers. Sandhills and Mecklenburg Collaboratives held a combined total of 97 outreach events on preconception and interconception health. Under the breastfeeding EBS, a total of 762 staff were trained in lactation education, peer counseling and related areas across all ICO4MCH sites in FY22.Under Triple P, 29 new practitioners were accredited representing Mecklenburg (24) and Sandhills (5) Collaboratives. In addition, a total of 1,877 caregivers and 3,323 children ages 0-5 were served in Mecklenburg and Sandhills regions. ICO4MCH staff at Family Connect sites (HCC and Durham) conducted virtual visits in FY22 due to rising COVID-19 numbers. Across the two sites, 475 visits were completed.

Title V funding supported the Infant Mortality Reduction Program in FY22 by providing funding to 21 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 program; reproductive life planning services, increased access to long-acting reversible contraception; and tobacco cessation and prevention services. During FY22, three LHD staff were trained on Centering Pregnancy and 61 patients received Centering Pregnancy services; three patients engaged in doula services;13 LHDs collectively provided infant safe sleep educational sessions to 799 patients; three LHDs served 265 patients and staff completed 1,658 home visits under Nurse Family Partnership; 17 staff representing 11 LHDs were trained in reproductive life planning and educated 9,713 patients; and three LHDs trained 14 staff on 5As and/or as Certified Tobacco Treatment Specialists (CTTS). The four CTTS counseled 21 people, and the 14 trained staff referred 66 clients to QuitlineNC. In addition, staff at the three LHDS screened 10,152 patients regarding tobacco use.

NPM#4A-B – 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 not only of the NC Title V Program but also part of the state Early Childhood Action Plan. The most recent data available from the National Immunization Survey (NIS) data for NC births occurring in 2019 reported that 83.4% of infants were ever breastfed, yet by 6 months of age only 22.1% of infants were exclusively breastfed, below the national average of 24.9%. Additionally, breastfeeding initiation data obtained from birth certificates for infants born in 2021 indicate that 80.8% of all infants were breastfed at hospital discharge. However, this data reflects national trends of breastfeeding racial/ethnic disparities, with Hispanic infants (86.7%), non-Hispanic white (83.7%), and NH Asian/PI (89.1%) more likely to initiate breastfeeding than non-Hispanic Black (69.9%) or non-Hispanic American Indian (52.2%) infants. These disparities were also present for babies born in 2020 to women enrolled in prenatal WIC with breastfeeding initiation rates of 85.5% and 70.6% for Hispanic and non-Hispanic white women respectively, but only 65.1% of non-Hispanic Black and 49.3% of non-Hispanic American Indian women enrolled in prenatal WIC.

During FY22, 37% of participants in the Healthy Beginnings Program breastfed for 24 weeks or more. In addition, 15% of Healthy Beginnings Program participants are currently breastfeeding at 6 months. The NC BLP Program served 214 pregnant women during the report period, and, among those participants, 60.6% breastfed for some period, and 10.7% were still breastfeeding at 6 months.

The continuation of COVID-19 pandemic coupled with a nationwide infant formula shortage brought light to gaps in breastfeeding support. Parents and healthcare providers requested increased breastfeeding support and equitable access to breastfeeding aids. The North Carolina WIC Program expanded breast pump issuance protocols while DCFW and DPH collaborated with NC Medicaid to add breast pumps to each NC Medicaid health plan as a value-

added benefit. FY22 served as a rebuilding year for breastfeeding activities disrupted by the COVID-19 pandemic. The provision of clear guidance from the CDC and the AAP on COVID-19 protocols allowed hospitals to reinstate steps that facilitate breastfeeding including rooming-in, immediate and continuous skin to skin contact, and initiation of breastfeeding in the first hour. Six maternity centers were awarded the North Carolina Maternity Center Breastfeeding Friendly Hospital designation during FY22 bringing the total to 40 of North Carolina's 90 maternity centers. North Carolina's Maternity Center Breastfeeding Friendly Hospital designation awards maternity centers for with one star for every two steps of the World Health Organization's Ten Steps to Successful Breastfeeding implemented. The North Carolina WIC Program began their phased approached of implementation for the United States Department of Agriculture's WIC Breastfeeding Curriculum structured in four tiered levels of learning based on staff roles. Over 1,200 state and local WIC staff completed Level 1, and 135 peer counselors completed Level 2. The curriculum aims to provide consistent messaging and support among WIC staff in breastfeeding.

In FY 22, the NC WIC Program continued to partner with the Carolina Global Breastfeeding Institute for the continued provision of virtual prenatal breastfeeding education classes utilizing their *Ready, Set, Baby* curriculum to ensure consistency in breastfeeding messaging. The Regional Lactation Training Centers provided LHD staff and health care providers practical solutions for facilitating breastfeeding support during the COVID-19 pandemic through over 60 plus in-services and continuing education trainings reaching more than 1,000 unduplicated providers.

As part of the Child Fatality Task Force's Perinatal Health Committee, discussions occurred related to NC establishing a statewide Breastfeeding Hotline during FY22. Conversations then moved to the feasibility of NC Medicaid/Division of Health Benefits, providing some funding under the CHIP Authorization.

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 led by the Pediatric Nutrition Consultant (PNC) whose work includes breast/chest and human milk feeding along with other activities. This position is funded by Title V MCH Block Grant and is located in the DCFW/WCHS. The objective of the Coordination team is to maximize resources to maintain and expand the state's breastfeeding infrastructure, reduce duplication of activities, and allow integration of services with shared populations. The 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 this 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. The coordination team has resulted in 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 Request for Applications 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 NC DHHS 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

The NC WIC Program operated through CNSS is federally mandated to provide breastfeeding promotion and support to their participants through the anticipatory guidance, counseling, and breastfeeding educational materials, a greater quantity and variety of foods for breastfeeding dyads, longer participation in the program for breastfeeding mothers, access to breastfeeding aids such as breast pumps, and all staff trained in breastfeeding promotion and support. The NC WIC Program established the Regional Lactation Training Centers in 2005 to enhance the statewide infrastructure to support breastfeeding across the state by providing breastfeeding peer counselors, breastfeeding peer counselor managers, public health agency staff and other medical professionals serving the WIC eligible population with accurate, standardized, evidence-based lactation management training and continuing education in the respective perinatal region. Since implementation, the centers have provided over 1,000 in-services in lactation to over 10,000 different public health agency staff and health care providers.

To help monitor NPM#4, ESM 4.1 (number of eligible WIC participants who receive breastfeeding peer counselor services) was selected. Since the Breastfeeding Peer Counseling (BFPC) Program funds were made available to local agencies in 2005, the program has grown from four local WIC agencies to 85 of 86 local WIC agencies accepting BFPC funds. In FY19, Peer Counselors provided their services to 27,587 pregnant and breastfeeding participants enrolled in the WIC Program; however, there were more than 52,000 clients who were eligible for those services, so increasing this number by 15% by 2025 seemed like an achievable goal when it was set in 2020. The onset of the COVID-19 pandemic brought decreased participation in the BFPC program, and in FY21, there was an 11% decrease in participation compared to FY19. However, FY22 has been a year of rebuilding for breastfeeding activities with 22,599 WIC Program participants receiving BFPC Program services. While this total remains below the goal established in FY19, it represents a stabilization and slight increase over SFY21. The COVID-19 pandemic disrupted the referral process for WIC Program participants enrollment into the BFPC program for services. The BFPC Program is dependent on referrals for the initiation of program services and without in-person services, Peer Counselors had to adapt recruitment practices. The implementation of standardized referral processes within local agencies for enrollment in program services has allowed the program to rebuild. The BFPC program is one of the most successful interventions for the initiation and continuation of breastfeeding. The NC WIC Program reported an approximately 3.5% increase in breastfeeding initiation rates from 72.1% in FY21 and 74.6% in FY22.

The NC WIC Program also contributed to the development and maintenance of the NC Lactation Educator Training Program operated by Northwest Area Health Education Center to provide a statewide program to train hospital and

health department staff members. The objective is to support breastfeeding women across the entire state in a consistent and standardized manner. Since its implementation in 1996, the course has trained over 1,800 healthcare staff members in all 100 counties in NC with 116 healthcare staff members completing the training in FY22. Five percent of total participants have become credentialed as an International Board Certified Lactation Consultant (IBCLC) as a result of course completion, leading to 70 new IBCLCs in North Carolina.

Breastfeeding Friendly Designations

NCDHHS developed the first state designation to recognize incremental implementation for the World Health Organization's *Ten Steps to Successful Breastfeeding* through the NC Maternity Center Breastfeeding Friendly Designation (NC MCBFD). The NC MCBFD awards maternity centers one star for every two steps implemented. The NC MCBFD is led by the NC DCFW. Since its implementation in 2010, over 70% of NC maternity centers have achieved at least one or more stars and currently over 44% of NC maternity centers are designated. Additionally, in 2010 one maternity center was designated as a Baby-Friendly Hospital from Baby Friendly USA for the implementation of all *Ten Steps to Successful Breastfeeding*. Today, there are 21 hospitals in NC who have achieved the Baby-Friendly designation from Baby Friendly USA. As the World Health Organization (WHO) updated the *Ten Steps to Successful Breastfeeding* in 2018, the application must be revised to align with current programmatic requirements to align with the implementation timeline of 2023.

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 take the application from an incremental designation to a requirement of all *Ten Steps to a Breastfeeding Friendly Child Care*. DCFW/CNSS staff members work with NC Child Care Resource and Referral Council and Child Care Health Consultants (CCHCs) to provide resources, trainings, and technical assistance for the implementation of the five standards. The PNC and CCHCs also help to promote the NC Breastfeeding Friendly Child Care Designation. During FY22, ten childcare centers were designated as NC Breastfeeding-Friendly Child Care center for the implementation of all *Ten Steps to a Breastfeeding Friendly Child Care*.

Another strategy adopted by NCDHHS to increase breastfeeding is to support LHDs who are working toward or awarded the NCBC's Mother-Baby 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, 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 this 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 FY22 a total of seven LHDs have received the award, and others are known to be working toward it. Additionally, the Child Health 351 Agreement Addenda (AA) added as evidenced based strategy as an optional activity to encourage and support LHDs (and other clinics within their communities that they wanted to work with to implement breastfeeding friendly practices within their clinic. Only one LHD Child Health Program chose to work on this Award for FY22 (Swain County) and their efforts to work on this were delayed due to COVID-19 prioritization of work. Additionally, NCBC lost some of their own momentum in FY22 to review and grant the Award but have noted that they will catch up and again revise their application in FY23.

Other Breastfeeding Activities

During FY22, 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 2021, the Breastfeeding Coordination Team presented and recorded a 60-minute webinar titled *NC Worksite Breastfeeding Support in Action*. This webinar, the Making It Work toolkit (for free downloading), and a 2-minute promotional video are all available here, along with sample social media posts and images to help promote the toolkit. As of December 2021, over 150 people had viewed the webinar and 100% of the survey respondents rated the webinar as Excellent or Good.
- In FY22, the name of the DPH Breastfeeding Coordination Team changed to reflect the establishment of DCFW and hence the team was renamed to the DPH/DCFW Breastfeeding Coordination Team. Other activities of the team included a greater focus on inclusivity and a change in the purpose of the team: ... *Work collaboratively across the DPH and DCFW to effectively share human milk feeding promotion for all individuals and their families in NC among local agencies and community partners. Ensure all breastfeeding team members understand what each member is working on to support integration, effectiveness, collaboration, and transparency.*
- The DPH/DCFW Breastfeeding Coordination Team planned a free webinar titled *Inclusive Lactation Support for LGBTQ+ Families* for August 18, 2022, in celebration of National Breastfeeding Month. The goals of the webinar (based on a successful implementation of a similar training for staff in WICSS) were to help participants learn about providing more inclusive lactation support for LGBTQ+ Families in NC; to examine personal biases about breastfeeding; to understand the importance of inclusive language in lactation care; 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 NCPD contact hours and Recertification Credits upon completion.

Additional breastfeeding coordination activities planned for FY22 were put on hold as staff members had to continue to prioritize COVID-19 work and restructuring.

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.

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. One specific example includes the NC Breastfeeding Mother-Baby Friendly Clinic Award.

In FY19, the CDIS's 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

Nutrition staff from the NC Title V Program and CDIS work together as part of the NC DPH/DCFW Breastfeeding Coordination Team to coordinate and share information across programs to help focus TA and training, reduce duplication of effort, and increase outcomes.

LHD maternity clinics provided prenatal care, which is inclusive of breastfeeding promotion, through counseling and education in FY22. Care Managers for the CMHRP program provided education on the benefits of breastfeeding for the pregnant person and the infant. Additionally, the CMHRP Care Managers educated patients on the value-added benefits related to breastfeeding, provided by Medicaid Managed Care Pre-paid Health Plans. Each enrolled patient is assessed prenatally and in the postpartum period to determine the infant feeding plan for the infant. Patients who indicated their plan to breastfeed were provided on-going education and information during FY22 by their Care Manager. If the patient indicated a need for breastfeeding support at any time, the CMHRP Care Manager made an appropriate referral to the needed support services and documented these findings and interventions in the patient's Comprehensive Needs Assessment in the Virtual Health documentation record system.

Additional Breastfeeding Efforts by Infant Mortality Reduction Programs/Initiatives

In FY22, 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. Among all Healthy Beginnings postpartum/interconception program participants in FY22, 77.3% initiated breastfeeding, and 35% breastfed for 6 months or longer, which is an increase from the FY19 baseline of 13.7%. Healthy Beginnings staff completed the WIC Breastfeeding Peer Counselor training program to build their knowledge and skills to assist program participants with their decisions about breastfeeding.

Breastfeeding initiation and duration rates continue to be a challenge among NC BLP participants. In FY22, the NC BLP program enrolled 72 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 FY22, NC BLP participants were breastfeeding at a rate of 47.5% at discharge (an increase from FY20); however, plummeted to 11.1% at 6 months. In the Fall of 2021, the NC BLP Evaluation team facilitated focus groups to help determine reasons for the lower rates. The top reason reported by participants for stopping breastfeeding was the lack of community support, particularly when parents had to return to work or school. Of those that attended the focus groups, many confided that they wanted to breastfeed; however, because of the challenges to maintain resorted to formula feeding. To address these issues, the NC BLP staff strengthened their relationship 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 are being discussed.

In FY22, 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 four 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 FY22, Durham County hosted 20 outreach and education events, reaching 315 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 started a breastfeeding support group and also hosted a health fair with Breastfeed Durham with 20 sponsoring community and government agencies.

Mecklenburg Collaborative reached 1,030 women during their prenatal visits this year with the Patient Decision Aid program. Staff collaborated with Charlotte AHEC to host Mother's Gift Conference in May and presented and recruited speakers. They provided a breastfeeding in-service in March 2022 to the HOPE project for Mecklenburg LHD Social Workers and in May to CMARC and Nurse Family Partnership. In addition, they hosted a Black Breastfeeding Roundtable, discussing how to build trust between Black mamas and providers and why representation matters.

Sandhills Collaborative's Richmond County hosted their first in-person breastfeeding class since the start of the pandemic in FY22. All public schools across the four counties successfully established pumping spaces and have been trained on Breastfeeding Friendly Businesses, and they are now partnering with courthouses to put in nursing spaces. Sandhills Collaborative staff served as a guest speaker in the NC WIC Conference. They began utilizing Child Passenger Seat education as a way to capture the priority population for breastfeeding education.

In terms of social media, Wake County launched a monthlong social media campaign that was informed by their community action team (CAT) and promoted support for breastfeeding mothers and families and featured racially/ethnically diverse families. It was featured on Wake County Government’s social media pages, two community billboards, two local media websites, one Spanish-language radio station, and two historically African American and one Spanish language newspapers. In addition, Wake County established two public lactation spaces in Sunnybrook Road clinics for parents who desire private spaces to feed or express milk. They worked closely with WIC and Wake County Health and Human Services-General Services to maintain these spaces. Wake County also hired two home visiting nurses and one CHW to contribute to breastfeeding support resources.

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 FY21, 20.2% of MIECHV participants reported any breastfeeding at 6 months of age, while non-MIECHV NFP sites were at 26.2%. In FY22, 28.8% of MIECHV participants reported any breastfeeding at 6 months of age, while non-MIECHV NFP sites were at 32.3%.

Both NFP and HFA programs practice numerous 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, 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.

NC MIECHV requires each site to complete a Continuous Quality Improvement (CQI) project each year, and, in

2022, two sites chose to focus on improving their breastfeeding rates; Robeson County NFP and Northeastern NFP at Halifax Community College (HCC).

Robeson County NFP also participated in HRSA's CQI Practicum in 2022 along with eight other MIECHV State awardees. Northeastern NFP at HCC participated in the CQI Practicum in 2021 and were able to use their learnings for their work in 2022, as well. Both sites completed key driver diagrams to determine primary and secondary factors to breastfeeding success and completed Plan-Do-Study-Act (PDSA) cycles to test and implement strategies, which included partnering with local organizations on breastfeeding resources and support and developing classes (both in-person and a virtual video to share) to help families with their breastfeeding goals.

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. In late FY21 and continuing into FY22, the PNC began to re-establish relationships with the Office of Rural Health and a new relationship with the NC CHW Association to secure and review the Core Competency curriculum to assess to what degree (if any) breastfeeding, food insecurity and other related nutrition topics are included as part of the curriculum.

SPM#2 – Percent of women who smoke during pregnancy

Decreasing the percent of women who smoke during pregnancy (SPM#2) 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 2021, this percentage decreased to 5.6%. Hispanic women (1%) and non-Hispanic Asian women (.5%) were least likely to smoke during pregnancy, and non-Hispanic American Indian women were most likely to smoke (17.4%) in 2021. Non-Hispanic Black women (5.3%) were less likely to smoke than non-Hispanic White women (7.3%) and non-Hispanic multi-race women (7.8%). 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 214 pregnant women during FY22. Of those pregnant, 87.9% reported abstaining from tobacco during pregnancy, with 90.8% 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 abstention rates of 77.2% and 78.6% respectively.

All Healthy Beginnings program staff are 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 receive education and monthly tobacco use assessments and cessation support when needed. During FY22, 95% of pregnant program participants and 93% of postpartum/interconception program participants did not

use tobacco. In FY22, 98% of pregnant program participants and 94% of postpartum/interconception program participants did not use other tobacco products or ENDS. Throughout FY22, 95.3% of pregnant program participants and 97.2% of postpartum/interconception program participants did not allow smoking in the home to avoid secondhand smoke exposure.

CMHRP Care Managers continued to employ interventions to assist pregnant persons with tobacco cessation in FY 21-22. Medicaid beneficiaries, as well as low-income individuals who did not qualify for Medicaid coverage, who reported tobacco use during pregnancy at the same level as before pregnancy, were eligible for CMHRP services. All pregnant and postpartum individuals who are eligible for CMHRP services were assessed by a CMHRP Care Manager, received 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 the Tobacco Cessation Pathway resource for care managers. 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 patient's prenatal provider.

During FY22, the ICO4MCH HCC site held two 5As trainings, training 38 LHD staff which was 13 more than the previous year and also had 11 LHD staff trained as Certified Tobacco Treatment Specialists (CTTS). Due to complications because of the COVID-19 pandemic and grant funding ending, progress was halted on Alleghany County Smoke-Free Government Buildings, Avery Tobacco-Free Parks, and Town of Boone Tobacco-Free Policy in FY22. However, HCC worked on a new policy in FY22, Smoke-Free Bus Stop Signage, in collaboration with an Appalachian State University professor, and installed no smoking/vaping signs at the 40 sheltered bus stops. They continued to work on this project, striving to update all the smoke-free signage on campus. Their project was also focused on publicizing the dedicated vaping area on campus to prevent unwanted secondhand smoke exposure for students.

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 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 FY22, 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. The PHW Program Manager worked collaboratively with Albemarle Regional Health Services (ARHS) and Guilford County Health Department to plan for two Preconception Peer Educator (PPE) trainings. ARHS conducted a virtual training in February 2022 with approximately 25 students and advisors, and Guilford County's training occurred in fall 2022 with 26 people in attendance. With tobacco use being a critical focus area for preconception health, the PHW Program Manager held one WATCH leadership and one WATCH coalition meeting during FY22. In addition, WATCH members and other partners collaborated to plan a fall 2022 Women's Health and Tobacco virtual conference.

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 FY24. 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 FY24, 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^{SM} with birthing facilities in each region that have not been assessed within the last two years. The Perinatal Nurse Champions, in collaboration with the State Provider Support Network, consisting of the Nurse Champions, OB Champions, Family Medicine Champions, and Pediatric Champions within each perinatal care region, 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 neonatal levels of care and develop maternal levels of care. The NCIOM will continue convening the Neonatal Levels of Care Action Team of the PHEC to implement recommendations for adopting neonatal levels. This will include developing updated levels of care and working with partners and payors on impact and what additional resources would be needed to support a risk-appropriate system. The NCIOM will also continue convening the Maternal Levels of Care Action Team of the PHEC to finalize recommendations, draft language, and focus on fiscal impact related to maternal levels of care in collaboration with the DHSR.

Providing Behavioral Health Support to Maternal Health Providers

To increase awareness of the NC Maternal Mental Health MATTERS program and NC-PAL in FY24, staff members will continue to offer informational and educational webinars to NC LHDs and LME/MCOs. The NC MATTTERS program has perinatal psychiatrists and perinatal mental health specialists who will serve as the subject matter experts for the educational webinars.

In FY24, the MATTERS program will continue targeted outreach and technical assistance to LHDs to build provider capacity and support for patients and will provide monthly case consultations to LHDs receiving targeted QI support. In addition, MATTERS will aim to identify at least two new LHDs to engage in targeted QI efforts, while continuing to provide technical assistance as needed for the previous two LHDs that received QI technical assistance and support in FY23. MATTERS will develop a toolkit of essentials components for the QI work with each LHD along with optional technical assistance items that allow support to meet the unique needs of the LHDs. While working with the pilot counties will be the priority in FY24, providers from any county in NC can call NC-PAL, and WICWS staff members will be encouraging all LHDs to do so.

In FY24, the Maternal Health Branch (MHB) Licensed Clinical Social Worker (LCSW) will provide maternal mental and behavioral health related trainings for LHD staff based on data collected in the needs assessment survey administered in FY23. Based on the needs assessment results, the following training topics will be developed and offered:

- Engaging in conversations to reduce stigma and improve disclosure of maternal mental health issues
- Maternal mental and behavioral health drivers of maternal mortality, such as suicide, interpersonal violence, and substance use.

The MHB LCSW will also aim to coordinate a 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 FY24, the WICWS nurse consultants will update orientation materials for new LHD staff to include a one pager information sheet that outlines resources available through the NC MATTERS program. This information sheet will include the number to NC-PAL which provides LHD staff working with pregnant or postpartum people access to consultation with a perinatal psychiatrist or referrals by a behavioral health consultant. The one pager will direct new LHD staff to other services available through NC MATTERS such as brief intervention and behavioral health toolkits on evidence-based guidelines for screening, referrals, and medication management. The orientation materials will continue to include resources that support the psychosocial component of the Agreement Addendum.

