Maternal and Child Health Services Title V Block Grant

North Carolina

FY 2023 Application/ FY 2021 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

August 12, 2022

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 2023. 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:
D7B16E4CBA6F4A8...
Kody H. Kinsley
Secretary

Enclosure: *Maternal and Child Health Services Title V Block Grant FY23 Application/FY21 Annual Report*

cc: Susan Kansagra, MD, MBA, 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: January31, 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). 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 NC Department of Health and Human Services (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. To ensure coordination and collaboration between DPH and DCFW, the Divisions have jointly created a DPH-DCFW Steering Committee which is in the process of finalizing a charter to codify cross-divisional coordination and an Interagency Memo of Agreement (IMOA) which will include the Title V requirements and expectations. 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 impact the maternal and child health population.

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, and the NC DPH Strategic Plan. The needs assessment process afforded the DPH an opportunity to reexamine the 2015 priority needs which were intentionally written broadly and had not changed much since they were selected back in 2005. A 2020 NC Title V Needs Assessment Leadership Team was created in February 2019 which consisted of the Title V Director, the CYSHCN Director, the WHB Head, and the State Systems Development Initiative (SSDI) Project Coordinator. This group met monthly to create and implement a needs assessment work plan. The WCHS hosted a Title V MCH Internship Team supported by the National MCH Workforce Development Center during summer 2019 which allowed two MCH students, one in graduate school and the other an undergraduate, to assist in qualitative data collection activities. The needs assessment process included many opportunities for involvement by stakeholders, including families and community representatives, other state agencies, program participants, and programmatic partners and providers including a MCHBG Big Questions Needs Assessment Survey administered in spring 2019 at conferences and meetings of programs supported by Title V; focus group and key informant interviews; and an electronic survey of WCHS partners and stakeholders to identify priorities and guide planning within the five MCHBG population domains. Partners and stakeholders received a personal invitation from the NC MCH Title V Director and/or WCHS Branch Heads to respond to the survey which elicited 934 completed responses from at least 99 counties.

In March 2020, an expanded Section Management Team (SMT) meeting, which, in addition to the Section Chief, Branch Heads, and Operation Manager also included unit supervisors and other critical WCHS members invited by SMT, was held to review the qualitative and quantitative data and determine the 2020 NC Title V Needs Assessment Priority Needs. Prior to the meeting, the Leadership Team developed prioritization criteria which was shared with staff along with an overview of the Title V Performance Measure Framework. A simple dot voting process was then used to determine the top priority needs. The Branch Heads worked with their staff and the SSDI Project Coordinator

to draft the strategies, objectives, performance measures, and evidence-based or -informed strategy measures for the State Action Plan which was revised and completed by the Leadership Team in the context of NCDHHS strategic priorities and goals. The following table lists the eight selected priority needs and the accompanying National and State Performance Measures (NPMs & SPMs) by population domain. 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 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. In addition, effective July 5, 2022, the Immunization Branch will move 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 will allow greater coordination and collaboration. This will also bring together most key COVID-operations into the Epidemiology Section. The NC Title V Program will continue to work across the NCDHHS and partners to promote maternal and child health and well-being as reflected by the priority needs below.

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 data and stakeholder feedback supported continued use of most of the NPMs it was using for the past five years, 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 including the NC Early Childhood Action Plan. 