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 and implementing a CMHRP Care Management Pathway for Perinatal Mood Disorders. This Pathway will guide care managers in providing the most current, best practice interventions for patients identified with any level or type of perinatal mood disorder. Care management interventions from this Pathway will be highlighted in the monthly CMHRP program update. 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. CMHRP Care Managers will routinely be directed to behavioral training webinars provided by NC MATTERS or facilitated by WICWS staff, such as the MHB LCSW.

Newborn Screening Follow-Up Team

In FY24, 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 FY24 (Mucopolysaccharidosis Type II [MPS II] and Guanidinoacetate N-Methyltransferase [GAMT]).

The NCSLPH NC Newborn Screening Program added MPS-1 and Pompe to their screening panel on February 13, 2023, allowing for the identification of 1 MPS-1 case and 6 Pompe cases. Additionally, the Program worked diligently to apply for the HRSA funding opportunity No. HRSA-23-065, State Newborn Screening System Priorities Program (NBS Propel) which was awarded on June 9, 2023. The goals to be accomplished for FY24 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 FY24. 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 FY24. 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 Family Focus Email will be expanded to include a Spanish version. The EHDI program will finalize and distribute an updated on-line Residency Training Module to educate medical residents on EHDI 1-3-6 goals. To further educate families regarding the 2019 Joint Committee on Infant Hearing best practice guidelines related to risk factors for late onset or progressive hearing loss, a Risk Factor Monitoring Fact Sheet providing background information on why follow-up might be needed will be developed in FY24.

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

FY24 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. Town Hall community meetings will continue in FY24 to continue increasing awareness and gathering feedback on the PHSP.

In addition, work to support the NC CFTF will continue. Specific priorities for FY24 will be established later this summer, but they will likely include continuing to work on legislation to strengthen the statewide Child Fatality Prevention System, youth suicide prevention, firearm safety, nicotine use prevention, improve birth outcomes, and motor vehicle safety. As part of Session Law 2023-14, $250,000 in non-recurring funding was appropriated by the NC General Assembly to Safe Sleep. Funds were also appropriated to support Medicaid increased reimbursement for maternal health.

Infant Mortality Reduction Programs/Initiatives

In FY24, 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.

The Healthy Start NC BLP program will continue to provide the services described earlier in the PIH Domain Annual Report, and the program will continue its enhanced focus on mental health, breastfeeding, co-parenting, and improving self-sufficiency for FY24. NC BLP will continue to participate in community events and outreach where permitted and appropriate to increase awareness of enrollment in program services. The program will also continue use of additional funds to provide mental/behavioral health services to any participant that scores above the threshold on the depression screening or who requests additional mental/behavioral health support. One-on-one counseling and care plans will be provided for those at higher risk and group counseling sessions will be available for those who desire that type of support. These sessions will be facilitated by a provisionally licensed clinical social worker dedicated to the NC BLP program.

In FY24, five ICO4MCH sites representing nine counties will continue implementation of six evidence-based strategies to improve maternal health and infant birth outcomes. The strategies include reproductive life planning and improving preconception and interconception health for Aim A. Improved Birth Outcomes; 10 Successful Steps for Breastfeeding (with specific focus on Steps 3 and 10) and tobacco cessation and prevention for Aim B. Reduced Infant Mortality; and Triple P and Family Connects newborn home visiting for Aim C. Improved Health Status of Children Ages 0-5.

In FY24, the name of the Infant Mortality Reduction Program will change to Reducing Infant Mortality in Communities. The Reducing Infant Mortality in Communities (RIMC) program will continue to awards funds to LHDs to implement evidence-based strategies that are shown to improve birth outcomes through addressing pregnancy intendedness, preterm birth, and infant mortality. The RIMC program is focused on reducing the infant mortality disparity ratio while addressing the overall infant mortality rate in communities. The RIMC program requires each LHD to implement at least two of these evidence-based strategies: 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.

An RFA was released twice, and funding will be provided to seven LHDs to implement evidence-based programs in the counties that have experienced the highest infant mortality rates during the five-year period of 2016-2020. A third RFA will be released with applications due in July 2023. It is anticipated that one or two additional sites will be identified and recommended for funding. Decisions will be made in late September 2023.

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 FY24 under the leadership of the NC DPH/DCFW Breastfeeding Coordination Team.

WIC Breastfeeding Peer Counseling Program

In FY24, the NC WIC Program will complete roll-out training of the four-tiered United States Department of Agriculture's WIC Breastfeeding Curriculum, which will assure consistent training for each WIC staff based on their role within the program. This training will create a structured referral process for peer counselors to elevate complex breastfeeding issues to trained experts known as WIC Designated Breastfeeding Experts (DBE) within their agency. The WIC Lactation Area Training Center for Health (LATCH) will continue to provide orientation and continuing education trainings for DBEs and peer counselors, and their managers, as well as assist the local agencies with the development and maintenance of external relationships to improve their referral opportunities and structures. During FY23, the LATCH has focused on the establishment of relationships with local WIC agencies, identifying partners, and understanding the needs of the community. In FY24, the objective is to collaborate with external partners to establish a mutually agreeable structured referral procedure that allows more consistent and varied breastfeeding support to WIC Program participants. The implementation of a structured referral process with clear guidance on when to refer has been found to increase breastfeeding initiation, intensity, and duration rates, as well has result in greater retention rates with peer counselors.

Regional Lactation Training Centers and NC Lactation Educator Training Program

In FY23, the LATCH grant was awarded to Eastern AHEC to provide breastfeeding trainings and community engagement support to the North Carolina WIC Program. This new regional model changed from six part-time staff to three full-time staff which has led to more consistent breastfeeding support for local WIC agencies and the expansion of training options for local agency staff. During FY23, each LATCH region focused on a landscape analysis of North Carolina's breastfeeding support infrastructure specifically the resources available to WIC Program participants. The centralization of the LATCH grant from six independent entities to one centralized provider has positively impacted program visibility with external programs having greater clarity on the program entity, and this has facilitated improved collaboration with a focus on improving communication between the local WIC Program and the external provider serving similar populations. With these entities taking collaborative ownership of the development and implementation of referral procedures, that may lead to more successful implementation and sustainability in FY24 and the future.

Breastfeeding Friendly Designations

Competing priorities due to short staffing and implementation of the multi-tiered training curriculum have delayed activity pertaining to Breastfeeding Friendly Designations. However, it is essential that the NC Maternity Center Breastfeeding Friendly Designation is reflective of the current guidance from the WHO and CDC, therefore it remains the goal for DCFW/CNSS to update the NC Maternity Center Breastfeeding Friendly Hospital Designation application to align with the WHO's updated *Ten Steps to Successful Breastfeeding* and updated Baby-Friendly, USA guideline evaluation criterion for implementation in FY24. CNSS will coordinate endorsement of application with the NC Healthcare Association, NC Pediatric Society, Child Fatality Task Force, NCIOM, and other pertinent professional organizations.

Also, in FY24, DCFW/CNSS will be working with CCHCs and other child care partners to develop a *Making It Work* tool that will be specific to early care and education settings. Once developed, trainings that complement the new tool and the NC Breastfeeding Friendly Child Care Designations will be developed and implemented.

Additional Breastfeeding Efforts by Infant Mortality Reduction Programs/Initiatives

In FY24, the Healthy Beginnings program will continue to provide breastfeeding education and support to all pregnant and postpartum/interconception program participants. All newly hired Healthy Beginnings program staff will be required to receive WIC Breastfeeding Peer Counselor Core training. In FY24, all breastfeeding program participants will continue to receive monthly breastfeeding assessments and support to maintain breastfeeding rates for 6 months or longer.

To increase the percentage of participants who breastfeed in FY24, the NC BLP staff will continue to strengthen 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. The NC BLP Program Coordinator, a Certified Lactation Counselor, will continue to assist with facilitating breastfeeding education and provide helpful tools for partners to support their pregnant or nursing partners. Representatives of the NC BLP program will continue their participation in the Local Action Networks (LANs) to elevate the community's responsibility in supporting breastfeeding families. The LAN will continue implementation of action plans to promote schools and businesses adopting policies to support breastfeeding families.

ICO4MCH grantees will continue their focus on Steps 3 and 10 of the Ten Steps for Successful Breastfeeding. FY24 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 FY24, 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 FY24 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.

Additional Strategies to Increase Breastfeeding Rates

Additional strategies to increase breastfeeding rates in FY24 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 Mother Baby Friendly 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, technical assistance, and coordination with the DPH/DCFW Breastfeeding Coordination Team will help to increase the total number of LHDs 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, to ensure that some breast/chest/human milk-feeding information (and as feasible, Food Insecurity and other important nutrition topics) are included as part of the Knowledge Base Core Competency for NC CHW.
- Continuing dissemination and use of the *NC Making It Work Tool Kit*, including promotion of the *North Carolina Worksite Breastfeeding Support in Action Webinar* to help breastfeeding mothers return to work. The focus of the webinar, which was done in FY22, was to share more about the *NC Making It Work Tool Kit* and other breastfeeding-friendly worksite initiatives and to hear from LHDs working on community/worksite breastfeeding support as part of ICO4MCH initiative. This webinar, tool kit (for free downloading), and a 2-minute promotional video are all available here. Sample social media posts and images to help promote the toolkit are available here. 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.

In addition, the WICWS Nutrition Consultant, in collaboration with the DPH/DCFW Breastfeeding Coordination Team, is planning to launch a social media campaign during Breastfeeding Month to promote breastfeeding and the recently launched Breastfeed NC website. Also, DPH/DCFW staff members and their partners will continue to work with the PHEC to ensure breastfeeding strategies and resources are highlighted in the PHSP and the work of the Collective. NC also has plans for the development of a statewide Breastfeeding Hotline. An advisory council of statewide partners has been created to help inform the development of the hotline. A request for proposals has been drafted and is expected to be released in FY24.

The State Child Care Nurse Consultant will continue to participate in the DPH/DCFW Breastfeeding Coordination Team in FY23 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 Child Care Health Consultants 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 FY24. The Tobacco Cessation Pathway has been updated in partnership with You Quit, Two Quit/UNC CMIH to ensure the most current best practice, evidenced based information is provided to CMHRP Care Managers. Refresher training will be provided on the updated pathway in FY24. WICWS will look for ways to partner with Medicaid Managed Care Pre-paid Health plans on tobacco cessation efforts for pregnant people. In addition, the NC Title V Program will look for additional ways to partner with the DHB, CMIH, and the CDIS on tobacco

cessation efforts for pregnant persons.

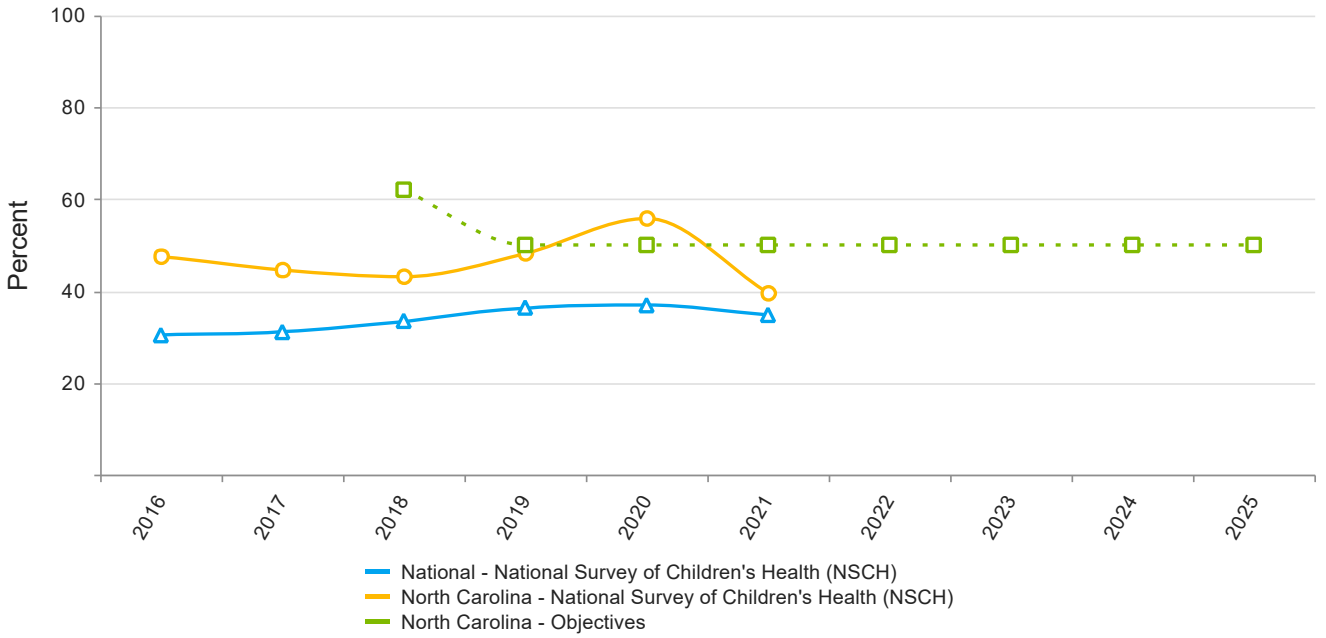
Preconception Health and Tobacco Cessation Activities

The PHW Program Manager position has been vacant since September 2022. Several rounds of interviews have been conducted and one strong candidate was identified; however, the person withdrew from consideration to take another position. In the interim, the ICHB Head will continue efforts to engage and recruit members and convene WATCH meetings during FY24. Action steps to be completed include identifying and recruiting prospective members to fill vacancies among constituency groups previously represented or new to WATCH and developing and launching a brief survey 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 begin the review of the *Guide for Helping to Eliminate Tobacco Use and Exposure for Women*. 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. The ICHB Head will also connect with WICWS and DCFW leadership to confirm that all direct service programs are providing smoking cessation counseling to enrolled participants. Trainings will be arranged in collaboration with the UNC CMIH and other WATCH partner organizations and provided to WICWS and DCFW staff members on the 5As of tobacco cessation, women's health, QuitlineNC, and e-cigarettes in FY24.

Child Health

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	62	50	50	50	50
Annual Indicator	44.4	43.0	48.1	55.8	39.5
Numerator	120,289	112,720	119,658	123,695	94,883
Denominator	270,809	261,906	249,001	221,849	240,161
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	50.0	50.0	50.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - 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
Annual Objective			80	85
Annual Indicator		75	80.9	75.4
Numerator		51	55	49
Denominator		68	68	65
Data Source		DCFW/WCHS staff internal log	DCFW/WCHS staff internal log	DCFW/WCHS staff internal log
Data Source Year		FY19-20	FY20-21	FY21-22
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	90.0	95.0	100.0

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

Annual Objectives			
2023	2024	2025	
Annual Objective	15.0	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
Annual Objective			90	90
Annual Indicator	80.1		75.9	76.5
Numerator				
Denominator				
Data Source	2017-19 National Immunization Survey		2018-20 National Immunization Survey	2019-2021 National Immunization Survey
Data Source Year	2019		2020	2021
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	90.0	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 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past 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 6.1 - 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 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

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

Priority Need

Promote safe, stable, and nurturing relationships

SPM

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

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. Continue to allow Title V funding to be used to offer a variety of evidence-based and informed strategies 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 Home Visiting and Parenting Education (HVPE) System 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; Prevent Child Abuse 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 3

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)

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 is funded for five years (2018-2023).

NCE4C is focusing on policies which promote economic mobility for families and norms change regarding support for positive parenting. The current focus remains on policy, practice and norms change related to family friendly workplace policies with an emphasis on paid family leave. During the reporting period, all NCE4C activities were pivoted from in-person to virtual due to COVID. NCE4C has focused on responding to the needs of employers during COVID-19 through Family Forward NC. The pandemic has affected all industries across the state, but particularly on the targeted industries of hospitality and manufacturing and all small businesses. Strategies were adjusted to remain relevant during the pandemic. As the target industries adapt to business practices under COVID, Family Forward NC developed a 'Rapid Response' program through which hospitality, manufacturing, and small business owners or managers can access:

- Human resources experts to assist in considering and/or applying industry-appropriate workplace benefits.
- A Family Forward NC Return to Work toolkit for manufacturing and hospitality employers. This toolkit, adaptable for small businesses, is designed to help employers offer workplace benefits for successfully transitioning back into reopening or retooling and moving forward.
- A series of webinars that highlights family-friendly supports that targeted industries and small businesses can incorporate immediately and over time to support families and their bottom line and stay resilient throughout the COVID crisis.
- A blind spot analysis to help employers figure out what they need.
- A limited number of opportunities for no cost, target consultation for individual employers

NCE4C continues to work with the MomsRising Educational Fund to build public awareness about the benefits of paid family leave policies and increase community capacity to implement paid family leave policies at the local government level. MomsRising worked over the reporting period to engage community level partners, provide technical assistance to local governments, and coordinate storytelling campaigns and media toolkits for community partners. Because of COVID-19, all activities have been held virtually. During the reporting period, MomsRising's most significant accomplishments on winning concrete family-friendly workplace supports were the Buncombe County expansion of paid parental and family leave for county employees, the town of Rural Hall's adoption of paid family leave, and the unanimous approval by the Perinatal Health Committee of the NC CFTF of a package of

proposals including endorsement of paid family and medical leave insurance, paid kin care and safe days, pregnancy and lactation workplace accommodations, and breastfeeding supports.

NCE4C partnered with other CDC funded projects and other partners to develop and implement an Injury Free NC Academy on family friendly workplace policies**.** The primary goal of the Academy was to build capacity with community-based teams to help them effectively promote, advocate for and/or implement workplace policies that reduce the risk for violence and increase protective factors for individuals and families. Due to COVID-19, this Academy has been adapted to three, two-day virtual sessions (rather than in person) and ongoing virtual coaching. Eleven multidisciplinary teams received experienced coaching and technical assistance on their project during the training and in-between the virtual sessions. Two sessions of this Academy were held during FY21 and one in FY22.

NCE4C worked with five communities on the development of local community prevention actions plans. During the reporting period, these plans were completed in Onslow, Clay, and Wake counties. Plan development continues in Transylvania and Pitt counties.

The Early Well initiative (which was formerly the NC Initiative on Young Children's Social Emotional Health) continued to be led by NC Child, in collaboration with early childhood leaders including the NC Early Childhood Foundation, 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 Interim 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.

In addition to the Early Well efforts, a cross-sector group of partners across NC, including representatives from the DCFW/WCHS, participated in an Infant and Early Childhood Mental Health (IECMH) Consultation workgroup focusing on expansion of IECMH Consultation in the state. In January 2022, the group, under the leadership of Dr. Marian Earls, applied for and was awarded a Technical Assistance Grant opportunity with the IECMH Technical Assistance Center at Georgetown University. The IECMH workgroup identified equity, research, and evaluation as focus areas of TA, specifically looking at training for workforces on the impact of structural racism on children's mental health and identifying meaningful metrics for outcomes and data sources.

NPM#6 – 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 NPM#6 (Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed tool in the past year) and the corresponding ESM 6.1 (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 developmental screenings 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), and ensuring that families can access appropriate care for further assessment. Per the 2020-21 NSCH, 39.5% of children in NC between 9-35 months had received appropriate developmental screening which is a decrease from 48.1% in the 2018-19 NSCH although NC remains higher than the national average of 34.8%. It should be noted that the percentage for NC should be interpreted with caution as the estimate has a 95% confidence interval width exceeding 20 percentage points and may not be reliable. The decrease in developmental screenings during this

period of time is not surprising due to the impact of the COVID-19 Pandemic and parents being fearful to schedule preventative visits with their medical home. Nationally, preventative visits decreased by approximately 40% which was comparable to NC as well.

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 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 clients in their homes or other locations. Screenings that are required at age-appropriate times for visits 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. The NC Medicaid schedule of recommended visits and screenings are based on Bright Futures guidelines which are described in detail in the most current NC Medicaid Health Check Program Guide (HCPG). In FY22, 75% of the 65 LHDs providing clinical services for children had staff members who had been trained in appropriate use of screening tools. The number of LHDs providing clinical services for children decreased to 65 due to three LHDs making the decision to assure CH services in FY21.

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 Senior Medical Director (SMD) who still serves in a role of PMC for Title V, provided monthly training related to caring for children during COVID-19 for child health clinical staff in LHDs. Included in several of these trainings was an update on Medicaid requirements for well visits related to use of telehealth, and importance of promoting well visits with patients during the pandemic which includes the use of developmental, psychological, and behavioral health assessments, based on recommendations from Bright Futures. Results of these assessments are reviewed by the practitioner with the parent and/or youth, and anticipatory guidance is provided by the nurse. The COVID-19 Child Health webinars also provided child health program clinical staff with resource information for: NC-PAL (Psychiatry Access Line); AAP/AACAP/CHA Declaration of National Emergency in Child and Adolescent Mental Health; and resources on suicide prevention, fear and anxiety, promoting positive childhood experiences, and ways providers can protect child and youth mental health. 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 FY22. Presentations included data on the drop in well visits and immunizations and 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 referrals to early intervention services and the processes available to physicians for exchanging information such as developmental screening results with early intervention service providers.

The DCFW/WCHS SCHNC and RCHNCs did not conduct in-person individual site visits to review child health services but did continue to provide technical assistance and education about best practices to LHD staff virtually during FY22 on a variety of topics including the importance of well visits continuing during COVID-19 to incorporate developmental surveillance, screening, referral and anticipatory guidance using LTSAE materials as well as Ages and Stages Questionnaires® and Parents' Evaluation of Developmental Status (PEDS) developmental screening tools as an essential component of health supervision visits and clinical care.

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 ITP continued with training to increase use of screening using the Ages and Stages Questionnaires®: Social-Emotional statewide. The FY22 Child Health Training Program (CHTP) was held virtually due to the continued impact of the COVID-19 Pandemic. 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 have continued to promote this archived webinar with LHDs and CHTP students 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:

- September 2021 – Children, Mental Health, and COVID-19
- December 2021 – RSV, COVID-19, and Childhood Lead: What Can You Do?
- March 2022 – Caring for Infants & Children in Foster Care
- June 2022 – Caring for Children and Adolescents in Foster Care

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 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.

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

During FY22, 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 Care of NC, 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 those 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 NC DHHS' Plan of Safe Care Interagency Collaborative. The CMARC program continued to support staff to navigate enhancements and reports in Virtual Health/Care Impact Platform documentation systems. The CMARC staff provides technical assistance and training to ensure program expectations are met as described in the Program Guide Management of High-Risk Pregnancies and At-Risk Children in Managed Care.

NC Medicaid Managed Care went live on July 1, 2021, and, during FY22, CMARC state staff worked with NC Medicaid to assure that care management services for the birth to five population were maintained and enhanced 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 develop a process for LHDs to have first right of refusal to terminate or transition CMARC coverage to another county. The Companion Guide for Care Management Service Termination and Transfer of Services Process was established August 30, 2022.

The CMARC program manager and several other Title V staff (Access to Care Specialist and a RCHNC) also continued to partner with Dr. Pretzel and Dr. Crais (UNC-CH) on a HRSA State Implementation grant (2019-2023) titled *Navigating Pathways for Coordinated Care for Children with ASD/DD* to increase early identification of young children with special developmental needs. The grant has a component that focuses on providing training to pediatric practices to facilitate screening and referral and increasing family navigation services and resources.

Triple P

The 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 local implementing agencies (LIAs). In FY20, a five-year NC Triple P Model Scale-Up Plan (sometimes referred to as the strategic plan) was developed to provide detailed information to state, regional, and local Triple P coordinators, funders, policymakers, and other partners about the core activities, strategies, structures, and processes needed to scale-up and support the Triple P system of interventions for whole-community reach driven by local needs within North Carolina counties. This system was still in place for 2022, 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.” It was an opportunity to listen and learn from LIAs, about their challenges to meet staffing needs, demands of the original strategic plan, and other operational challenges precipitated by the pandemic and ongoing environmental/fiscal challenges facing the LIAs. The NC Triple P Model Scale-up Plan was originally drafted by the NC Triple P Design Team on behalf of the NC PSG, the NC Triple P Support System, and the NC Triple P Learning Collaborative. Collectively, these partners envisioned Triple P expansion across the state to support positive parenting in all families and prevent child maltreatment. Population-level impact goes further than any one agency’s service delivery and will depend on a collaboration of agencies working together toward strengthening positive parenting as a community norm. In FY22, LIAs developed their Year Two Plan as part of the Model Scale-Up Five-Year Plan with flexibility allowed for due dates since the pandemic had impacted LIAs’ ability to fulfill all their original goals. 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. An Annual Progress Action Plan will follow that initial plan, detailing any nuances, revisions, or substantive changes to the initial plan. There is no score or critical review of that plan, other than feedback and consultation provided by the Design Team.

In FY22, 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 state-wide data collection and reporting and using data for local CQI projects.

In addition, the DCFW/WCHS continued partnering with the NC DSS to support Incredible Years and Strengthening Families cohorts in local communities and integrate those evidence-based family strengthening programs with Triple P as those initiatives are very compatible and integrate well with 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. 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. In FY22, funds were used to hire a Level IV trained practitioner in local DSSs, plus train all the Child Protective Services (CPS) case workers in Level III. CPS case workers delivered Triple P in the home and then referred high need cases to the Level IV practitioner.

During FY22, 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 on ongoing focus for FY22 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 additional training for practitioners, and purchase outreach and media materials to promote Triple P in their service area. The partnership between DPH, DSS and The Duke Endowment has continued to support the state-wide 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 “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. Nonetheless, practitioners are still available in all 100 counties of the state, and more practitioners are trained annually.

Two ICO4MCH project sites (covering six counties) selected Triple P as one of their evidence-based strategies to improve health among children ages zero to five during FY22. Three sites (inclusive of seven counties) implemented the Family Connects Home Visiting Program.

NC Child Care Health Consultation Resources

The State Child Care Nurse Consultant (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 FY22. 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. The SCCNC collaborated closely with the CCHSRC to offer support through training, technical assistance, and coaching services to 78 Child Care Health Consultants (CCHCs) providing local and regional coverage for 5,605 licensed child care programs across the state.

The SCCNC and Regional Coach from CCHSRC, serving as subject matter experts, continued to collaborate with DCDEE and DHHS to maintain the *NC DHHS ChildCareStrongNC Public Health Toolkit* which provided COVID-19 guidance for child care settings. Additionally, throughout FY22, webinars were held for CCHCs across the state at

the time of each update and publishing of the public health toolkit.

Recognizing the significant impact of the pandemic on the early educator workforce and in support of staff mental health and wellness, the SCCNC collaborated with partners from NC DMH/DD/SAS, NC Psychological Association, DCDEE, and the Duke University Center for Child and Family Policy to coordinate two offerings of a webinar titled *Addressing the Stress: Prioritizing Self Care and Workday Wellness*. The events were held at different times of the day/evening to accommodate more early educators, and more than 400 early educators participated.

In FY22, the CCHC System Workgroup consisting of representatives from DCFW, DPH, CCHSRC, DCDEE, NCPC, LHDs, and local Smart Start agencies met monthly to prioritize action steps and discuss implementation of a strategic plan. Four core agencies including CCHSRC, DCFW/DPH, DCDEE and NCPC provided a joint governance structure for the NC CCHC system. Beginning in FY21 and continuing in FY22, Child Development Block Grant funds were used to expand the CCHC network and provide coverage to 50 NC counties that had not previously had CCHC services. 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 provided extensive outreach to hiring and funding agencies in CCHC expansion counties and provided coaching support for CCHCs and their supervisors. During this expansion, the SCCNC partnered with the DCFW SMD and the SCHNC to offer a Child Health Provider Webinar titled *Child Care Health Consultant and You: Building Healthy Partnerships* to help educate LHD staff on the role of the CCHC and explore partnerships between health care providers, the local CCHC and child care facilities.

The CCHSRC offered three cohorts of the NC CCHC course for 31 new CCHCs in FY22. The four CCHC coaches served as course instructors. Medication Administration and Child Care Development Fund Overview Train-the-Trainer was offered within the CCHC courses. Additionally, both the Infant/Toddler Safe Sleep and SIDS Risk Reduction in Child Care (ITS-SIDS) and the Emergency Preparedness and Response (EPR) courses were reviewed and offered multiple times to CCHCs and other technical assistance providers across the state, resulting in 32 individuals trained as trainers for ITS-SIDS and fifteen newly trained EPR trainers. The CCHSRC distributed four quarterly e-newsletters with health and safety themes and maintained a CCHC Resource Library providing information on COVID-19 guidance and current health and safety requirements, including recommendations for meeting best practice standards for child care facilities.

The SCCHC 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 FY22. Topics included *Enhanced Feeding & Nutrition Practices in Child Care Settings* and *Trauma-Informed Practices: Address the Stress.* 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 external partners from UNC-CH, Go NAPSACC (Nutrition and Physical Activity Self-Assessment for Child Care) program, and the Carolina Global Breastfeeding Institute (CGBI), as well as the Infant Toddler Trauma Informed Care Project (ITTI Care) from Duke University, who served as subject matter experts. On average 42 CCHCs serving child care facilities across the state participated in the learning collaboratives.

In partnership with CCHSRC staff and TA provider from Buncombe County Smart Start, the SCCNC also led two Breastfeeding Friendly Child Care train-the-trainer events (October 2021 and June 2022) for 30 CCHCs and Birth to Three Specialists from the Child Care Resource and Referral (CCR&R) TA System.

SPM#3 – Percent of children with two or more Adverse Childhood Experiences (ACEs) as measured through the NSCH

One measure of the NC Title V Program's success at promoting safe, stable, and nurturing relationships is SPM#3. This indicator was also selected as one of the Healthy NC 2030 indicators and is part of the Early Childhood Action Plan. Results from the 2020-21 NCSH indicate that 17.8% of children in NC experienced ≥2 ACEs as reported by their parents. This is up from 15.3% in the 2018-19 survey, but with overlapping confidence intervals this is not a significant change. It is comparable to the 2020-21 national rate of 17.2%.

In FY22, 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, 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 FY22. 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 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. In addition to the previously documented activities regarding the use of LTSAE materials in FY22, the CMARC staff continued to provide LTSAE and the AAP's Books Build Connections Toolkit materials 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 uses 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 the Reach Out and Read Program (ROR) during the CHTP for CHERRNs and during a couple of monthly webinars for child health and CMARC staff related to care of children during COVID-19. During FY22, six LHDs provided the ROR program using Title V funds through the Child Health Agreement Addenda.

Child Health Agreement Addenda

The DCFW/WCHS continued to refine the Child Health Agreement Addenda with LHDs in FY22 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) Standardized measures and improved the 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 FY22 Child Health Agreement Addenda 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) Reach Out and Read program 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; 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 Child Care Health Consultants; 15) Nutrition and Physical Activity Coalition; and 16) Addressing Food Insecurity and/or Healthier Food Access.

During FY21, the DCFW SMD and SCHNC developed and offered a new child health service option related to firearm safe storage that was added as an option for LHD as part of the FY22 agreement addenda process. This was in response to increasing injuries and suicides with the use of firearms in our state in children due to unsafe storage. In addition, there was an increase in purchasing of guns in NC seen during the pandemic. Three rural LHDs applied during FY22 with proposals to use funding to address firearm storage.

The Pediatric Nutrition Consultant in DCFW/WCHS also continued to provide training and technical assistance in cooperation with partners and the SCHNC and RCHNCs to local child health nurses implementing the Child Health Agreement Addenda optional strategies on supporting Mother-Baby Breastfeeding Friendly Outpatient Healthcare Clinics, Local Nutrition and Physical Activity Coalitions, and Addressing Food Insecurity and/or Healthier Food Access. This last activity aligns well with NC Medicaid Transformation and the CMARC program along with NCCARE360, Healthy Opportunities Pilots, and the NC Early Childhood Action Plan.

Home Visiting and Parenting Education (HVPE) System

Given the complexities of the current home visiting and parenting education landscape and the multiple invested partners and funding, an inclusive, structured planning process was needed to develop a comprehensive, statewide system encompassing both home visiting and parent education in North Carolina. 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. The Title V Director who co-chairs the effort and the Title V CYSHCN Director are members of this coalition. In FY21, these system planning efforts moved towards implementation with the hiring of a HVPE System Director and system planning transitioned to governance through the HVPE Collaborative Board. Throughout FY22, staff participated in HVPE meetings. The following HVPE committees meet on a regular basis: Assessment & Planning, Collaborative Board, Communications, Finance, Programs, Community Advisory Board, and Family Advisory Board.

In FY22, the DCFW/WCHS continued working with the NFP sites to ensure that sites were meeting their funded caseload capacities. In order 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 who are 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 FY22, 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.

Movement toward integrating home visiting data into the NC Early Childhood Integrated Data System (ECIDS) resumed in fall 2021 after having been delayed due to the COVID pandemic and a vacancy for the NC ECIDS Program Manager position. The NC ECIDS team set up meetings between their data staff and NC MIECHV's Local Implementing Agency (LIA) supervisors and data partners to ensure that LIAs understood the purpose of NC ECIDS and the benefits of including home visiting data in the system. NC MIECHV will begin by integrating data from two of the HFA LIAs into NC ECIDS, and a formal memorandum of agreement was drafted.

MIECHV Regional Meetings were held quarterly for the professional development of home visiting staff. The topics for FY22 included Substance Use During Pregnancy, Fetal Alcohol Spectrum Disorders: The Impact of Alcohol-Exposed Pregnancies; Perinatal Mood and Anxiety Disorders: An Introduction to Behavioral Health Care in the Perinatal Period and Use of Psychiatric Consultation Services; the Diaper Bank of North Carolina; the IRS program: Volunteer Income Tax Assistance (VITA); NCCARE360; Infants, Children, and Youth Public Health Updates; and Exploring the Developmental Progression of Parenthood. Additionally, a monthly email was sent to home visitors with professional development opportunities which include webinars, journal articles, and upcoming conferences/trainings.

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 not part of NCDHHS and is not funded by Title V, the position of the Executive Director of the CFTF is in the NCDHHS Office of the Secretary, and several section 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 North Carolina Safe Kids, the University of North Carolina 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.

During its 2021-22 study cycle, the CFTF had a total of twelve meetings, including nine committee meetings and three full CFTF meetings where attendees heard presentations from more than 35 organizations on 27 topics. Experts and leaders making presentations to the Task Force and its committees represented academic institutions and state and local agencies, as well as national, state, and community programs. The CFTF approved nine legislative recommendations and 10 administrative efforts for inclusion on its 2022 Action Agenda which addressed issues such as, but not limited to, funding to enable comprehensive toxicology testing in all Medical Examiner jurisdiction child deaths, increase funding for programs to prevent harm to youth and infants caused by tobacco and nicotine use, and suicide prevention and youth mental health efforts. Efforts to strengthen and restructure the statewide CFP System are ongoing.

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, director of the local department of public health, and a health care provider. CFPTs also include the following members: An 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 eighty percent 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 North Carolina CFP System. The state CFPT Coordinator and SMD serve as members of the State CFPT Team. The State CFPT Team 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 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 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 Plan of Safe Care referrals. Annual recommendations are reviewed bringing together local CFPT, CCPT, and state CFPT topics to share with the Child Fatality Task Force.

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. The CFPT Coordinator position was vacant in late 2020 and an interim Coordinator stepped in to continue consultation and technical assistance via email and telephone (due to COVID-19 travel restrictions) to 40 local CFPTs for the majority of FY22.

The interim state CFPT Coordinator focused on developing training for team roles of CFPT to aid the counties setting up new teams and developed a calendar of reports and deadlines to assist teams in planning their requirements throughout the year. The interim state CFPT Coordinator spent a significant amount of time to purge and restructure office contents from the previous coordinator in accordance with NC State Records Retention Schedule and historical significance. This work set up a filing system to facilitate the new coordinator's assimilation into the role. Finally, in advancing the communication and collaboration with the local CFPTs, the interim state CFPT Coordinator revamped the annual survey, asking for additional information from local CFPTs and established a notebook of past surveys to understand how teams and survey responses had evolved overtime.

The full-time state CFPT Coordinator started on April 1, 2022, and contacted all 100 CFPTs across the state for introductions and to gain a sense of team operation and existing challenges in order to best support and provide technical assistance. The state CFPT Coordinator continued maintenance of the database of submitted review forms. During FY22, there were 1,714 completed fatality report forms entered into the database. The state CFPT Coordinator focused time on reinstating the required monitoring of local CFPTs in line with their LHD reaccreditation schedule. Finally, the state CFPT Coordinator continued collaboration between local CFPT work and state CFPT reviews in order to continue the process of bridging actions and noted recommendations throughout the CFP System structure.

Additional Strategies to Promote Child Health and Decrease ACEs

The DCFW/WCHS and the Early Intervention Section continue their enduring partnerships with agencies and organizations such as NC Child, the NC Pediatric Society, the NC Academy of Family Physicians, ECAC, NC Partnership for Children, Family Support Network, Carolina Institute for Developmental Disabilities, and Prevent Child Abuse NC. In FY22, they also supported and continued to participate in Early Well and began creating an ACEs Work Group as part of work on the NC State Health Improvement Plan that measures outcomes and progress on Healthy NC 2030 goals.

The Title V Program continued to work with Duke and other partners to expand the NC Telehealth Partnership for Child and Adolescent Psychiatry (NCTP-CAPA) technical assistance and education and NC-PAL 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. A statewide map youth mental health care dashboard from Medicaid claims data from 2017-18 was shared with providers using NC-PAL consultation. The DCFW SMD continued to promote the resources available through NCTP-CAPA to primary care providers and to promote NC-PAL with private and LHD child health providers in multiple presentations during FY22 related to child and perinatal mental health (NC MATTERS).

In FY22, 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 North Carolina. 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 are also provided.

The DCFW SMD also presented data on lead screening and highlighted changes and actions with the NC Childhood Lead Poisoning Prevention Program to LHDs and to pediatricians across the state in partnership with the NC Pediatric Society. Updates provided in the lead training were related to reduction in blood lead testing, LeadCare test kit recalls, and CDC lowering the blood lead reference value. SCHNC and RCHNCs partnered to provide technical assistance to LHDs on the LeadCare test kit recalls and 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 8,233,303 doses of vaccine, including 312,770 doses of influenza vaccine and 6,098,200 doses of COVID vaccine in FY22.

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 2019-2021 National Immunization Survey (NIS) results (for children born 2018-19) were released in January 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 76.5%, which was higher than both the national estimate of 70.1% and NC's previous year NIS results of 75.9%.

Results of the 2021 NIS-Teen, released in the fall of 2022, 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 96.2%, which was higher than the national estimate of 89.8% and an 8% increase from the 2018 baseline of 88.9%. The 2021 meningococcal conjugate coverage estimate in NC was higher for teens age 13 to 15 than the national estimate (95.6% v. 88.5%) and was an increase of 9% from the baseline of 87.4%. Regarding the percent of teens ages 13 to 15 who were up to date on the HPV series, the 2021 NC estimate was higher than the national estimate for all teens regardless of gender (65.6% v. 58.5%), and 72.3% of females were up to date while 60.4% 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 FY22, IB initiated 295 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 FY22 that included highlighting the need for well visits and immunizations and the decreasing immunizations rates due to COVID-19.

Child Health - Application Year

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

As reported in the CH Domain Annual Report, the Title V Program is continuing work on its five-year NCE4C Initiative with its multiple NCDHHS division and non-governmental organization partners in one of the largest efforts to promote safe, stable, and nurturing relationships for children. Specific examples of NCE4C strategies which support the NC ECAP Approaches, include:

- Work with the business community to increase employer-based family friendly workplace policies with an emphasis on industries where employers are less likely to have access to family friendly policies and benefits;
- Build public awareness at the state and local levels about the benefits of family friendly workplace policies, including paid family leave and the impact of ACEs on the health and development of young children, which may lead to norms change;
- Increase community capacity to implement paid family leave policies at the local government level;
- Focus on racial equity and the disparate ways economic policies, including family friendly workplace policies, may impact families;
- Exploration of alternative strategies for implementation of paid family leave (e.g., insurance); and
- Alignment of local plan development or implementation.

The Title V's five-year NCE4C initiative ends on August 31, 2023, but the Title V Office is applying for continued funding from the CDC for an additional five years of funding for NCE4C. If funding is received, the focus will include: 1) enhancing state-level surveillance infrastructure to collect, analyze and use ACE and positive childhood experiences (PCEs) data to inform prevention strategy implementation; 2) implement evidence-based ACEs primary prevention strategies and approaches; and 3) conduct data-to-action activities to inform changes or adaptations to existing prevention strategies. NCDPH will continue to leverage multi-sector partnerships.

The Title V Director and SMD will continue to be part of the leadership working on updates for the annual NC State Health Improvement Plan (NC SHIP) related to several HNC 2030 objectives related to women and children's health. The SMD has been involved with the three groups which have met and will be voting to decide on the final action steps to address three HNC 2030 objectives related to ACEs, short term school suspensions and third grade reading. The focus for the short-term suspensions has been on addressing staff diversity and to address early care and learning suspensions. Local and state community leaders have been involved from different sectors: education, public safety, foundation, private agencies, etc.

The Title V CYSHCN Director, SMD and other DCFW/WCHS staff members will continue to help with the implementation of strategies developed and supported by the refresh of the NC ECAP and the foundational strategies from the Pathways to Grade Level Reading. The NC ECAP refresh focuses on four areas: food insecurity, permanent homes for children in foster care, high quality early learning settings, and infant mortality (addressing the racial disparity). Title V staff members will continue to add to an action map created by Pathways to Grade Level Reading that will help to identify and coordinate strategies to support children's optimal development beginning at birth and will provide resources for ongoing supports for social emotional development and trauma informed care to try to reduce the impact of ACEs on young children.

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 and to help suggest changes in how

providers and systems engage families and provide TA to medical homes.

In FY24, DCFW will reconstitute and convene an Early Childhood Matrix Team (ECMT). The ECMT will go through a strategic planning process over the next several months to determine priority area(s) internal and external to DCFW related to IECMH. A small planning group within DCFW met during FY23 to develop a strategic planning process and initial survey to start to assess the IECMH landscape that intersects with DCFW efforts. This planning group consisted of the SCHNC, SCCHC, EHDI coordinator, SMD, Title V CYSHCN director, two MIECHV program state level staff, and several behavioral health program staff. The proposed ECMT strategic planning process will include assessing the landscape by creating an inventory of internal and external data, efforts and partnerships and challenges; assessing how to address one or more elements of the IECMH priority: data, policy, work force, practice (i.e., screening, management and treatment), interface with families, and funding; determining data that needs to be collected to measure how we are achieving improvement on the identified internal and external priorities; and creating an action plan to address the priorities.

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

The DCFW/WCHS SCHNC, RCHNCs, and the SMD will continue to include trainings for child health clinical staff in LHDs regarding information about the importance of developmental surveillance and screening, identification, management, and referral, especially with many children experiencing different environments and caregiving arrangements.

The DCFW/WCHS SCHNC and RCHNCs resumed onsite monitoring and technical visits for LHDs in May 2022 while still offering the option to hold virtual visits through Microsoft Teams meetings. Prior to May 2022, onsite monitoring and technical assistance visits had been postponed for two years due to COVID-19 restrictions and enormous demands on LHD Child Health Program staff. The SCHNC and RCHNCs will continue to utilize Microsoft Teams technology to meet with LHD Child Health Program clinical staff virtually to provide consultation and technical assistance. DCFW/WCHS staff members will continue to review child health services and provide technical assistance 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 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 and access resources for anticipatory guidance, and community partners when concerns are identified in LHDs based on Bright Futures and AAP recommendations. The DCFW/WCHS SCHNC and RCHNCs will provide technical assistance and review charts and electronic health records of clients seen in LHDs on the Medicaid requirement to provide, document, and discuss the results of developmental and behavioral health screenings with families as well as review the charts for other items. 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 screenings. DCFW/WCHS staff will also continue to work with the Pediatric Program at CCNC/CCPN, Clinically Integrated Network, and the EarlyWell Initiative to increase awareness about developmental, behavioral health and social-emotional screenings.

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

The SMD, SCHNC, and RCHNCs plan to hold monthly statewide webinars to provide child health programmatic updates which will include 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 possibility of holding a statewide Biennial Child Health Conference in FY25 will be explored in FY24. 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 one training about developmental surveillance and screening, identification, management, and referral for the CHTP participants. 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 technical assistance to CHERRNs, physicians, and advance practice practitioners in LHDs on topics such as refugee health updates, obesity prevention and screening; oral health prevention and screening in addition to other topics as needed.

In FY24, the CMARC program will continue to collaborate 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 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 technical assistance 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 FY24 to promote the HOP and continue to coordinate care management efforts with the NC InCK pilot program.

With the launch of NC Medicaid Managed Care which occurred on July 1, 2021, CMARC state staff will continue to work with NC Medicaid Division of Health Benefits 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 using the SWYC. Additional technical assistance will be 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 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 authorize targeted case management, evaluation and management services offered by service providers at several CDSAs. The SMD will also work with several CDSA providers to increase outreach to medical homes about developmental screening, management and appropriate referrals to EI and other agencies. NC ITP management, CDSA leadership, the remaining physicians and advanced practice providers and the SMD will review the process for and content of the established conditions list for eligibility for EI and several other EI policies and processes and explore how to create processes and policies that are consistent across all CDSAs to support billing and access to evaluation, management and treatment with developmental services and supports for eligible infants and children.

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, technical assistance, 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, 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 FY24. 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 the NC DSS. Funding from NC DSS enables the DCFW/WCHS to maintain its funding level to support and provide coverage of Triple P services to all 100 counties.

NC Child Care Health Consultation Resources

In FY24, the SCCNC will continue to work collaboratively with programs within the DCFW/WCHS and across Divisions, as well as with local and state partners, to establish and maintain links to promote and advocate for the health and safety of young children in early learning environments. Specifically, the SCCNC will continue to partner closely with the NC CCHSRC to support child care health consultation across NC, supporting 83 local and regional based CCHCs. 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. Three Regional CCHC coaches from the NC CCHSRC in addition to the SCCNC will continue to provide coaching services to CCHCs in FY24 as well as serving as instructors for the NC CCHC Course and other courses. Additionally, the SCCNC will partner with the NC CCHSRC to offer quarterly webinars for CCHCs and supervisors.

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

The CCHC Systems Workgroup, established in FY21, will continue its work in FY24. 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 FY24, the SMD will 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.

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

The CMARC staff will continue to provide LTSAE with additional training around the Reach Out and Read (ROR) Campaign, 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 Early Childhood Champion, the two LTSAE NC Ambassadors, child care health consultants, 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 FY24, 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 FY24 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.

Home Visiting and Parenting Education (HVPE) System

The North Carolina Partnership for Children (NCPC), which leads the statewide Smart Start Network and hosts the NC HVPE System, was awarded a $1 million grant from The Duke Endowment to support HVPE advocacy and system-building goals through 2027.

The HVPE System is led by a statewide collaborative board that includes partners who support the HVPE system in many roles – through funding, advocacy, policy, and research. The System's goal is 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.

With funding from The Duke Endowment, the NC HVPE System will work to lay the foundation for creating a centralized intake system for HVPE services statewide that is based on community needs. The HVPE System will ensure decisions are coordinated across the state and are equitable, transparent, and data driven. Also, with the grant funding, the HVPE System will improve its infrastructure for coordinating across the state. Funding will also support a statewide HVPE expansion plan in collaboration with local communities. Communication tools developed with the funding will focus on equity and amplifying family and community voice.

During FY23, NC MIECHV successfully signed and completed Memorandums of Agreement (MOAs) for six of the seven LIAs for data sharing (two HFA LIAs and four NFP LIAs). The NC MIECHV CQI/Data Manager and NC MIECHV's data partners have been working with the NC ECIDS Program Manager. Together, they have selected a subset of home visiting data to be shared and finalized the definitions and details of the data. NC MIECHV and their data partners have been granted access to NC ECIDS' Secure File Transfer Protocol (SFTP) server for secure file transfers. The plan is to integrate home visiting data for these six LIAs 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.

Nurse Family Partnership

NFP has been granted an additional $1.5 million dollars in the state budget to support sustainability and allow for expansion. This funding will enable NFP to serve at least 150 additional families across the state.

The NC NFP All-State Community of Practice will be held in November 2023. 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. Northeast NC NFP at Halifax Community College will be hosting the event.

NC Child Fatality Prevention System

In FY24, the state CFPT Coordinator 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 training needs assessments with all 100 local CFPTs through the annual activity survey.
5. Accept quarterly reports from local CFPT and submit an annual report to the State Child Fatality Prevention Team and the CFTF.
6. Provide individualized trainings to new CFPT Chairpersons and support county level staff taking on CFPT responsibilities.
7. Conduct monitoring activities for 33 local teams via virtual meetings and site visits.
8. Update the report form local CFPT's use when reviewing resident child fatality cases in order to collect additional data points and distribute aggregate data state-wide.
9. Onboard all local CFPTs with completion of an 'Operating Procedures' document to supplement the statewide CFPT procedural manual by outlining the operations of each individual team.

Additional Strategies to Promote Child Health

In FY24, 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 FY24, 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 FY24, the SMD and a RCHNC will work with the NC Childhood Lead Poisoning Prevention Program and other partners to review the materials and guidance.

As with previous action plans, the PNC will continue in FY24 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. 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.

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 SPAN grant staff, the State Child Care Health Consultant, the Community and Nutrition Services Section (WIC and Child and Adult Care Food Program [CACFP]), 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 & healthy eating that partners could use, especially with a diversity, equity, and inclusion lens. Another activity continuing in FY24 is that the PNC monitors 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.

Other work for FY24 includes work planned by the PNC for FY23 related to Oral Health and Nutrition that was put on hold due to a vacancy in the Oral Health Section and specifically their Perinatal Health Coordinator. The emphasis on this work will be to explore nutrition and dietary aspects directly linked with Oral Health (promotion of breastfeeding, decreasing sugar-sweetened beverages, etc.). This work will focus on providing resources and possibly ensuring referrals for nutritional needs identified during preventive dental visits.

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

Vaccines for Children Program Strategies

In FY24, 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 communications staff plans 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 FY24. 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.

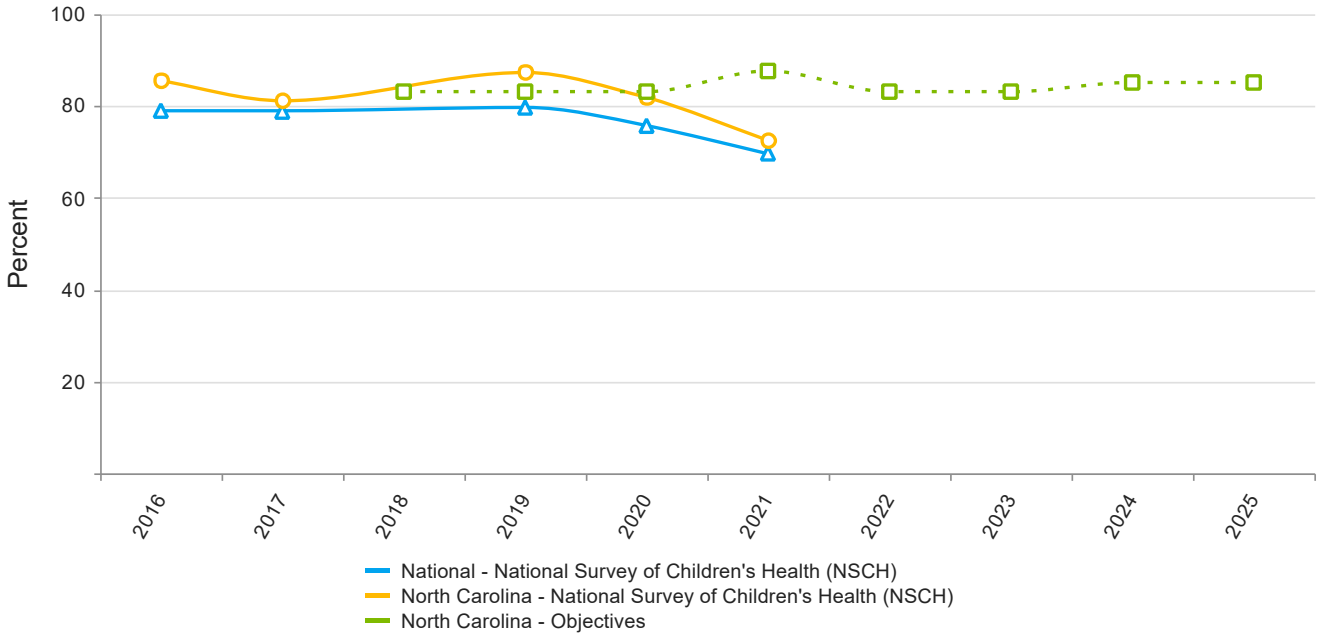
Among the many impacts of COVID-19 on NC is a marked decrease in the rates of well child visits and childhood vaccinations. In FY24, the Title V Office will continue to monitor vaccination rates closely and work with partners on outreach and sharing of best practices to increase vaccination rates and 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 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	83	83	83	87.5	83
Annual Indicator	81.0	81.0	87.3	81.6	72.4
Numerator	638,902	638,902	786,182	698,073	588,143
Denominator	788,733	788,733	900,582	855,558	812,116
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	83.0	85.0	85.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - 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
Annual Objective			24,225	8,000
Annual Indicator		16,676	7,656	16,169
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
Data Source Year		2020	2021	2022
Provisional or Final ?		Provisional	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	17,000.0	17,500.0	18,000.0

ESM 10.2 - 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
Annual Objective			66.3	75
Annual Indicator			71.6	71.2
Numerator			4,334	5,073
Denominator			6,054	7,122
Data Source			LHD/HSA	LHD/HSA
Data Source Year			SFY20-21	SFY21-22
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	77.0	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 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past 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 10.1 - Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center	Active
ESM 10.2 - Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

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 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. Although the school health nurse consultants 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 NPM#10 (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 school health centers about the importance of using behavioral health screening tools (i.e., HEEADSSS, PHQ-2/PHQ-9, CRAFFT). Technical assistance has been provided by 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. 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.

NPM#10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

Data from the 2020-21 NSCH indicate that parents report that 72.4% of adolescents in NC received a preventive medical visit in the past year which is lower than results from the 2016-17 survey (81%). NC did have a higher percentage than the nation in both the 2016-17 (78.7%) and 2020-21 (69.6%) surveys, although the confidence intervals overlap, so there is probably not a significant difference. In NC in 2020-21, YSHCN were more likely to have received a visit than those youth without a special health care need (YSCHN – 83.6% v. non-YSHCN – 67.5%).

In one effort to help increase this percentage, the Title V Office chose ESM 10.1 (Number of adolescents age 12 to 17 receiving a preventive medical visit in the past year at an LHD child health clinic or school health center) for this NPM. The number of adolescents receiving a preventive medical visit (CPT codes 99384 and 99394) in LHDs in FY22 was 7,122 which is a 17.6% increase from the number receiving visits in FY21 (6,054), but a 43.1% 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 21-22 indicate that 9,047 preventive medical visits occurred at the NC School Health Centers (SHCs). For FY and SY22, there was a combined total of 16,169 adolescents receiving preventative medical visits at the LHDs and SHCs.

An additional ESM chosen for this NPM is ESM 10.2 (Percent of adolescents who had a behavioral health screening at time of preventive care visit at a LHD). For FY22, 71.2% of adolescents age 12 to 17 received a behavioral health screen at the time of their preventative care visits at a LHD. Baseline data for this measure were collected in FY21 with 71.6% of adolescents who had behavioral health screenings (CPT 96127) during a preventive health visit at

their LHDs during that time. In SY22, SHCs also completed 4,702 total depression screenings. The DCFW/WCHS will continue to promote integrating mental health screenings during well-child visits through regularly scheduled child health webinars.

Supporting the Development of Teen Friendly Clinics

SCHNC and RCHNCs continued to encourage LHDs to choose to allocate Title V Child Health Agreement Addenda funds to support the development of teen friendly clinics. A sample Attachment C template continued to be 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 FY22, the SCHNC, RCHNCs and the DCFW SMD continued to provide TA to LHDs about the strategies from the Attachment C template with LHDs as part of providing technical assistance 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/strategy to promote adolescent preventive care visits via web/electronic

resources, social media, meetings and events, and/or traditional media.

- Well-Visit Marketing Tools and Templates
- Marketing the Adolescent and Young Adult Visit

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 have been incorporated into the most current version of the Health Check Program Guide (HCPG) which is used by the Medicaid program as the standard for preventive health care for children up to 21 years of age. During FY22, the DCFW SMD, SCHNC, and RCHNCs provided ongoing technical assistance to LHDs about the required and recommended components of adolescent preventive health care and the importance of following 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 about new recommendations from the NC High School Athletic Association was shared with LHDs and NC Pediatric Society providers to allow for safe athletic participation and clearance during COVID-19. 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 is posted on their website as a resource to help to adolescent well visits. LHD staff were 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 (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety) interview tool and the CRAFFT substance use screening tool. The 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, and during FY22 it assisted the SMD with providing targeted technical assistance to meet the needs of three individual providers.

Child Health Program audits of LHDs were not able to be done by the Best Practice Nurse Consultant (BPNC) due to COVID-19 travel restrictions and the continued demands on LHD staff. However, consultation and technical assistance 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 requirements for an adolescent visit continued to be included in the most current NC HCPG which was promoted and shared with LHDs by the child health nurse consultants. These 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 annual well adolescent visit. The Consultants and SMD provided specific TA with LHDs to improve confidentiality and share best practice strategies for interactions with adolescents and with use of LHD electronic health records (EHRs). 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 and about the toll that the pandemic has had on adolescent emotional wellness and social connectedness and the 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 is 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 twenty-one 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 twenty-one years of age. The role of the CHERRN is to improve access to care and to link children & 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 2021-22 CHTP was held virtually using Microsoft Teams technology. Course content covered in FY22 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 health care transition. 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 FY22:

- Children, Mental Health and COVID
- STI and Sudden Death in Children and Youth Updates
- Caring for Children and Adolescents in Foster Care

Annual School Nurse Conference

The Annual School Nurse Conference has been held for the past 37 years and is attended by around 50% of the state's more than 1,600 school nurses. Participant evaluations and input from adolescents and parents 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 37th Annual North Carolina School Nurse Conference on December 7-9, 2022.

School Health Nurse Consultation

School nurses facilitate the well-being and educational success of North Carolina'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. During FY22, school nurses were largely dedicated to COVID-19 mitigation and response efforts. FY22 continued to bring an improvement in the average NC school nurse to student ratio, moving from 1:890 to 1:833, these positions are largely supported through temporary COVID-related funds. There was sustained difficulty to fill school nurse positions during FY22 with districts reporting 131 vacancies for longer than 6 months. Any sustainable impact on school nurse ratios and FTEs will require a permanent funding response.

The School Health Nurse Consultant team held Regional Lead School Nurse Update meetings biannually during

FY22 to provide technical assistance 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 COVID-19 mitigation and response, school-based testing and contact tracing for COVID-19, and case management of adolescent students with chronic health conditions, including mental/behavioral health. The School Health Chronic Condition Nurse Consultant and the Behavioral Health Clinical Consultant created a behavioral health tiered document for school nurses. The guide is intended to assist with supporting student health and chronic health condition management within a collaborative multi-tiered system structure.

School Nurse Chronic Conditions Case Management

An average of 17% to 19% of the North Carolina 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. 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 LEAs continued progressively throughout FY22.

School Health Nutrition Consultation

The PNC serves on the DPI Healthy Schools “Choir” team (along with School Nurse Consultants) which meets monthly to share information among nutrition and physical activity partners in the state whose focus is the school setting. In FY 21, the PNC collaborated with DPI Healthy Schools and Nutrition Services staff, along with the Alliance for a Healthier Generation to present a 3-part series on School Wellness Policies.

School Health Centers (SHCs)

DCFW/WCHS funds 31 of the state’s 90 plus SHCs in order to increase access to primary and preventive health care for older children and adolescents, ages 10 to 19 years old, living in underserved and high-risk communities across the state. For many 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. These centers provide primary and preventive care for the purpose of improving adolescents’ and pre-adolescents’ health and academic success, which directly contribute to the effort by DCFW/WCHS to meet NPM #10. During FY22, the SHC’s began to recover from the effects of the pandemic, as SHCs began returning to normal capacity and normal operating hours. By the end of FY22 all schools began transitioning to 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 School Health Unit (SHU) 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 SHU. Applicable and appropriate action is taken to evaluate SHCs for a credentialing status via a review of compliance with "Quality Assurance Standards" and a Medical Record Review of a minimum of ten random de-identified patient records for all applicable medical services provided. During FY22, SHCs continued to receive support/technical assistance as schools began to return to normal operating hours. SHCs noted a marked increase in the number of students needing behavioral health services since the onset of the pandemic. In collaboration with school nurses, counselors, and teachers, SHCs worked 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 restrictions were lifted. Monitoring assistance and advising has remained consistent for all SHC's. Scheduling changes due to employment vacancies and transition as well effected re-credentialing delays. Mental health services remained relatively consistent with a minimal reduction in the number of behavioral/mental health procedures. SHCs reported 12,171 behavioral health procedures during FY22. This reduction was minimal and fairly consistent while SHCs began to transition to normal operation despite the challenges that the pandemic presented.

Youth Leadership and Partnership

During FY22, the Youth Health Advisor (YHA) Team convened virtually twice monthly to provide support to programs in the DCFW/WCHS that serve adolescents. This year, 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 member topics included mental health care access in schools, pre-teen nutrition education, mental health stigma in Latinx communities, youth physical activity and safe spaces to be active, youth environmental stewardship and more. Team members developed presentations of their findings and shared them within their respective schools or communities.

The YHA Team also continued to extend their expertise to DCFW/WCHS partners in DPI, DMH, and other divisions in NCDHHS throughout FY22 in matters of social and emotional learning, adolescent preventive care and education, and reproductive health programming. The team served as subject matter experts in effective youth engagement and the development of youth advisory council structures for several other states and organizations throughout FY22. The Adolescent Health Coordinator and two NC youth continued to serve on AMCHP's Youth Voice Amplified Committee, committing to ensure the inclusion of diverse and inclusive youth experiences in AMCHPs programs and policies as well as the broader MCH field.

Outreach Efforts to Medicaid and Health Choice Enrollees

Through partnerships with the Division of Health Benefits (NC Medicaid), the Prepaid Health Plans for NC Medicaid Managed Care, LHDs, and SHCs, the DCFW/WCHS staff continue 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, 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 FY22 are described in the CYSHCN Domain Annual Report.

NC Psychiatric Access Line (NC-PAL)

The NC Title V Director, CYSHCN Director, Adolescent/Behavioral Health Coordinator, SMD, and other DCFW/WCHS staff, particularly those in the Child Behavioral Health Unit, continued to advise and participate in NC Psychiatry Access Line (NC-PAL) implementation work during FY22. The purpose of NC-PAL, formerly known as the NC Telehealth Partnership for Child and Adolescent Psychiatric Access (NCTP-CAPA), is a free telephone consultation and education program to help health care providers address the behavioral health needs of pediatric and perinatal patients, with an emphasis on rural and underserved areas of the state. Behavioral Health Consultants can respond to questions about behavioral health and local resources and can connect providers to one of our on-call psychiatrists to assist with diagnostic clarification and medication management questions. The four key objectives of NC-PAL for pediatric primary care centers are: 1) Develop a multidisciplinary statewide network capable of providing mental health and telehealth support to pediatric primary care sites; 2) Enable pediatric primary care sites in every NC county access to timely and relevant mental health consultation; 3) Enable pediatric primary care providers in every NC county access to specialty care, community and/or behavioral health resources; and 4) Enable pediatric primary care sites in every NC county access to timely and relevant mental health education and training. The Title V Director and DCFW/WCHS staff members continued to meet virtually every other month with NC-PAL staff and HRSA teams to provide updates. During FY22 NC-PAL was available to all of North Carolina's 100 counties. Direct assessment of patients through telehealth was made available on a limited basis to providers for specific consultations. To date, the program has taken over 3,000 provider calls from 54 of North Carolina's 100 counties.

Funding for NC-PAL 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 FY22, NCDHHS more than doubled the investment in this program by dedicating more funding through the Mental Health Block Grant and Medicaid. With the increased funding, NC-PAL has been able to expand offerings to include the following supports:

- Participation in daily clinical staffing calls with NCDHHS, county DSS, 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 training initiative for psychiatrists and other practitioners to support behavioral health needs of children in their practices and local communities.

During FY22, the program began planning to expand its offerings, including additional resources for clinician training, complex consultation services, and school-based consultation services. The NC-PAL advisory committee continued meetings with partners from public health, mental health, academic centers, pediatrics, family medicine, psychiatry, rural health, and other disciplines. REACH (Resource for Advancing Children's Health) training was held four times which trained 104 clinicians serving youth in North Carolina. Thirteen pediatric and family medicine residents were trained at Duke University through a curriculum adapted by the NC-PAL program called Behavioral Health Expansion in Pediatric Residency Training (Be ExPeRT).

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. During FY22, the Adolescent Health Coordinator began work to integrate a youth and parent partner component to this work with an emphasis on educating parent and community members on the fundamentals of social and emotional learning and how to integrate youth and parent perspective in state team objectives. Regional school nurse consultants and the Adolescent Health Coordinator also engage in the state School Mental Health Initiative, a multi-disciplinary partnership of stakeholders providing support to promote healthy social and emotional wellbeing and address the continuum of supports and services for student mental health and substance use. Regional school nurse consultants 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 FY22, DCFW staff began engagement in a School Behavioral Health Learning Community comprised of state health, education, and Medicaid leadership. The learning community set to building capacity to expand school behavioral health policies through learning evidence-based and evidence-informed strategies to address youth behavioral health outcomes through the school system. DCFW engaged with a state team and cross-sector partners and cross-state teams to improve coordination. The state team developed a landscape template intended as a resource providing information on current school behavioral health policy, funding, and agency leadership. The template offered insights into policy and funding gaps for a state school behavioral health program and helped shape the development of a unified school behavioral health plan (carried into FY23).

Additionally, during FY22, Title V and other DCFW staff submitted a plan to expand activities supported by COVID-19 testing funding to include mental and behavioral health wraparound supports for school-age children impacted by COVID. This plan detailed the impact of disruption on educational routine and environment, loss or parent or guardian, pandemic-induced anxiety and stress, and stigma of positive results. This plan was approved at the end of FY22 with implementation beginning shortly thereafter.

The Adolescent Health Coordinator served as a planning member for a youth suicide prevention academy in partnership with Injury and Violence Prevention Branch staff members. The academy included both prevention and postvention educational content for teams of school personnel across the state as well as other youth serving professionals.

Triple P (Positive Parenting Program)

Triple P has been implemented in all 100 counties in NC. A free online evidence-based adolescent component to help families manage behavioral problems is available for all NC residents, 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.

To strengthen the system of care for children and adolescents, representatives of the DCFW/WCHS and the State Title V Director and State Title V CYSHCN Director continued to meet with the Home Visiting and Parenting Education Systems Planning group in FY22.

Promote Importance of Adolescent Preventive Care Including Behavioral Health Risk Assessment

DCFW/WHS 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 FY22, the 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 Library. Title V staff members have worked closely with Fostering Health NC Transition Age Youth 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 FY22, the PNC began work to ensure trainings for health professionals, supported through programs through DCFW and with outside partners, included appropriate messaging to promote Health at Every Size® and Weight Inclusive principles and practices in order 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. The PNC shared nutrition and physical activity resources with the Adolescent/Behavioral Health Coordinator, Regional School Nurse Consultants, and also within the Child Health Program. This work will continue in FY23 and beyond.

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 will be the creation of a children's mental health dashboard for the state. An internal dashboard is in its final stages of development and should be released in summer 2023, with the public dashboard being unveiled during FY24.

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 in order 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 FY24, 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 FY24 continue 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 FY24, 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 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. Technical assistance on best practices for how to provide a sports physical (preparticipation physical evaluation) which is 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 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 FY24 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 2023 conference began in early 2023. Regional School Health Nurse Consultants, local school nurses and the state adolescent health coordinator will participate on the planning committee. Representatives from the Youth Health Advisor Team will contribute to 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 other mood disorders, vaping, and substance use prevention.

In FY24, 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 FY24 include continuation of funding for 30 of the state's >90 SHCs. SHCs are beginning the recovery process from pandemic related activity experienced over the past couple of years. While most SHCs have managed to remain appropriately staffed, some have experienced minor reductions but have managed to slowly redevelop appropriate staffing to support the needs of children. In FY24, 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. Mental health services will also continue to be prioritized. The monitoring process for SHCs will be ongoing to assure that resources, guidance, and technical assistance are readily available. Assistance and resources may be provided in the form of suggested trainings, contract development and revision, processes, budget assistance or data collection.

The NC SHC Program will also continue its family and youth engagement through their participation in the bi-annual NC SHC Advisory Council Meetings and on behalf of their state funded health centers at the DCFW/WCHS meetings. The NC SHC Advisory Council's primary purpose is collaboration with the NC SHC Program in order 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. Students will provide presentations for council members and DCFW/WCHS staff about their positive school health center experiences. They will also share feedback about how youth are effectively communicating with the health care staff and suggest ideas for increasing adolescent enrollment at their school health center. Through these activities, the NC SHC Program will increase internal collaborations with the FLS and FP and increase external collaborations with youth, families, and school

health center staff. Additionally, SHC will have access to a DCFW Medical Director for the purpose of providing medical consultation.

School Health Center Credentialing

In FY24, the SHU 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 FY24, the plan is to complete any outstanding or required credentialing. A required submission of Medical Record Audits will occur by the SHCs for review of all applicable medical services provided. Policies will also continuously be developed and reviewed through a collaborative effort with the School Based Health Alliance. In addition, policy, quality assurance, and credentialing will also be addressed and continuously developed through an ongoing collaborative engagement with the NC SHC Advisory Council.

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 FY24, building upon partnership work established during FY23. The team will prioritize partnerships with youth-led organizations that are comprised of CYSHCN. The team will prioritize planning activities and outreach for Adolescent Health Month during FY24. In addition, the team will continue to focus on redeveloping website content for youth and parents/guardians to promote the adolescent well visit. The YHA team will continue to use social media networking platforms to feature the Youth Advisors sharing pertinent and timely messages for teens. 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.

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 into Medicaid 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 more 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, 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 be explored during visits with pharmacists who may offer access to COVID-19 vaccines, oral contraceptives, and nicotine replacement therapy using recent state health director standing orders.

North Carolina Psychiatric 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 provide support to schools via consultation services or other program offerings through continued grant funding during FY24.

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 FY24, 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.

Triple P (Positive Parenting Program)

During FY24, the NC Triple P System will continue to focus on adolescents through the work of the NC PSG 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 with concrete strategies for developing relationships with adolescents and caregivers, encouraging more practices that caregivers want to see from adolescents such as teaching adolescents new skills

and behaviors; 5) Implement adolescent focused strategies to Increase 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 caregiver adjustment, which results in caregiver competency, allowing them to be better equipped in using effective strategies proactively.

Promote Importance of Adolescent Preventive Care Including Behavioral Health Risk Assessment

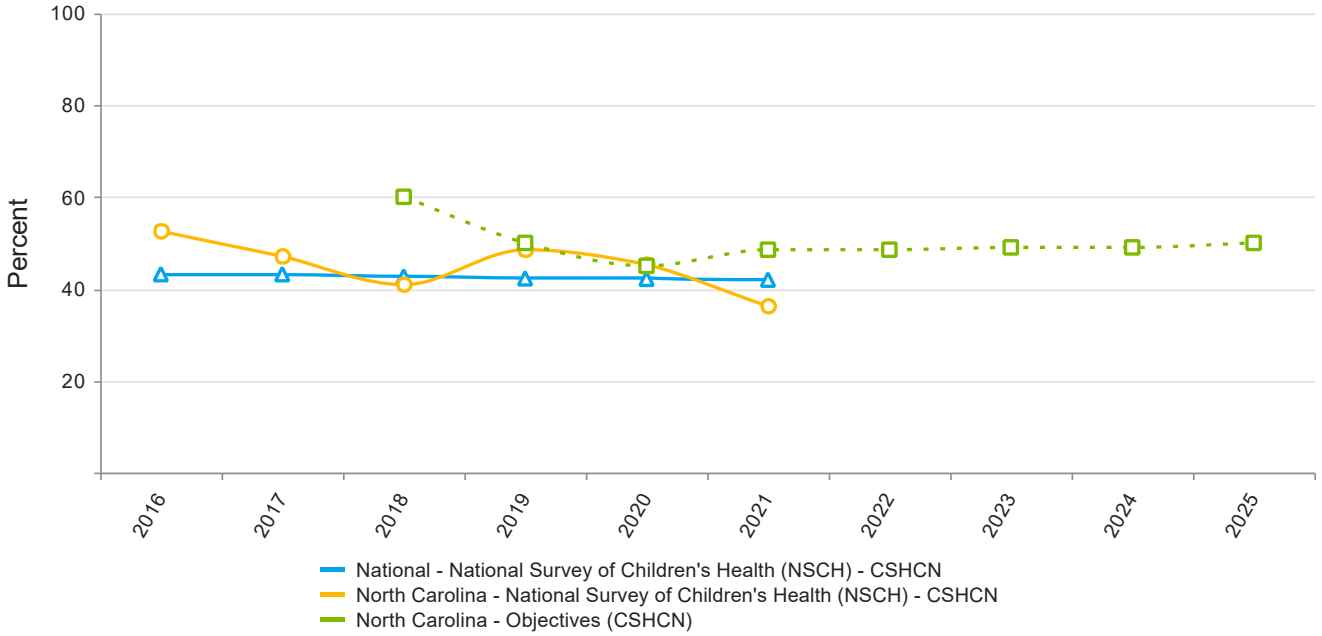
The SMD and CYSHCN outreach staff will continue to promote the importance of adolescent preventive care including behavioral health risk assessment in policies and processes and during meetings, presentations, and discussions with state and community agency partners. These partners include but are not 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 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	60	50	45	48.5	48.5
Annual Indicator	46.9	41.0	48.4	45.2	36.3
Numerator	225,282	199,181	241,421	227,867	184,239
Denominator	480,138	485,743	498,468	504,402	507,316
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	49.0	49.0	50.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of children with special health care needs who received family-centered care

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	87.0	90.0	90.0

ESM 11.2 - 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
Annual Objective			10	12
Annual Indicator		8	9	17
Numerator				
Denominator				
Data Source		DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	18.0	19.0	20.0

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 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

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 11.1 - Percent of children with special health care needs who received family-centered care	Active
ESM 11.2 - 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 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

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 11.1 - Percent of children with special health care needs who received family-centered care	Active
ESM 11.2 - 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 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

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 11.1 - Percent of children with special health care needs who received family-centered care	Active
ESM 11.2 - 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 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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, the DCFW/WCHS intentionally restructured personnel 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 FY22 to improve the health of all children and decrease child deaths and morbidity.

NPM#11 – 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 NPM#11 (Number of children with and without special health care needs, ages 0 through 17, who meet the criteria for having a medical home). Data for NC from the 2020-21 NSCH indicate that 36.3% of CYSHCN had a medical home as compared to 51.8% of children and youth without special health care needs (non-CYSHCN). National rates for this measure are 42% for CYSHCN and 47.7% for non-CYSHCN.

In addition to NPM#11, two ESMs have been selected to help monitor progress in this area: ESM 11.1 – the percent of CYSHCN who received family-centered care as reported in the NSCH and ESM 11.2 – 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.

Baseline data for ESM 11.1 was taken from the 2017-18 NSCH when 80.8% of parent respondents indicated that their CYSCHN received family-centered care. This increased to 85.4% in the 2018-19 NSCH and decreased back down to 80.3% in 2020-21. There probably is not a significant difference in these survey data, however, as the confidence intervals overlap for all three years. The state rate was higher than the national rate in the 2018-19 NSCH, but below it the other two years, with the national rate being 82.7% in the most recent 2020-21 NCSH. Baseline data for ESM 11.2 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 FY22 there we at least 17 relevant meetings where medical home promotion was discussed.

Several DCFW/WCHS staff members and Family Partners (FPs) continued to participate in the Children's Complex Care Coalition of NC (C4NC) advisory committee that started as funding from a grant from the National Center for Complex Health and Social Needs. This effort continued without grant support to be led by UNC and Duke and included several other academic centers, Legal Aid of NC, additional state and local agencies, health professionals, community-based organizations, and families of CYSHCN. The C4NC 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 FY22, the Advisory Committee met quarterly 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. The convenings identified seven themes (Training and Education, Stigma, Family Support and Empowerment, Care Coordination, Cross Sector Collaboration, Access, and Funding and Reimbursement) which impact the use of the medical home approach and health care transition. More information can be found in the

resulting white paper *Improving Systems of Care for Children with Complex Health Needs in North Carolina*.

Late in FY22, the DCFW SMD met with staff for two exploratory meetings to investigate developing a medical home training. Drafting both a family-focused module and a provider-focused module about building and maintaining partnerships between families and providers including information about health care transition was considered.

Education, Training, and Support for Providers Regarding Medical Home

In FY22, information to support the medical home approach and partner 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 2021-22 Child Health Training Program (CHTP). The DCFW SMD and SCHNC worked with NC DPH Office of the Chief Public Health Nurse to include information in trainings for LHDs that included guidance related to required child health services and telehealth flexibilities 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. 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 during the COVID-19 pandemic. The SMD specifically always included information about the Children with Special Needs Help Line. The SMD tried to stay current on Medicaid policies related to telehealth and vaccine coverage and when changes occurred in order to provide TA and consultation to providers in LHDs, and pediatric practices in order to increase access to whole child health care in the medical home for children. The SMD also continued to try to explore interest from providers and agencies about having the Family Liaison Specialist (FLS) contact them to discuss the use of Parents as Collaborative Leaders training to help them increase engagement of families in the care in their agencies. NC Office on Disability and Health continued to offer accessibility reviews for LHDs at their request to enhance the care of CYSHCN and to assist in achieving accreditation requirements.

The SMD provided multiple presentations for pediatric providers in LHDs and other settings serving as medical homes or working with medical homes caring for children during the pandemic which included: the status of COVID-19 cases and increased risks for COVID for CYSHCN; ongoing school and child care guidance changes which impact 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 FY22. 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 and other partners to provide care coordination for infants exposed prenatally to substances. 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 and connected them to community resources, which is amplified by NCDHHS HOP efforts to address non-medical drivers of health as part of NC Medicaid Managed Care and the development of

NCCARE360, a statewide coordinated care platform to link individuals to resources. Webinars and care pathways were developed and made available for CMARC care managers to help them partner with Advanced Medical Homes, Clinically Integrated Networks, and Health Plans to care for children with a variety of conditions such as asthma, sickle cell, foster care, and neonatal abstinence syndrome.

Title V funding continued to be used to support CMARC services although the CMARC Program Nurse Consultant was vacant during FY22. 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 from Health Choice are coordinated. The outreach team experienced a vacancy in the DCFW/WCHS Minority Outreach Coordinator position during some of FY22 requiring work to be maintained by other staff.

DCFW/WCHS staff members continued to provide support to the NC Commission on CYSHCN and its workgroups (Oral Health and Behavioral Health) in FY22. The Commission's nine members were appointed by the Governor and met bimonthly to review and make recommendations related to issues affecting CYSCHN. Support included the preparation of reports, gathering data, 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 a Title V Parent Representative to participate on the Commission and to attend the Behavioral Health and Oral Health workgroups.

After the launch of NC Medicaid's Standard Plan (which covers the majority of Medicaid children, including CYSHCN) in FY22, the Commission invited representatives from the five Prepaid Health Plans to join meetings to discuss their care management services and provide feedback and recommendations from families and providers. The Commission also reviewed and provided feedback on the ongoing development of the Tailored Plan, which will serve children and adults with intellectual and developmental delays and complex behavioral health needs. Quality care management, provider capacity (particularly regarding behavioral health), and barriers for families of CYSHCN were key issues among stakeholders. 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 information from the Commission, kept apprised of ongoing developments in behavioral health care from various sources 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 WCHS employed two part-time program consultants, both dental hygienists, to conduct presentations for dental providers. Dental providers were offered two different presentations to encourage inclusion of CYSHCN in their practices by addressing access needs and clinical strategies. The first discussed practice accommodations and strategies to support CYSHCN. The second presentation, co-presented with the NC Office on Disability Health, provided additional information on the Americans with Disability Act and its impact on dental providers and practices. Both presentations offered continuing education credit to dental providers. The Oral Health Workgroup's initiative to provide education about the importance of a dental home resulted in 21 trainings reaching 534 healthcare providers in FY22.

The Commission continued to monitor the anticipated renewal of the Community Alternatives Program for Children (CAP/C) Waiver in FY22. A CAP/C subcommittee was proposed and sanctioned by the Commission 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 subcommittee 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. Additionally, the CAP/C

subcommittee elevated the urgent need for highly skilled healthcare workers providing nurse attended care.

The CYSHCN Access to Care Specialist participated in eight 90-minute ECHO (Extension for Community Health Outcomes) sessions to address families with Intellectual/Developmental Disability (I/DD) who struggle to access comprehensive, updated information while navigating multiple complex systems in our state. Subject matter experts from local, regional, and state organizations shared their knowledge and expertise with a community of providers who support families across central North Carolina. Participants were linked to mentors specializing in service coordination, social work, and resource navigation.

The CYSHCN Help Line Coordinator presented to several community medical practices as part of an academic health system to increase use of the Help Line and also to increase conversations about issues coming up for CYSHCN in medical homes in the community in December 2021. The SMD connected the CYSHCN Help Line Coordinator with two additional rural health pediatric practices and with the Cherokee Indian Hospital based pediatric practice. Efforts stalled when the CYSHCN Help Line coordinator left for a new position. Expanding the Help Line outreach into medical practices across the state remained a goal for the SMD because it is beneficial and encourages new partnerships for all those working with CYSHCN.

The SMD served on the Medical Home Work Group with the Family to Family Health Information Center agency in NC as part of the statewide EarlyWell Initiative to address social emotional health in children birth to eight years of age. The Medical Home Work Group generated a white paper and recommendations for how to best increase the knowledge, skills, and abilities of medical homes to promote relational health and to identify and address social emotional concerns and social drivers (including structural racism) using a family-centered equity lens. This included value-based payment strategies to compensate medical home providers for meaningful and ongoing family engagement such as serving as family advisors. 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 stakeholders.

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 the Help Line Coordinator, who received ongoing feedback from families. Messaging about renewing Medicaid coverage, providing feedback on Medicaid managed care (contact the Ombudsman), and the CAP/C Waiver Renewal was promoted on the CYSHCN webpage. 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 in FY22. The Help Line is staffed by a 1.0 FTE with backup provided by WCHS staff. The CYSHCN Help Line contact volume for FY22 was 486 inquiries. Families and caregivers of CYSHCN reflect 73% of the call/email volume. Most Help Line users (80%) utilized direct phone contact which allows callers to talk directly with staff. Ninety-four percent of Help Line users communicated in English, 5% in Spanish, and one caller spoke Swahili. For their child's primary insurance, 73% of Help Line users reported Medicaid or Health Choice, 21%-private insurance, and 6% reported their children were uninsured (reduced from 10% in FY21). Almost half 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: 38% from birth to 5 years old, 29% from 5 to

11, 21% from 12 to 18, and 12% over 18 years old. The top three topics discussed with Help Line users were health insurance (25%), financial resources (19%), and exceptional children's services (16%). Help Line users indicated they learned about the Help Line using various methods: 41% via the website, 21% as a referral from a state/local agency, and 17% 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 so nice and knowledgeable. After our conversation, she immediately sent me an email with a ton of resources. I am so thankful and appreciative."
- "I felt like I was drowning--and (the Help Line staff person) gave me a life raft! I will be reaching out to these resources! Thank you!"

Outreach efforts to promote the awareness and access of Help Line services utilized several strategies. Supplemental Security Income (SSI) applicants, ages birth to 18 years, received direct notification about the Help Line as a resource which in FY22 reflected 1,244 families. The letter sent to SSI applicants was reviewed and rewritten to include information about COVID-19 vaccines for children. WCHS staff shared Help Line information at stakeholder meetings, presentations targeting 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 3,218 Help Line info cards were distributed via mail (2,336) and at outreach events (882) in FY22.

Through the Commission's Oral Health initiative, families of CYSHCN were offered training that focused on effective ways to partner with their dental provider for a more positive, lifelong dental experience for their child. This presentation was co-presented with a dental hygienist consultant and a WCHS family partner. In FY22, six virtual presentations addressing families of CYSHCN were completed, reaching 92 families. Finding the Right Dental Home for Your Child or Youth with Special Health Care Needs checklist is also shared with family members to assist them in finding the dental home that best suits their child's needs. All of the attendees felt their confidence level (defined as increased ability to share information, gain ideas for accommodations and strategies, and obtain resources related to oral health for CYSHCN) improved. Participants reported:

- "I was given a lot of good ideas for simple things to ask for that can make a big difference."
- "I learned how to advocate and that there are places out there willing to allow some of these accommodations."

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, 36 FPs were reimbursed for 462 documented hours in FY22 towards DCFW/WCHS program efforts. The FLS position experienced a vacancy

beginning in November 2021 requiring other staff to support family engagement efforts. In addition, the DCFW/WCHS continued to employ a part-time Parent Consultant who served the EHDI Program. The CYSHCN Access to Care Specialist role, briefly vacant from August through October 2021, provided technical assistance to the FPs in addition to managing the FP reimbursement system. Activities conducted by the Youth Health Advisor Team are described in the AH Domain Annual Report.

The DCFW/WCHS FP Steering Committee, which represents nine family partners 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 family partners and DCFW/WCHS staff members. The Committee met four times in FY22 and participated in bidirectional communication regarding topics including parent training cadre updates, the AMCHP scholarship application process, Medicaid Transformation, and DCFW/WCHS staff roles and transitions.

The DCFW/WCHS Parent Leadership Training Cadre 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 22 trainings (13 in English and nine in Spanish) to 167 parents and caregivers of CYSHCN across the state during FY22. One hundred percent of attendees felt the training contributed to their knowledge and skills for leadership. Participants reported:

- "I expect to apply what I learned at the training to guide parents I work with in becoming leaders."
- "The training helped me to see there is a role for parents both in history and the present."
- "Transmitiré la información para apoyar a los nuevos padres de niños con necesidades especiales". (I will pass on the information to support new parents of children with special needs.)

The DCFW/WCHS continued to invest in Title V family leadership development by sponsoring family partners to attend national conferences, specifically AMCHP (three attendees) and the National EHDI (three attendees) conferences, both virtual in FY22. 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. The virtual platform offering minimized barriers for families of CYSHCN that may have prevented their in-person attendance. The attending family partners reported back to either the FP Steering Committee or the DCFW/WCHS EHDI Advisory Committee on what they learned and how they plan 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.

Other FP engagement opportunities during FY22 included:

- Joining the (FLS position) interview team
- Reviewing newly developed genetics factsheets for families
- Participating on the NC Triple P Partnership for Strategy and Governance (PSG) /NC Learning Collaborative (NCLC)
- Contributing to the MCH Block Grant review process
- Partnering with the PMC to share COVID vaccination materials with communities
- Attending DCFW/WCHS Meetings and Town Halls
- Co-chairing the NC GGAC
- 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 stakeholder engagement and outreach, and to develop updated outreach materials.

Attending state and community stakeholder outreach events remained mostly virtual in FY22 due to the COVID19 pandemic. With a new Minority Outreach Coordinator in place, full capacity and innovative ideas positively influenced outreach function. During her tenure, the Minority Outreach Coordinator collaborated with a Latinx Youth Health Advisor group member to develop a PowerPoint presentation that addresses the need to tailor Children's Health Insurance Program promotion to youth, educate on transition of care from pediatric to adult, and taking charge of their own health. Focused efforts by the Outreach Team utilizing the virtual climate to reach priority populations resulted in 137 outreach events reaching 3,215 participants. Specific outreach activities addressed Smart Start, Innovative Approaches, LICCs, Food Banks, churches, and community health centers in counties with a high rate of uninsured children. Activities included sending materials for specific events (exhibits), sending materials, and joining meetings (collaboration and consultation), and presenting information on slide decks (presentations). Outreach staff prepared and mailed information packets to site contacts for inclusion in their distribution efforts; A total of 4,382 (English/Spanish) NC Medicaid/NC Health Choice informational flyers were distributed in FY22. 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 progress with Medicaid managed care, learning about cultural events and festivals, 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/Health Choice presentations onto (virtual) PACL training modules.

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 and Health Choice. Regular attendees represent: DCFW/WCHS, Fostering Health NC, Office of Rural Health, Office on Refugee Health, NC Association of Community Health Centers, NC Child, NC Justice, NC Budget & Tax Center, Community Care of North Carolina, Family Resource Center South Atlantic, and the NC Partnership for Children. Coalition meeting topics included rich discussion on the NC transition to managed care, the Medicaid Ombudsman program, and post public health emergency plans for Medicaid recipients.

Innovative Approaches Initiative

FY22 marked the third year of the three-year (2019-2022) funding cycle for IA. The DCFW/WCHS continued to support four LHDs (serving ten counties) to assess and improve the local systems of care for CYSHCN through their IA initiatives. IA sites continued to work directly with families to implement action plans addressing community systems of care for CYSHCN. IA received a Best Practices designation from AMCHP in November 2018. To continue to build the evidence for IA, the initiative completed year three of a rigorous process evaluation to link effectiveness in improvement of NOM 17.2 and NPM's 6, 11, 12, and 15. The evaluation team from UNC Chapel Hill presented their final report in May 2022. The evaluation results suggest that overall, IA strengthened the community capacity to serve CYSHCN through systems changes. Community members and partners were overwhelmingly

positive about the value of IA in their communities, specifically related to partnership development, advocacy, and resource development. When compared to other families in NC, IA families reported more shared decision making within a medical home, higher rate of developmental screening, and well-coordinated health care transitions.

All IA sites continued to utilize a part-time Parent Outreach Coordinator position whose primary purpose was to perform outreach activities to engage parents of CYSHCN and to recruit their active involvement in the IA initiative. In FY22, 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, maintained a commitment to advocacy and educating other families, agencies, and health care professionals on issues that affect CYSHCN. PAC members met monthly with service providers and agencies to promote collaboration and make recommendations to the IA Steering Committee.

In FY22, the Cabarrus, Gaston, Rowan, and Union IA site focused efforts on building capacity within health care communities to better serve CYSHCN and equipping youth with special health care needs for successful transitions. A toolkit was developed for providers to encourage additional training related to serving CYSHCN and promote health equity. Dental providers with Cabarrus Health Alliance participated in a *Dental Home for Children and Youth with Special Health Care Needs* training provided by a retired dental hygienist with DCFW/WCHS and NC Office on Disability and Health staff members. The texting platform, Text4YourHealth, developed to address health care transition for youth and young adults with intellectual and developmental disabilities was translated into Spanish and piloted among 18 youth with special health care needs. Transition to independent living after high school was also addressed with the development of the *Roadmap to Meaningful Employment & Independence.* This resource is available in English and Spanish and was incorporated into the transition planning in four local school systems.

The Henderson County IA continued its focus on its accessibility initiatives. Its ongoing collaboration with Kids in Parks/TRACK Trails, local parks and recreation, parents, nonprofits, and the health department continued with Accessibility Reviews on trails in Henderson County. Seven reviews were completed that offered recommendations for ways to modify outdoor spaces to increase inclusivity for CYSHCN. In FY22 TRACK Trails was accepted into AMCHP's MCH Innovations Database as a "Cutting-Edge Practice." The TRACK Trails project has not only encouraged CYSHCN and their families to be more active but also resulted in expanded partnerships and plans for additional accessible and inclusive elements in local parks. TRACK Rx works in conjunction with TRACK Trails to encourage clinical providers to prescribe the use of trails to CYSHCN. TRACK Rx program continued to expand into LHDs during FY22.

The Henderson IA also focused on training and improving resource materials for parents of CYSHCN. Training related to Trauma-Informed Practices and Triple P continued through FY22. Care Notebooks were disseminated to more than 100 parents of CYSHCN with plans to develop this resource in an electronic format and translate into Spanish. IA continued to promote the CDC's Learn the Signs, Act Early materials among childcare subsidy, early learning programs, preschools, care management, and nurse visiting programs.

During FY22, all four IA sites experienced significant staffing transitions and vacancies that impacted the reporting and full realization of system changes. The Granville/Vance site was without an IA Coordinator for the first half of FY22, and the new hire was not able to complete some of the original goals before the end of FY22. The IA site in Robeson County experienced staff vacancies throughout FY22 and was unable to fill positions before the end of FY22. The IA Coordinators in both Cabarrus and Henderson IA sites transitioned out of their roles in April 2022. Staff

hiring and training for those sites minimized the ability to complete activities for Q4 of FY22.

Additional Strategies to Support CYSHCN

The SCCNC working collaboratively with the NC CCHSRC, continued to provide training, technical assistance, and support for 78 local CCHCs to develop strategies for the inclusion of CSHCN in the state's 5,605 licensed child care facilities. In the CCHC Service Model, which aligns with *Caring for Our Children* best practice standards, priority of services is given in order of the vulnerability of the children in early care settings, beginning with those serving infants and children with special health care needs.

During FY22 the SCCNC in collaboration with the NC CCHSRC offered monthly professional development opportunities on various topics pertaining to the safe inclusion of CSHCN for children ages 0-5 enrolled in early learning settings. CCHC Learning Collaboratives topics included Inclusive and Accessible Environments, Allergies and Anaphylaxis, Seizures, Diabetes, and Enteral Feedings. 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 physician partners from UNC-CH, ECU and Wake Forest University who served as subject matter experts. On average, 48 CCHCs serving child care facilities across the state participated in the monthly learning collaboratives. The SCCNC and NC CCHSRC began planning for a Learning Collaborative on the topic of asthma for FY23.
The SCCNC continued to participate as a partner with the EarlyWell Initiative to address the social and emotional health of children birth to third grade, including children enrolled in early care and education settings.

The EHDI Advisory Committee continued meeting quarterly and assisted with outreach efforts and program evaluation. EHDI Program staff increased collaborative efforts with other programs and agencies such as CMARC, Family Connects, EIB, MIECHV, NFP, LHDs, WIC, Hands & Voices, National Center for Hearing Assessment and Management (NCHAM), HRSA, CDC, and EHDI programs in other states and territories to influence system change.

To address the 2019 Joint Committee on Infant Hearing best practice guidelines related to risk factors and late onset and progressive hearing loss, a new quality improvement effort focused on the creation of a Parent Education Risk Factor Card was designed. PDSA testing was completed at a few NICUs across the state. After PDSA testing, NC-EHDI decided to make the parent education card available statewide.

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 deaf or hard of hearing and their families. NC-EHDI sponsored two in-person and one virtual Family Fun Day events. The in-person events offered families time to enjoy being together, making connections and participating in fun activities. CARE Connect, a Facebook Live program was continued focusing on timely topics of interest to families of children who are Deaf/Hard of Hearing (D/HH).

NC-EHDI sponsored a virtual The Care Project Parent Professional Collaborative in February 2022. This event brought 80 parents and professionals together for a two-day learning experience covering a range of topics such as Mental Health & Self Care, Social Determinants of Health & Adverse Childhood Experiences, and Finding Joy.

NC-EHDI hired a part-time Spanish speaking parent consultant to increase outreach and engagement with the Hispanic community. NC-EHDI team members are 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.

NC-EHDI, in consultation with the EHDI Advisory Committee, parent partners and other key partners developed a

plan to address diversity and inclusion in the EHDI system. NC-EHDI will utilize departmental wide resources/programs and five priority strategies to reach our goal: 1) Utilize data, research, and evaluation to identify and respond to the causes and consequences of health inequity; 2) Create opportunities for engaging priority populations in planning, implementing, and evaluating EHDI strategies; 3) Collaborate with partners working to positively impact health of priority populations and the determinants of health; 4) Build capacity of EHDI staff to advance health equity; and 5) Use tailored communication strategies to educate partners. EHDI's initial focus area will be the growing Hispanic/LatinX population.

The EHDI Parent Consultants continued coordination of the EHDI Parent Support Team to offer parent-to-parent support for families of children who are D/HH. 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). Three new mentors were added to the team during this reporting period. 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 continues to look for ways to collaborate with and educate partners on these important issues that impact our work. Three sensitivity trainings focused on newborn hearing screeners, pediatric audiologists, and early intervention providers, include information and resources on cultural competency/humility, implicit/unconscious bias, social determinants of health, and health equity. 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 D/HH children that are identified through EHDI programs is limited. With the shift in focus toward evaluating long-term outcomes for children who are D/HH, 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.

The AAP NC EHDI Chapter Champion, who is deaf,: 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) consulted with the NC Pediatric Society and the DCFW/WCHS PMC to identify strategies to share hearing loss information with its members, including presentations at meetings.

The 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) participation in one of the EHDI learning communities focused on expanding the infrastructure for hearing screening beyond the newborn period; 5) attendance at Parents as Collaborative Leader Trainings; 6) attendance at the National EHDI conference; and, 7) co-presenting with EHDI regional consultants at stakeholder 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 continues 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.

NC Office on Disability and Health

The 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 FY22. This integration helped to promote access to care, inclusion and health equity within program practices and policies in collaboration with state and community stakeholders.

NCODH works with LHDs to increase accessibility and inclusion for CYSHCN by providing information, technical assistance and resources and conducting on-site accessibility reviews. Due to the COVID-19 pandemic, NCODH was unable to travel for on-site accessibility reviews for the first part of FY22 but resumed on-site accessibility reviews in April 2022. NCODH provided two on-site accessibility reviews in FY22, with many more scheduled for FY23. As result of recommendations made by NCODH, the North Carolina Local Health Department Accreditation Program recently began requiring LHDs to conduct an accessibility assessment within two years of accreditation, and NCODH is able to assist with these assessments.

Involvement in emergency preparedness efforts continued in FY22 as the NCODH strengthened the partnership with NC Emergency Management (NCEM) and adjusted work to include COVID-19 Response. 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, Shelter Accessibility Workgroup, and FAST (Functional Assessment Support Team) Workgroup. In FY22, 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 related to the COVID-19 Response 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 a 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 collaborated with other partners including the NC Commission on CSHCN Oral Health Workgroup and the I/DD Dental Access Workgroup to ensure that the oral health needs of CYSHCN are being addressed. NCODH participated in presentations for dental providers, specifically addressing accessibility needs and ADA compliance within dental practices.

NCODH continued collaboration with the NC Office of Health Equity (formerly the Office of Minority Health and Health Disparities) to address inclusion of people with disabilities and CYSHCN in efforts to address health equity. NCODH continued to collaborate with NCDHHS Historically Marginalized Population (HMP) Workstreams to ensure the needs of people with disabilities and CYSHCN were addressed during the COVID-19 Response. In FY22, NCODH moved to a leadership position within HMP workstreams and continued working to promote access and inclusion of people with disabilities and CYSHCN. Resources for CYSHCN were included in multiple toolkits, websites, and on flyers; public facing communication materials were reviewed for accessibility and inclusion; and community-based organizations serving people with disabilities and CYSHCN were included in state-wide and local

outreach efforts. To promote equity through access, NCODH led the development of the document *Providing Access for Everyone: Accessibility for COVID-19 Vaccination, Testing and Treatment Sites* which was widely distributed and used by community-based organizations to improve access. NCODH provided multiple trainings in FY22 to community-based organizations, community health workers, and providers to increase awareness of the physical and communication access needs of children and adults with disabilities in context of COVID-19 Response efforts.

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 a 2018-19 baseline of 16.5% to 21.5% by 2025. The 2019-20 NSCH results showed that NC remained at 16.3% and 2020-21 NSCH results show an increase to 20.4% of YSHCN receiving transition services. Regardless, 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 FY22, the IA Director dedicated a portion of her time on Health Care Transition (HCT) and coordinated the work on health care transition at the Branch level. The DCFW/WCHS Transition Work Group, including family representatives from the BFPs, met and reached out to external partners to learn about their efforts and partner with them as appropriate and continue to implement and revise relevant CYSHCN Strategic Plan Recommendations. The Transition Work Group invited the Got Transition center to speak and review their website materials. The PMC participated in a national group with several states (i.e., Texas, Wisconsin, New Mexico) and Got Transition staff to explore how to address health care transition in the school setting and especially with Individualized Education Programs (IEPs). This national group began to explore examples of policy language to help increase and support special education settings in each state. The CYSHCN web page remained a source of information on transition and was updated to include additional resources on a regular basis.

The SMD continued to try to promote communication among academic and community providers working on HCT efforts for YSHCN (I.e., Duke, ECU, Wake Forest Baptist) and with DCFW/WCHS programs to share best practices on a group listserv. The Help Line for CYSHCN linked families to the ECAC, GotTransition.org, and the AAP for transition information and resources. The SHC program continued to emphasize the importance of “on-site” clinical services to support the needs of YSHCN and to support programs, incentives, and educational opportunities that help adolescents transition into all aspects of adult life. SHC’s ensure that all students enrolled or served have a medical home and dental home. Results of all visits to the SHC 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 transition as a requirement of the annual well visit for all adolescents is strongly recommended Division of Health Benefit’s Health Check Program Guide (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 health care transition 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 SMD continued to co-chair the Transition Age Youth (TAY) Work Group with staff members from Fostering Health NC in FY22. A young adult with lived experience has served as co-chair since March 2022 and has helped to plan for all of the bimonthly meetings and participated in five of these 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. Activities included developing and disseminating widely this one-page flyer entitled *Ensuring Health for Young Adults Formerly in Foster* Care. This flyer was vetted by many members of the workgroup and others including the young adult cochair, the Child Welfare Family Advisory Council, and several young adults involved with the Hope Center at Pullen. Through the work group, DCFW/WCHS staff members continued to collaborate with LINKS, NC Child, Youth Villages, Life Skills, CCNC, Medicaid, Strong Able Youth Speaking Out, and other partners to discuss types of educational resources for transition age youth on transitioning to an adult medical home and applying for Medicaid. 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. Five Wishes was chosen and NC state DSS began working on the process to purchase this for use with youth in foster care and to ask Fostering Health NC TAY Work Group to help with training a variety of professionals from groups mentioned already.

Modifications to Agreement Addenda and Contracts

Due to COVID-19 priorities and staff shortages, the DCFW/WCHS Transition Work Group was not able to meet often and explore contract language options to include HCT. However, during FY22, the Child Health Program continued to offer TA related to incorporating HCT into LHD agency policies and included transition information in several training opportunities with LHD staff and CHTP students even though it could not be formally included it in the AA language.

Prophylactic Antibiotics for Children with Sickle Cell Disease

The NC Sickle Cell Syndrome Program provided services to 1,903 clients with sickle cell disease, ages 0 to 21, during FY22. 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 work collaboratively with health care providers to support clients in living healthier lives. Parents with children ages three months to five years with sickle cell disease are 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 is provided during the initial intake process and annually until the child reaches five years of age or as recommended by the hematologist. Additionally, parents are 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 is 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, local health departments, local housing authorities, DSSs, and other agencies including faith-based organizations. Slides for a webinar about penicillin have been drafted and are being reviewed internally, with plans to record and distribute information by June 30, 2023.

Based on feedback obtained from a staff/partner survey done in Fall 2021, the Sickle Cell Education Consultant planned and conducted the following trainings in Spring 2022:

- *Effective Strategies for Working with Parents of Newborns/Children with Sickle Cell Disease* which was done in collaboration with Duke University Comprehensive Sickle Cell Center staff members.
- *Sickle Cell Disease Mental Health Training* which focused on common mental health issues experienced by individuals with sickle cell disease.
- *Comprehensive Sickle Cell Medical Center Updates and Information on New Sickle Cell Research Therapies* which was presented by pediatric and adult hematologists representing all six comprehensive sickle cell medical centers across North Carolina.

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 Women, Infant and Community Wellness Section 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 FY24, 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 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 encourage child health providers in LHDs to improve screening and billing related to SDoH. 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. The Child Health Training Program will be held once during the fiscal year to train new CHERRNs to help LHDs serve as medical homes for children, especially CYSHCN, or work with the child's medical home, and continue program monitoring of services and policies in LHDs. 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 and FP to develop a slide set to use for health care providers and other professionals about family-centered and culturally sensitive care delivery as part of quality medical home approach. 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 from the presentation. 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 FY24, the Title V CYSHCN director will continue to work with DCFW/WCHS staff to review the themes, challenges, and recommendations from Path4CNC convenings and C4CNC advisory group 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 education, support, and trainings to be planned for FY24 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 NC 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 technical assistance 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 Pilot 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. CMARC staff will work with recipients needing extra sustainability with the LME/MCO's related to Behavioral Health I/DD Tailored Plans for a limited timeframe until officially launched. 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 guardian. 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, PT, OT), 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.

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. It will also reach out to the state's largest insurer to begin an active dialogue on private insurance coverage of services for children with special health care needs and explore ways in which private pay 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 children with special health care needs have access to a quality dental home. The Community Alternatives for Children (CAP-C) Workgroup will continue to meet with DHB staff to pilot a tool that was developed to assist providers in completing the CAP-C application process for their patients.

The Commission's recently established Pediatric Home Nursing Crisis 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. Workforce development issues, including salary, education and training will continue to be at the forefront of discussions and recommendations

The CYSHCN Help Line Coordinator and SMD plan to reach out to two additional pediatric medical homes, including those in rural areas, to increase use of the Help Line and to increase conversations about issues coming up for CYSHCN in medical homes in the community. In addition, several staff members from the DCFW/WCHS will continue to serve on the state partner advisory committee of EarlyWell Initiative and promote actions on the recommendations developed from the Medical Home Work Group.

Education, Training and Support for Families Regarding Medical Home

In FY24, a small work group comprised of the FLS, CYSHCN Outreach Staff, and FP will continue work to develop and try to pilot a medical home focused training based on themes, training format, and topic preferences obtained from a "parent training choices" survey that was conducted in the Fall of 2022. 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 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 to determine a timeline and processes to update the CYSHCN Strategic Plan by 2025 which will include strategies to support the family-centered medical home approach. The past Path4CNC and ongoing C4CNC advisory group efforts will also be used to help to determine additional education, support and trainings planned for FY24 for families and youth related to medical home. The DCFW/WCHS also will continue to explore how NC can learn from other states about the use of the Family Voices Family Engagement 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 on COVID-19. The CYSHCN webpage will continue to be updated in FY24 to include more specific information about the use of a medical home and updated as needed using ongoing feedback from the FLS, Access to Care Specialist, FP, and families who visit the website and use the Help Line. 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 FY24 to promote the need to address emergency preparedness for all children including CYSHCN during presentations and discussions with a variety of agencies including but not limited to LHDs, Emergency Medical Services for Children, DSS, pediatricians affiliated with Mountain Children's Network (covering the western part of the state), the NC Medical Society (state chapter of the AMA), 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 the current 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 FY24 which will be easier with the FLS position filled during FY23. The FP 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 across the state and new opportunities for families of CYSHCN will be built on that model. Plans for FY24 include offering a three-module series called *Teaching Children with Disabilities about Sexual Health* and a Medical Home training. 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. Recruiting new FP from the training participant pool will be explored.

In FY24, the FLS will hold regular phone or webinar meetings with the IA Parent Outreach Coordinators to provide support and guidance, as well as host an opportunity for them to share best practices, successes/challenges, and support each other in their work.
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*.

The DCFW/WCHS will continue to offer Triple P Stepping Stones seminar training events in FY24 to further expand into unserved regions of the state or offer a more advanced level of Triple P Stepping Stones to the first cohort of twenty FP who were previously trained. The DCFW/WCHS will also continue to support a parent of CYSHCN who is trained as a Triple P practitioner to attend the quarterly, statewide NC Triple P Learning Collaborative, the Partnership for Strategy and Governance, and the NC Triple P Partners Collaborative.

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 expand family engagement by hiring up to two additional parents of children who are D/HH to serve as part-time EHDI Parent Consultants. The two current EHDI Program Parent Consultants 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.

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 FY24. The newly hired Minority 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 Hispanic/Latino/a/x populations Strategies will be used to strengthen relationships with additional agencies and organizations caring for additional underserved populations including but not limited to refugees, Asian Americans, and American Indians. 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 NC CHW Coordinator in the Office of Rural Health, CHW master trainers, and other agencies involved with revising and providing the CHW certification training is offered through the state's community college system.

Innovative Approaches Initiative

FY24 marks the second 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 minority 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, using websites to share transition resources, and integrating the use of Care Notebooks as a tool that can be used by families of CYSHCN.
- 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.
- 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.
- Support health care transition services and continue to explore ways to involve school nurses and expand training for providers.
- Expand advocacy and education efforts to promote inclusion of CYSHCN in community activities such as YMCA, parks and recreation, and Boys and Girls Clubs.

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 FY24, the 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 FY24 agenda. The Oral Health Workgroup's monitoring of Medicaid Transformation issues will be maintained as oral health remains carved out and

is often left out of the conversation. Careful scrutinizing of the process to end expansion coverage (put in place because of the COVID-19 pandemic) will be a priority.

Additional Strategies to Support CYSHCN

The SCCNC will continue to provide training, technical assistance, and support for 83 local and regional based CCHCs to develop strategies for the inclusion of CSHCN in the state's licensed child care facilities in FY24. 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. The learning collaboratives and accompanying toolkit resources will be created by the SCCNC in collaboration with the NC CCHSRC regional CCHC coaches and staff, as well as subject matter experts on the given topics. The goal of the learning collaboratives is to provide professional development opportunities for CCHCs and provide resources and tools to use in supporting child care providers in caring for and inclusion of CYSHCN in early learning settings in partnership with the child's medical home and specialty providers. Archived webinars and resources from previous learning collaboratives will be accessible to active CCHCs and will continue to be promoted. These archived webinars include the following topics: Inclusive and Accessible Environments; Specialized Enteral Feedings; Diabetes; Seizures; Allergies and Anaphylaxis; Asthma; Responsive Feeding; and Responsive Caregiving and Trauma Informed Practices. Additional CCHC learning collaboratives will be developed in FY24.

The SCCNC, SMD, and CCHSRC staff will partner with the Asthma Alliance of NC to update the Asthma Education Curriculum for Child Care Providers. This will be an additional resource that CCHCs can use when supporting child care facilities caring for children with asthma.

The DCFW/WCHS SPHGC will continue to provide additional trainings and technical assistance for multiple audiences including medical homes about children and youth with and at risk for genetic conditions in FY24. 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 FY24 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 FY24.

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 EHDI Program will be co-sponsoring the 2024 CARE Project + NC EHDI Parent Professional Collaborative in February 2024, and the theme of this conference will be Changing the Culture of Communication. This meeting brings families of D/HH children and the myriad of professionals who work with D/HH children together for a unique opportunity to learn and discuss important topics from both a family and a professional perspective.

The “D/HH Heroes” initiative will be expanded in FY24. 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 FY24, NCODH will continue to provide technical assistance 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.

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 FY24.

Transition Work Group and CYSHCN Strategic Plan HCT Recommendations

Due to staffing issues in FY23, the Medical Home Work Group was only able to meet twice. However, DCFW anticipates staff during FY24 to restart Medical Home Work Group to address medical home broadly and include transition as a significant component of the medical home approach. Several DCFW/WCHS staff members on this workgroup (SMD, Adolescent Health Coordinator, Help Line Coordinator, and FP) will restart and coordinate efforts on medical home and HCT at the Section level.

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. TA and consultation provided by the state and regional child health nurse consultants and SMD to LHDs will continue to include 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 FLS, Access to Care Specialist, SMD and other DCFW/WCHS staff in partnership with staff from ECAC will continue to explore strategies to address HCT. The Help Line for CYSHCN 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. As a result, the Transition Age Youth Work Group will no longer exist. The SMD will partner with the former co-chair who is a young adult who was formerly in foster care and DSS to incorporate HCT work into existing work groups in FY24. One idea is to embed into DSS' design team more efforts to increase engagement, retention, and active and consistent participation from multiple young adults who have been in foster care. This will involve including 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 as directed by DSS. These materials and trainings share strategies to increase use of shared decision making and informed consent about preventive health, sick care, mental health, and oral health services, and to ensure that youth have access to this 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, and Access to Care Specialist and Commission for CSHCN will continue to be involved with providing feedback on the foster care specialized plan being developed by DHB and try to work with DSS to share information about the Support Act that allows youth who were formerly in foster care in other states to be able to be on Medicaid in NC until age 26. The DSS Well-Being Design Team will work with DSS to explore the need for additional agency training and guidance to help social workers to support shared decision making with young adults about how to choose a health care power of attorney and decide what young adults want related to life-saving measures in a living will using a document for advance care planning called Five Wishes: https://www.fivewishes.org/for-myself/.

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. In addition, the Commission on CSHCN Behavioral Health Workgroup will continue to monitor and provide feedback on North Carolina's Children and Families Specialty Plan.

Modifications to Contracts

The Medical Home and Transition Work Group will 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 will continue to carry out newborn screening follow up efforts to infants that have an abnormal hemoglobin result when tested at birth in FY24. Sickle Cell Educator Counselors and CBO SC staff will contact, and schedule follow up appointments with parents to provide one-on-one information to parents and family members about sickle cell disease and its complications, will 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.

During FY24, the Sickle Cell Education Consultant, in collaboration with Sickle Cell Educator Counselors and CBO sickle cell staff members, will continue to incorporate the use of the prophylactic antibiotics toolkit (prophylactic penicillin protocol) for parents that includes information about the importance of prophylactic antibiotics for children with sickle cell disease. Sickle Cell Educator Counselors will 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 as required in writing and in the WCS-Web Database.

The Sickle Cell Education Consultant, along with hematologists from two of the six sickle cell comprehensive medical centers, will complete work on the provider webinar with the purpose of educating them on the importance of prophylactic antibiotics for children living with sickle cell disease. The Sickle Cell Education Consultant and planning team will finalize work on a plan to promote the webinar and develop a post-webinar questionnaire to measure the increase in knowledge gained. The webinar will be conducted in fall 2023 and will be archived on the NC Sickle Cell Syndrome Program’s website.

CDSA Nutritionist Sharing Calls

In FY24, the PNC will continue biannual networking calls with regional CDSA nutritionists, and topics again will be chosen by the RDN’s 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
Annual Objective			2.3	2.5
Annual Indicator	2.7		2.7	2.4
Numerator	12.5		12.8	12.1
Denominator	4.7		4.8	5.1
Data Source	NC Vital Statistics/SCHS		NC Vital Statistics/SCHS	NC Vital Statistics/SCHS
Data Source Year	2019		2020	2021
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	2.3	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
Objectives
CCSB 8A.1. The percent of NC Title V Program staff who complete the Health Equity Foundational Training annually will be at least 90%.
CCSB 8A.2. The percent of NC Title V Program staff who complete the HE Foundational Training within 3 months of hire will be 100%.
Strategies
CCSB 8A.1. Deploy the DPH Health Equity Survey within the NC Title V Program.
CCSB 8A.2. Launch DPH Health Equity Foundational Training in Learning Management System.
CCSB 8A.3. NC Title V Program will identify how they are currently incorporating the NCDHHS Health Equity Framework strategies into their work.
CCSB 8A.4. NC Title V Program will identify additional ways they can incorporate the NCDHHS Health Equity Framework strategies into their work.
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.

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

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.

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

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.

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 maternal and child health 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. 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 decreased slightly from 2014 to 2021, from 2.51 to 2.37, but this disparity ratio fluctuated from a low of 2.29 in 2015 to a high of 2.83 in 2020. The 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, although in 2021, the Black rate did drop to 12.1. In addition to being a 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 Early Childhood Action Plan, and an indicator in Healthy North Carolina 2030.

The WICWS houses several programs/initiatives (Healthy Beginnings, Healthy Start Baby Love Plus, Improving Community Outcomes for Maternal and Child Health, 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.

DPH Health Equity Framework

The NC Title V Office, the WICWS, and the DCFW/WCHS are working on eliminating disparities and increasing health equity in various ways including providing staff training, creating health equity teams, and ensuring that data are analyzed by race/ethnicity and other demographics as much as possible. The Division's Health Equity Committee developed a Health Equity Framework released in 2020 with these five priority strategies:

1. Utilize data, research, and evaluation to identify and respond to the causes and consequences of health inequity
2. Create opportunities for engaging priority populations in planning, implementing, and evaluating DPH strategies
3. Collaborate with partners working to positively impact health of priority populations and the determinants of health
4. Build capacity of Division staff to advance health equity
5. Use tailored communication strategies to educate partners

While work on structurally embedding these strategies into the work of the NC Title V Program has been limited due to the ongoing DHHS reorganizations, the need for implementing this framework or other health equity strategies was magnified due to the longstanding health inequities brought to light by the pandemic. NCDHHS has also been engaged with the new Office of Health Equity collaborating on intentional work to embed health equity, in particular

around the NCDHHS priority areas.

DPH Foundational Health Equity Training

The SDoH COIIN team, which was shepherded by a member of the WICWS and a colleague with the NC Chapter of the March of Dimes, developed a foundational health equity training module which was scheduled to be released to all DPH employees as a module in the Learning Management System (LMS) during FY21. The training uses components of the *Health Equity and Environmental Justice 101* training created by the Colorado Department of Public Health and Environment's Office of Health Equity as well as videos and other materials specific to NC. Due to a variety of reasons, mostly because of the pandemic workload, but also because of the reorganization plans for a new Office of Health Equity and the hiring and re-hiring of the Department's first Chief Health Equity Officer (one was hired in October 2021, but left, and another Chief hired in June 2022), the training has not yet been approved for use by NCDHHS. The initial plan was for the training to be required of every Title V Program employee, thus Objectives CCSB 8A.1. (% of NC Title V Program staff who complete the Health Equity Foundational Training annually will be at least 90%) and CCSB 8A.2 (% of NC Title V Program staff who complete the HE Foundational Training within 3 months of hire will be 100%) should be achievable and easily tracked and monitored in LMS once it is completed. After receiving the training, employees will be invited to participate in debrief sessions held by trained facilitators. It is hoped that this foundational training will ensure that all employees have a basic understanding of health equity principles, but that the learning will not stop with just this training. Other resources will be offered within the module, and the NC Title V Program will continue to encourage professional development and continuing education by staff members in this area.

While the foundational health equity training module has not been implemented, Unconscious Bias training modules were assigned to all Cabinet agency employees, which includes all NCDHHS employees, through LMS during FY22. 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.

DPH Health Equity Survey

In January 2020, the DPH Health Equity Committee conducted the DPH Health Equity Survey using a stratified random sample sampling design with organization units as strata. This survey was designed to measure how Division staff members understand and practice health equity at work by measuring the extent to which they 1) recognized the influence of social factors on health, 2) had a knowledge of foundational terms and concepts, and 3) recognized DPH Health Equity Framework strategies as components of their own work activities. The survey was intentionally deployed prior to release of the DPH Health Equity Framework so that a true baseline of health equity knowledge and practices could be obtained. The survey, which was optional, not required, was sent to 408 employees and yielded a 55% response rate. Initial results showed that while 86% of respondents were knowledgeable about the term health disparity, only 53% were knowledgeable about the term health equity. With regard to the five framework priority strategies, respondents agreed that all were important to their roles (range from 51% for "Build capacity of Division staff to advance health equity" to 72% for "Collaborate with partners to impact the health of priority populations"), but not as many respondents thought that these strategies were actually a part of their role, in particular to "Build capacity of Division staff" (29%) and "Create opportunities to engage priority populations in planning, implementing, and evaluating strategies" (34%). In response to the question of "In your opinion, how much does DPH focus on addressing health inequities?", 28% said the right amount, 32% said not enough, 1% said too much, and 39% said they did not know.

The NC Title V Program conducted this same survey in December 2020 with all of its staff members to get baseline data for the percent of NC Title V Program respondents to the DPH Health Equity Survey who agree that the five strategies are important to their work in DPH and also the percent of NC Title V Program respondents who can appropriately define the terms health equity, health disparity, and determinants of health. With an overall survey response rate of 48%, the results indicate that there is still much work to be done as only 51% of respondents could define health equity. More respondents (88%) could define health disparity, and while 90% or better identified income, employment, housing, education, and social supports as determinants of health, only 43% of respondents identified leadership as a determinant, and 47% identified political influence as one. Thirty-four percent of respondents thought that there is not enough focus on health inequities within DPH and 31% of respondents thought there was not enough focus within the NC Title V Program. The majority of respondents said that the DPH Health Equity Framework strategies were important to their work, with the highest percentage (78%) agreeing that two strategies (using tailored communication strategies to educate partners and collaborating with partners working to positively impact health of priority populations and the determinants of health) were the most important. DPH conducted an expanded follow-up survey during summer 2022 to inform the direction of the newly formed Diversity, Equity, and Inclusion (DEI) Council, and the questions, while they build on the baseline survey, are not comparable. The NC Title V Program did not conduct a survey in 2021 or 2022 and is determining how often the survey should be done internally and how to align activities now across DPH, DCFW and NCDHHS with the new Office on Health Equity.

Additional NC Title V Program Health Equity Plans and Activities

In the scope of work in the agreement addenda 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 has posted the *Resources for Promoting Health Equity – September 2021* training resource sheet on their website.

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. Connected to this effort also included planning the reinstatement of the Reading Circle. The Reading Circle allows for staff in WICWS and others to convene to discuss a specific book related to equity and/or social determinants of health. The Reading Circle reconvened in FY23.

The DCFW/WCHS convened a Health Equity Continuous Quality Improvement Team whose mission was to:

1. Promote the DPH Health Equity Foundational Training.
2. Encourage participation in and analyze results of DCFW/WCHS staff responses to the DPH Health Equity Survey to share back with the Section.
3. Assign a Health Equity Team member to each Branch within the DCFW/WCHS to discuss the Health Equity Foundational Training and develop next steps in implementing health equity strategies in staff workplans.
4. Review contracts and LHD agreement addenda to incorporate health equity strategies.

Unfortunately, due to the COVID-19 pandemic, staff changes, and competing priorities, this specific CQI effort was

put on hold.

Social Determinants of Health

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 focused on whole-person health as NC moves 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 HOP 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.

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.

NC's Title V MCH Block Grant continued to support 100% of the salary of the WCHS/DCFW Pediatric Nutrition Consultant (PNC) in FY22. 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 her capacity as the DCFW/WCHS, the PNC, a registered dietician nutritionist, provides nutrition expertise, training and technical assistance for regional school nurses and child health consultants and for all of the Sections' programs. She also regularly mentors nutrition/dietetic students who help support and expand nutrition contributions. During FY22 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 CHERRN course and through other programs, including work with programs that specifically target CYSHCNs. During FY22, the PNC updated and recorded the Well Child Nutrition Risk Screening webinar and the Well Child Nutrition Risk Screening, Healthy Feeding Relationships, Breastfeeding & Food Insecurity virtual training for the CHTP CHERRN training program.

The PNC co-leads (and helped form) the NC Farm to Preschool Network (NCF2PN) and the Farm to School Coalition of NC, two statewide coalitions. The NCF2PN received a three-year Farm to Early Care and Education (ECE) Implementation Grant (FIG) in FY21 from the Association of State Public Health Nutritionists (ASPHN). North Carolina and 10 other states received technical assistance, training, and funding ($90,900 for year 1 and 2 and $60K in year 3) to advance equitable farm to ECE initiatives at the state and local level through policy, systems, and environmental changes. In September 2021, NCF2PN did a midyear evaluation which the PNC helped write, and, out of the 30 centers/homes awarded FIG mini-grants, 23 created edible gardens, 17 taught lessons on locally grown food, 16 served local food in meals, snacks, and/or taste tests, and 10 visited a local farm, community garden, farmers market or had a farmer visit the classroom. Many other positive outcomes have occurred with this funding.

The PNC also co-led the writing and dissemination of the NCF2PN's 2021 NC Farm to ECE Survey result products/resources (including a one-page infographic, an Executive Summary, the Full Report, and a Sharing Toolkit). Launched in early 2021 and completed by 656 ECE providers in 83 of NC's 100 counties, the survey assessed activities, strengths, challenges, resource needs, and program characteristics. Survey results were used by the NCF2PN Advisory Committee and its partners to address expressed needs by ECE providers and to enhance the work of the Network. The PNC serves in a variety of leadership roles within NCF2PN, serving on the Advisory Committee, Steering Work Group/FIG Grant Leadership Team, Resources Workgroup, and Systems Change Workgroup. The PNC also serves similar roles with the Farm to School Coalition of NC (Steering Committee, Resiliency Workgroup, etc.).

During FY22, the PNC also continued her active involvement in the ASPHN through the MCH Nutrition Council and the Fruit and Vegetable Nutrition Council, and the PNC, Diane Beth, received their 2022 Outstanding Leadership for the MCH Nutrition Council award. This award recognizes outstanding leadership in expanding ASPHN's contribution to improving the health and wellbeing of the MCH population.

She also continued collaborative partnerships with the NC Partnership for Children; Go NAPSACC; the CDIS SPAN grant staff, the State Child Care Health Consultant, CNSS, Eat Smart, Move More NC, the State Nutrition Action Coalition, NC DPI School Nutrition Services, PHEC, 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.

During FY22, the PNC was advising and providing technical nutrition expertise to the DHB/Medicaid on Food/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. The nine Food/Nutrition Services in HOP include: Food and Nutrition Access Case Management Services; Evidence-Based Group Nutrition Classes; Diabetes Prevention Programs (DPP); Fruit and Vegetable Prescriptions; Healthy Food Boxes (Delivery and/or Pick-up); Healthy Meals (Delivery and/or Pick-up); and Medically Tailored Home Delivered Meals. During FY22, the PNC helped DHB by answering questions coming in from local implementing groups, assisting with a recorded training for Care Managers on HOP Food Services, helping plan for the operationalization of the HOP Food Services Operational Guidelines and Best Practices Working Group, and raising nutrition issues related to HOP where infants/children are the primary recipient of one of the nine Food/Nutrition Services.

The PNC also continued to facilitate quarterly networking calls with six nutritionists employed by regional CDSAs during FY22. The purpose of the calls was to discuss topics of common interest pertaining to nutrition care and medical nutrition therapy of infants and toddlers with special health care needs. Call topics included: getting feedback from the nutritionists on possibilities of Medically Tailored Meals for CSHCN as part of Healthy Opportunities Pilots; impact of DCFW formation on CDSA nutritionists, and other topics and case studies brought by the CDSA nutritionists.

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 and SNAP-Ed into closer alignment and synergy to address whole child and family health and nutrition (including food/nutrition security). In FY22, many collaborative projects were continued or started including data sharing agreements between SNAP, WIC, and Medicaid to increase cross-program referral and enrollment.

COVID-19 caused so much stress and hardship for individuals, children, and families in North Carolina, 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. This critical work, as part of the overall COVID-19 response in North Carolina, continued in FY22.

Cross-Cutting/Systems Building - Application Year

Priority 8 – Increase Health Equity, Eliminate Disparities, and Address Social Determinants of Health

With the COVID-19 pandemic exposing more fully the ongoing social and racial injustice and inequity in public 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 two years, including the creation of a Chief Health Equity Officer, a revitalized Office of Health Equity, and the new DCFW, along with the workload of many NC Title V Program staff members shifting during the COVID-19 pandemic, several planned activities have had to be reassessed for alignment and implementation, but will carry over into FY24. In FY24, NCODH will continue to build on this collaboration to promote the needs of CYSHCN through leadership roles within HMP Workstreams and ongoing work to address communication and physical access needs of people with disabilities, CYSHCN and their families.

Health Equity Framework

Promoting health equity remains a key goal for NCDHHS as illustrated by the NCDHHS Health Equity Portfolio, as well “Advance equity” as 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 (both hired in spring 2022) work together with the Assistant Secretary of Equity and Inclusion to determine next steps for NCDHHS with work across Divisions, the NC Title V Program will determine its next steps as well, not only regarding the previously released NC DPH Health Equity Framework, but also with regard to the Foundational Health Equity Training module for LMS and the Health Equity Survey. In addition, the work of the DPH DEI Council, which includes members from the NC Title V Program, continues 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 DEI; Office of Rural Health; and Office of Health Equity) is working on how best to operationalize these different pillars. In addition to the Framework, the Health Equity Portfolio has created a DEI Governance Model which has been 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 Plans and Activities

The WICWS will continue to require that all contractors’ staff who are working in a specific WICWS program, inclusive of LHDs, community-based organizations, hospitals, and universities participate in at least one annual training focused on health equity, health disparities, or social determinants of health in FY24. The WICWS will also continue implementing the Reading Circle as a venue for staff to discuss books representing various backgrounds and perspectives related to equity. In addition, the RHB added a Reproductive Justice staff position in May 2023 which will help drive both the work of the Branch and the Section. 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. The DCFW/WCHS is committed to reconvening its Health Equity Continuous Quality Improvement Team to continue its work as well. With the NC Title V Director now supervising the CDIS, there should

be more opportunity for collaboration between WICWS, DCFW/WCHS, and CDIS around a CDC grant focused on health equity that is currently housed in the CDIS.

Social Determinants of Health

As shared earlier, addressing SDoH is foundational to the PHSP and ECAP and a priority for NCDHHS. The updated PHSP will continue prioritizing SDoH including addressing poverty and racism, while strengthening collaboration with communities and other entities leading these efforts. In FY24, the NC Title V Program will continue to address SDoH as part of its programs and support the work being done by NCDHHS through its HOP and NCCARE360.

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, as highlighted in the NCDHHS State Action Plan for Nutrition Security released in April 2023. The action plan leverages programs like 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 during the pandemic.

There are many plans for work to continue in FY24 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.

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 with work by the DPH DEI Council and through work under the NCDHHS Health Equity Framework where feasible and reasonable. One planned activity is to update and disseminate a NC Federal Nutrition Food Assistance Program resource that the PNC developed in 2019. 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 Food and Nutrition Services Section.

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 FY24, the PNC and the SMD will continue to integrate food insecurity trainings into child health and specific nutrition trainings targeted in the CHTP for CHERRNs and continue to share these nutrition/food insecurity 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, and WIC. In addition, the PMC 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 providers.

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 state and regional child health nurse consultants 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) on the Fostering Health NC Transition Age Youth Work Group 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, 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 plans to develop 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

The NC Title V Program appreciates the assistance received from MCHB regarding the NCDHHS realignment to ensure that Title V requirements are met, as well as the connections to other States to consider lessons learned.

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
- MIECHV – Home Visiting Improvement Action Center Team (HV-ImpACT) for data and CQI
- 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.
- ASTHO – School Behavioral Health
- MCH Workforce Development Center's Advancing Equity Learning Collaborative
- NASHP Contraceptive Care Access

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 (There has been ongoing interest in NC to implement a FIMR and recommendations through the Child Fatality Task Force on the Child Fatality Prevention System for ongoing improvement, which may include the development of a FIMR. The CFTF worked with partners to draft potential legislation proposing necessary funding to implement these recommendations, but this has not moved forward at the time of this application/report.)
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 - NC TItle V-Medicaid IMOA MOU FY24.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Glossary of Acronyms Used in the FY24 NC MCHBG Application.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FY24 MCH Block Grant Application O-Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: North Carolina

	FY 24 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	$ 6,933,924	(36.7%)
B. Children with Special Health Care Needs	$ 7,405,979	(39.2%)
C. Title V Administrative Costs	$ 211,572	(1.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 14,551,475	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 46,722,582	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 65,322,845	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 70,327,754	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 182,373,181	
A. Your State's FY 1989 Maintenance of Effort Amount $ 29,063,379		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 201,244,913	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 435,531,229	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 636,776,142	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 129,675
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 2,012,757
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 233,373,435
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 12,447,118
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 259,448
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood	$ 298,628
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 443,071
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) > Office of Population Affairs (OPA) > Title X Family Planning	$ 6,050,110
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
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,071,406
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 241,952
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Children's Health Insurance Program Reauthorization Act (CHIPRA)	$ 251,686
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 18,935,466
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 110,138,430

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,756,901
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 3,538,541
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > SIckle Cell Funding	$ 252,294
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > COVID Immunization Funding	$ 36,410,396

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 18,806,308 (FY 22 Federal Award: $ 17,916,623)		$ 16,451,537	
A. Preventive and Primary Care for Children	$ 6,357,173	(33.8%)	$ 5,789,181	(35.1%)
B. Children with Special Health Care Needs	$ 7,339,060	(39%)	$ 6,730,265	(40.9%)
C. Title V Administrative Costs	$ 251,032	(1.3%)	$ 377,672	(2.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 13,947,265		$ 12,897,118	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 37,169,426		$ 45,802,293	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 65,371,749		$ 57,707,314	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 73,859,576		$ 70,327,753	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 176,400,751		$ 173,837,360	
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)	$ 195,207,059		$ 190,288,897	
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)	$ 456,342,218		$ 390,961,113	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 651,549,277		$ 581,250,010	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 4,347,563	$ 3,426,577
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,229,216	$ 1,476,030
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 933,785	$ 0
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 152,500,591	$ 94,534,417
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Children's Health Insurance Program Reauthorization Act (CHIPRA)	$ 251,175	$ 51,254
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,066	$ 183,059
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 4,450,000	$ 3,096,626
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 2,904,835	$ 1,712,819
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 7,164,114	$ 7,636,536
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 12,230,672	$ 7,262,581
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 242,814	$ 64,238
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood	$ 518,821	$ 188,769
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 237,222,422	$ 168,809,680

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,981,895	$ 1,145,963
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 120,639	$ 98,028
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 256,416	$ 2,515,855
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 197,894	$ 441,235
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > COVID Immunization Funding	$ 28,287,006	$ 98,013,960
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sickle Cell Funding	$ 252,294	$ 303,486

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2022**
	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. Since funds can be spent within two years, funds are rarely left unexpended.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: The variance is due to pay and benefit increases passed by the NC General Assembly.	
3.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Newly appropriated state funds totaling $7.2 million (one of which leverages federal funding - Nurse Family Partnership $1.5M) accounts for the variance between budgeted and expended amounts.	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Per the State Budget Act, 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%.	

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 1,242,236	$ 1,136,188
2. Infants < 1 year	$ 1,465,770	$ 1,075,550
3. Children 1 through 21 Years	$ 6,933,924	$ 5,789,181
4. CSHCN	$ 7,405,979	$ 6,730,265
5. All Others	$ 1,612,251	$ 1,342,681
Federal Total of Individuals Served	$ 18,660,160	$ 16,073,865

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 47,740,787	$ 42,254,266
2. Infants < 1 year	$ 21,245,596	$ 19,206,170
3. Children 1 through 21 Years	$ 58,038,446	$ 58,312,037
4. CSHCN	$ 26,885,262	$ 27,881,580
5. All Others	$ 27,305,836	$ 25,667,193
Non-Federal Total of Individuals Served	$ 181,215,927	$ 173,321,246
Federal State MCH Block Grant Partnership Total	$ 199,876,087	$ 189,395,111

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 14,823,204	$ 13,363,293
3. Public Health Services and Systems	$ 4,048,528	$ 3,088,244
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	$ 16,451,537

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 29,525,157	$ 27,485,664
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 14,554,421	$ 12,821,945
B. Preventive and Primary Care Services for Children	$ 13,632,493	$ 13,632,493
C. Services for CSHCN	$ 1,338,243	$ 1,031,226
2. Enabling Services	$ 141,881,714	$ 137,887,929
3. Public Health Services and Systems	$ 6,872,691	$ 7,486,826
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		$ 27,485,664
Direct Services Line 4 Expended Total		$ 27,485,664
Non-Federal Total	$ 178,279,562	$ 172,860,419

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIB. - Other - Other**
	Fiscal Year:	**2024**
	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: 122,733 **Data Source Year: 2021**

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	120,585 (98.2%)	1,537	336	336 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	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)	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			

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn Hearing	121,678 (99.1%)	5,367	245	245 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Title V Program provides long-term follow-up for people with Sickle Cell disease and provides short-term follow-up for the other genetic conditions. Long-term follow-up and medical management is transitioned to sub-specialists.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

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 2022

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	19,347	51.0	0.0	5.0	16.0	28.0
2. Infants < 1 Year of Age	6,412	68.0	0.0	3.0	5.0	24.0
3. Children 1 through 21 Years of Age	81,057	70.3	0.0	3.3	13.4	13.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	49,165	83.5	0.0	0.2	16.3	0.0
4. Others	9,054	36.6	0.0	17.6	42.2	3.6
Total	115,870					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	120,466	No	119,776	90.0	107,798	19,347
2. Infants < 1 Year of Age	122,683	No	123,698	99.1	122,585	6,412
3. Children 1 through 21 Years of Age	2,767,195	Yes	2,767,195	14.0	387,407	81,057
3a. Children with Special Health Care Needs 0 through 21 years of age^	636,561	Yes	636,561	11.0	70,022	49,165
4. Others	7,670,797	Yes	7,670,797	0.9	69,037	9,054

^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 2022, 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:	**2022**
	Field Note: Data source is Special Report of LHD-HSA data run by State Center for Health Statistics.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	Field Note: Data source is Special Report of LHD-HSA data run by State Center for Health Statistics.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Data source for Children Age 1 through 21 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:	**2022**
	Field Note: This is based on FY22 CMARC data from the CareImpact database and FY22 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:	**2022**
	Field Note: 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:	**2022**

	Field Note: Approximately 90% of obstetrical care providers (public and private) in the state are participants in the Pregnancy Management Program.	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2022**
	Field Note: Data source is the 2022 State Center for Health Statistics Provisional Birth Files for Resident Live Births of April 11, 2023	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: 99.1% of all infants received newborn hearing screening.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: Data source is the 2022 State Center for Health Statistics Provisional Birth Files for Occurrent Live Births of April 11, 2023	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Includes: 5 year-olds in 2022 per Census Bureau Population Estimates as all have received kindergarten health assessments and immunizations histories have been reviewed (122,585); Average monthly participation count of children being served by WIC (144,302) in FY22 - preliminary data as of 6/9/23; and the number of 12 year-olds in 2022 per Census Bureau Population Estimates as all are required by law to have received immunizations for school (131,294).	
6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Includes: CMARC, CYSHCN Help Line, Early Intervention Infant Toddler Program, and Help Line Outreach.	
7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**

Field Note:
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 2022

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	116,755	59,947	26,888	19,449	1,319	4,488	130	3,364	1,170
Title V Served	115,820	59,467	26,673	19,293	1,308	4,452	129	3,337	1,161
Eligible for Title XIX	62,435	22,419	20,533	14,393	1,043	1,206	80	2,088	673
2. Total Infants in State	118,309	58,435	27,565	21,457	1,230	3,746	115	5,761	0
Title V Served	117,362	57,968	27,344	21,285	1,220	3,716	114	5,715	0
Eligible for Title XIX	65,670	23,856	21,363	15,091	1,060	1,311	86	2,193	710

Form Notes for Form 6:

Data from the 2021 NC Composite Linked Birth File are not yet available from the NC State Center for Health Statistics, so 2020 data have been repeated. Data on the number of deliveries in the state and how many births and infants are eligible for Title XIX were obtained from the 2020 NC Composite Linked Birth File. The number of infants in the state is from the US Census Bureau (State Characteristics Datasets: 2020 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 2020 (99.2%) by the total number of deliveries and infants.

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: North Carolina

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 737-3028	(800) 737-3028
2. State MCH Toll-Free "Hotline" Name	CYSHCN Help Line	CYSHCN Help Line
3. Name of Contact Person for State MCH "Hotline"	Holly Shoun	Holly Shoun
4. Contact Person's Telephone Number	(919) 707-5605	(919) 707-5605
5. Number of Calls Received on the State MCH "Hotline"		486

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://dph.ncdhhs.gov/	
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites	https://twitter.com/ncpublichealth	
6. Number of Hits to the State Title V Program Social Media Websites		

Form 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	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: North Carolina

Application Year 2024

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 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

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 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 11 - Notes:

None

Data Alerts: None

NOM 12 - 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)

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

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	12.3 %	1.4 %	262,686	2,143,250
2019_2020	10.3 %	1.3 %	222,159	2,159,542
2018_2019	10.6 %	1.2 %	226,185	2,140,915
2017_2018	10.5 %	1.4 %	228,629	2,169,962
2016_2017	10.6 %	1.4 %	232,089	2,188,748
2016	12.1 %	1.7 %	258,785	2,147,521

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 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	10.2	0.7	212	2,075,212
2018_2020	9.4	0.7	193	2,061,614
2017_2019	8.9	0.7	182	2,048,817
2016_2018	9.2	0.7	187	2,030,330
2015_2017	8.9	0.7	179	2,007,053
2014_2016	9.4	0.7	187	1,983,550
2013_2015	8.5	0.7	167	1,965,337
2012_2014	7.8	0.6	152	1,955,097
2011_2013	6.7	0.6	131	1,955,777
2010_2012	6.9	0.6	135	1,963,873
2009_2011	7.8	0.6	154	1,976,599
2008_2010	7.7	0.6	152	1,980,406
2007_2009	7.4	0.6	145	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 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	22.1 %	1.5 %	507,316	2,292,411
2019_2020	22.0 %	1.6 %	504,402	2,288,946
2018_2019	21.7 %	1.5 %	498,468	2,293,539
2017_2018	21.2 %	1.7 %	485,743	2,294,344
2016_2017	21.1 %	1.7 %	480,138	2,278,464
2016	21.6 %	1.9 %	489,644	2,265,402

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 17.1 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	11.0 %	1.9 %	55,911	507,316
2019_2020	15.9 %	2.6 %	80,202	504,402
2018_2019	18.1 %	2.6 %	90,187	498,468
2017_2018	14.7 %	2.4 %	71,213	485,743
2016_2017	15.5 %	2.8 %	74,633	480,138
2016	18.9 %	4.2 %	92,477	489,644

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 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.3 %	0.4 %	43,973	1,937,566
2019_2020	3.2 %	0.6 %	62,087	1,947,019
2018_2019	3.1 %	0.6 %	59,792	1,919,851
2017_2018	1.8 %	0.4 %	34,874	1,942,945
2016_2017	1.7 %	0.4 %	33,264	1,954,259
2016	2.0 %	0.5 %	38,859	1,915,311

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 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	12.6 %	1.3 %	242,850	1,930,603
2019_2020	13.9 %	1.5 %	268,940	1,941,691
2018_2019	12.4 %	1.3 %	236,329	1,906,762
2017_2018	10.3 %	1.4 %	199,401	1,930,627
2016_2017	10.5 %	1.4 %	203,098	1,941,172
2016	10.4 %	1.4 %	197,676	1,898,666

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 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	51.8 %	5.1 %	160,319	309,456
2019_2020	48.7 %	5.6 %	141,080	289,676
2018_2019	52.7 %	5.2 %	141,170	268,024
2017_2018	50.6 %	6.1 %	121,773	240,512
2016_2017	43.2 %	6.4 %	95,209	220,209
2016	45.7 %	7.3 %	97,945	214,300

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 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	89.0 %	1.4 %	2,032,495	2,283,690
2019_2020	90.5 %	1.3 %	2,067,522	2,285,006
2018_2019	91.1 %	1.0 %	2,085,839	2,290,068
2017_2018	88.7 %	1.6 %	2,034,995	2,294,344
2016_2017	89.1 %	1.6 %	2,027,301	2,276,068
2016	89.6 %	1.6 %	2,025,041	2,260,610

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 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

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**
2020_2021	21.0 %	2.3 %	208,597	993,423
2019_2020	19.8 %	2.7 %	198,400	1,001,497
2018_2019	16.1 %	2.5 %	156,262	972,744
2017_2018	13.5 %	2.4 %	133,707	992,873
2016_2017	13.1 %	2.3 %	131,585	1,000,931
2016	12.6 %	2.0 %	113,147	898,624

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 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

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 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	3.9 %	0.7 %	90,030	2,287,770
2019_2020	3.1 %	0.7 %	69,995	2,284,363
2018_2019	3.1 %	0.7 %	71,828	2,280,941
2017_2018	3.5 %	0.8 %	79,386	2,266,104
2016_2017	2.9 %	0.8 %	65,333	2,259,072
2016	2.7 %	0.8 %	60,460	2,265,402

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 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: North Carolina

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			78	78	78
Annual Indicator		77.6	76.1	75.8	75.9
Numerator		1,412,575	1,386,809	1,385,665	1,383,829
Denominator		1,820,993	1,823,266	1,827,713	1,822,669
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	79.0	79.0	80.0

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	90	90	90	90	90
Annual Indicator	77.3	76.7	80.1	75.1	73.9
Numerator	1,560	1,269	1,375	1,253	1,266
Denominator	2,017	1,654	1,717	1,668	1,714
Data Source	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	90.0	90.0	90.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	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:**	**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.	
3.	**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.	
4.	**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.	
5.	**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.	

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80	84	85	85	85
Annual Indicator	84.9	82.5	80.3	85.0	83.4
Numerator	103,683	88,249	90,222	91,471	92,086
Denominator	122,165	106,953	112,365	107,553	110,468
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	85.0	85.0	85.0

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	24	25	26	26.5	27
Annual Indicator	27.0	23.4	23.3	20.2	22.1
Numerator	31,775	24,051	25,865	21,416	24,009
Denominator	117,705	102,887	111,143	106,047	108,844
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	27.5	28.0	28.0

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	62	50	50	50	50
Annual Indicator	44.4	43.0	48.1	55.8	39.5
Numerator	120,289	112,720	119,658	123,695	94,883
Denominator	270,809	261,906	249,001	221,849	240,161
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	50.0	50.0	50.0

Field Level Notes for Form 10 NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	83	83	83	87.5	83
Annual Indicator	81.0	81.0	87.3	81.6	72.4
Numerator	638,902	638,902	786,182	698,073	588,143
Denominator	788,733	788,733	900,582	855,558	812,116
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	83.0	85.0	85.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	60	50	45	48.5	48.5
Annual Indicator	46.9	41.0	48.4	45.2	36.3
Numerator	225,282	199,181	241,421	227,867	184,239
Denominator	480,138	485,743	498,468	504,402	507,316
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	49.0	49.0	50.0

Field Level Notes for Form 10 NPMs:

None

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
Annual Objective			59.7	60
Annual Indicator	55.9		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
Data Source Year	2019		2020	2020
Provisional or Final ?	Final		Final	Provisional

Annual Objectives

	2023	2024	2025
Annual Objective	60.3	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.

SPM 2 - Percent of women who smoke during pregnancy

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			8.1	7
Annual Indicator	7.6		6.8	5.6
Numerator	8,991		7,923	6,756
Denominator	118,725		116,755	120,501
Data Source	NC Vital Statistics/SCHS		NC Vital Statistics/SCHS	NC Vital Statistics/SCHS
Data Source Year	2019		2020	2021
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	6.8	6.7	6.5

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

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	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
Annual Objective			90	90
Annual Indicator	80.1		75.9	76.5
Numerator				
Denominator				
Data Source	2017-19 National Immunization Survey		2018-20 National Immunization Survey	2019-2021 National Immunization Survey
Data Source Year	2019		2020	2021
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	90.0	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
Annual Objective			2.3	2.5
Annual Indicator	2.7		2.7	2.4
Numerator	12.5		12.8	12.1
Denominator	4.7		4.8	5.1
Data Source	NC Vital Statistics/SCHS		NC Vital Statistics/SCHS	NC Vital Statistics/SCHS
Data Source Year	2019		2020	2021
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	2.3	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 1.1 - Number of LHDs that offer extended hours for FP services.

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	16.0	16.5	17.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - Percent of WICWS programs that utilize the PCH Outreach and Education Toolkit

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	10.0	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..	

ESM 1.3 - 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
Annual Objective			30	40
Annual Indicator			32.9	82.1
Numerator			28	69
Denominator			85	84
Data Source			WICWS Internal Log	WICWS Internal Log
Data Source Year			FY20-21	FY21-22
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.4 - 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
Annual Objective			74	85
Annual Indicator			84.5	73.7
Numerator			82	73
Denominator			97	99
Data Source			NC FP LHD Clinical Practice Survey	NC FP LHD Clinical Practice Survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	86.0	86.0	87.0

Field Level Notes for Form 10 ESMs:

None

ESM 3.1 - Percent of birth facilities with level of care documented using the CDC LOCATe tool.

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	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.

ESM 3.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL)

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			25	25
Annual Indicator		1.2	2.4	16.5
Numerator		1	2	14
Denominator		85	85	85
Data Source		WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	40.0	60.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Number of eligible WIC participants who receive breastfeeding peer counselor services

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			28,350	29,120
Annual Indicator	27,587	25,020	22,263	22,599
Numerator				
Denominator				
Data Source	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
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	29,900.0	30,660.0	31,425.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - 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
Annual Objective			80	85
Annual Indicator		75	80.9	75.4
Numerator		51	55	49
Denominator		68	68	65
Data Source		DCFW/WCHS staff internal log	DCFW/WCHS staff internal log	DCFW/WCHS staff internal log
Data Source Year		FY19-20	FY20-21	FY21-22
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	90.0	95.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - 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
Annual Objective			24,225	8,000
Annual Indicator		16,676	7,656	16,169
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
Data Source Year		2020	2021	2022
Provisional or Final ?		Provisional	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	17,000.0	17,500.0	18,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The data from the SHC Annual Report included more than just preventive visit CPT codes, but it's not possible to subset just the ones needed from the data source for 2020, thus this is an overestimate and marked provisional for this reason.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: These data are for State Fiscal Year for the LHD/HSA data (July 1, 2020-June 30, 2021) and School Year 20-21 data for the NC SHC Annual Report.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: These data are for State Fiscal Year for the LHD/HSA data (July 1, 2021-June 30, 2022) and School Year 21-22 data for the NC SHC Annual Report.	

ESM 10.2 - 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
Annual Objective			66.3	75
Annual Indicator			71.6	71.2
Numerator			4,334	5,073
Denominator			6,054	7,122
Data Source			LHD/HSA	LHD/HSA
Data Source Year			SFY20-21	SFY21-22
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	77.0	80.0	82.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Percent of children with special health care needs who received family-centered care

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	87.0	90.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.2 - 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
Annual Objective			10	12
Annual Indicator		8	9	17
Numerator				
Denominator				
Data Source		DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	18.0	19.0	20.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data are for State Fiscal Year (July 1 - June 30).	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data are for State Fiscal Year (July 1 - June 30).	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data are for State Fiscal Year (July 1 - June 30).	

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 **Unit Number:** 100 **Numerator:** Number of PRAMS respondents who reported that they wanted to be pregnant then or sooner **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 **Unit Number:** 100 **Numerator:** Number of women who report smoking during pregnancy **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. 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 **Unit Number:** 100 **Numerator:** Number of children with 2 or more adverse childhood experiences as reported by their parents **Denominator:** Number of children age 0-17 years
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 **Unit Number:** 100 **Numerator:** Number of NC children sampled, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) **Denominator:** Number of NC children sampled, ages 19 through 35 months
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 **Unit Number:** 1 **Numerator:** Black, non-Hispanic infant mortality rate **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 1.1 - Number of LHDs that offer extended hours for FP services.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of LHDs that offer extended hours for FP services by 10% (from 15 to 17) by 2025 in order to increase access to preventive medical visits.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of LHDs that offer extended hours for FP services. **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 1.2 - Percent of WICWS programs that utilize the PCH Outreach and Education Toolkit
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	By 2025, 20% of WHB programs will utilize the PCH Outreach and Education Toolkit in an effort to increase the percent of women who receive annual preventive medical visits.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of WHB programs that utilize the PCH Outreach and Education Toolkit **Denominator:** Number of WHB programs
Data Sources and Data Issues:	The WICWS Branch Managers will keep an internal log of programs using the Tool kit and will share this log with the WICWS Chief annually.
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit is recommended by the American College of Obstetrics and Gynecologists (ACOG). http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Well-Woman-Visit

ESM 1.3 - Percent of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and reproductive life planning (RLP).
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	By 2025, 50% of LHDs will have staff who completed training on reproductive justice framework, contraceptive methods, and RLP in an effort to increase intended pregnancies.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and RLP **Denominator:** 85 LHDs
Data Sources and Data Issues:	LHDs will report annual to the Family Planning & Reproductive Health Unit Manager the number of staff members completing training on reproductive justice framework, contraceptive methods, and RLP. In addition, any training sponsored directly by the WHB will have rosters providing LHD site information.
Significance:	Unintended pregnancy is correlated with late or inadequate prenatal care, low birth weight, neonatal death, domestic violence, child abuse, and exposure of the fetus to harmful substances like tobacco, alcohol, and other drugs. It is associated with social and economic co-factors such as economic hardship, marital dissolution, failure to achieve educational goals, and spousal abuse. Reproductive life planning is also a critical component of pregnancy intendedness. Individuals should receive the support needed to make the best decision for themselves concerning their reproductive health, while ensuring this decision is free of coercion and the individual is aware of all their options.

ESM 1.4 - Percent of LHDs offering same day insertion of both contraceptive implants and intrauterine devices (IUDs)
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	By 2025, at least 76% of LHDS will offer same day insertion of contraceptive implants and IUDs in an effort to increase intended pregnancies.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of LHDs that offer same day insertion of contraceptive methods. (IUDs & implants) **Denominator:** 99 counties
Data Sources and Data Issues:	NC Family Planning Local Health Department Clinical Practice Survey Note: Polk County does not provide FP services but assures services are available at Blue Ridge Health, the FQHC in their county.
Significance:	Unintended pregnancy is correlated with late or inadequate prenatal care, low birth weight, neonatal death, domestic violence, child abuse, and exposure of the fetus to harmful substances like tobacco, alcohol, and other drugs. It is associated with social and economic co-factors such as economic hardship, marital dissolution, failure to achieve educational goals, and spousal abuse. Reproductive life planning is also a critical component of pregnancy intendedness. Individuals should receive the support needed to make the best decision for themselves concerning their reproductive health, while ensuring this decision is free of coercion and the individual is aware of all their options.

ESM 3.1 - Percent of birth facilities with level of care documented using the CDC LOCATe tool.
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	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.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 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 **Denominator:** Total Number of birthing facilities in NC
Data Sources and Data Issues:	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.
Significance:	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.

ESM 3.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL)
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	By 2025, 75% of LHDs will use the NC-PAL in an effort to assist primary care providers in addressing the behavioral health needs of pregnant and post-partum patients.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of LHDs who are utilizing the NC-PAL **Denominator:** Number of LHDs providing maternal health services
Data Sources and Data Issues:	NC MATTERS Report
Significance:	Depression and anxiety during pregnancy and the postpartum period are common and have significant negative impacts on mother and child. Suicide is a leading cause of maternal mortality. Evidence-based efforts for screening, assessment, and treatment improve maternal and infant mental health, as well as overall family health, throughout the lives of women and children. NC-PAL or the NC Psychiatry Access Line, is a telephone consultation program designed to assist primary care providers in addressing the behavioral health needs of pediatric, pregnant, and post-partum patients. When primary care providers have a question about perinatal mental health, they can call the NC-PAL to be connected with the information they need. Care coordinators respond to questions within the scope of their expertise, provide resources and referrals, and can connect providers to psychiatric perinatal mental health specialists. Board-certified psychiatric perinatal mental health specialists can assist with diagnostic clarification and medication questions.

ESM 4.1 - Number of eligible WIC participants who receive breastfeeding peer counselor services
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	By 2025, the number of eligible WIC participants who receive breastfeeding peer counselor services will be 31,425 (15% increase from FY19 baseline of 27, 587).
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of eligible WIC participants who receive breastfeeding peer counselor services (determined by having a signed Breastfeeding Peer Counselor Program Letter of Agreement in the Crossroads WIC System) **Denominator:**
Data Sources and Data Issues:	NC Crossroads WIC System
Significance:	Systematic literature reviews have returned similar findings: “Dedicated lactation specialists may play a role in providing education and support to pregnant women and new mothers wishing to breastfeed and to continue breastfeeding (duration) to improve breastfeeding outcomes.”1 1 Patel, S., & Patel, S. (2016). The Effectiveness of Lactation Consultants and Lactation Counselors on Breastfeeding Outcomes. Journal of Human Lactation, 32(3), 530–541.

ESM 6.1 - 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 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

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 **Unit Number:** 100 **Numerator:** Number LHDs whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children during state fiscal year **Denominator:** Number of LHDs providing child health services
Data Sources and Data Issues:	The Pediatric Medical Consultant in the Children & Youth Branch will collect this information annually as she provides the majority of these trainings.
Significance:	The risk for developmental delay is increased in the population of low income children seen in LHDs. The appropriate use of evidence-based tools in developmental, psychosocial, and behavioral health screening for children greatly improves the ability to elicit and identify developmental concerns from parents. Formal tools are much more effective than in informal interview. Screening examines the general population to identify those children at most risk. Children identified with concerns are at risk for developmental delay and are referred for further evaluation. Evaluation goes beyond screening to ascertain diagnosis and develop recommendations for intervention or treatment. This is generally not done by the primary care medical home, unless co-located or integrated professionals are in the practice. The evaluation determines the existence of developmental delay or disability which generates a decision regarding intervention. Ongoing periodic screening gives a longitudinal perspective of an infant or child's developmental progress. All concerns must be clarified and a need for a referral for further evaluation and intervention needs to be determined. Early referral for diagnosis and intervention helps to: - prevent or reduce the impact of developmental delays - identify, build and reinforce developmental strengths in the child and family - prevent fully developed developmental conditions or disorders; and - support school readiness.

ESM 10.1 - Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

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 **Unit Number:** 100,000 **Numerator:** Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center **Denominator:**
Data Sources and Data Issues:	Local Health Department - Health Systems Analysis (LHD-HSA) and School Health Center Annual Report
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 10.2 - Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of adolescents who had a behavioral health screening at time of preventive care visit in LHD</td></tr>
<tr><td>Denominator:</td><td># of adolescents who had a preventive care visit</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Local Health Department - Health Systems Analysis (LHD-HSA)</td></tr>
<tr><td>Significance:</td><td>“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)</td></tr>
</table>

ESM 11.1 - Percent of children with special health care needs who received family-centered care
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	By 2025, increase the percent of CSHCN who received family-centered care to 90%
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CSHCN ages 0 through 17 that received family-centered care **Denominator:** Number of CSHCN ages 0 through 17
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org In the NSCH, family-centered care is comprised of responses to five experience-of-care questions: [provider] spends enough time with child, listens carefully to you, is sensitive to family values/customs, gives needed information , and family feels like partner.

ESM 11.2 - 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 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

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 **Unit Number:** 100 **Numerator:** Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by MCH staff with an agenda item related to medical home promotion **Denominator:**
Data Sources and Data Issues:	Internal log kept by C&Y Branch Staff
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org

Form 11
Other State Data

State: North Carolina

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: North Carolina

Annual Report Year 2022

	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	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	8) PRAMS or PRAMS-like
	Field Note: While the Title V Office has had consistent access to PRAMS data for many years (and access to the electronic data source on an as needed basis), an application for CDC funding was not submitted by SCHS in 2020. The SCHS rolled out a state survey, NC Pregnancy Assessment Survey (NC PAS), in May 2023 which includes questions identical to the 2020 PRAMS survey.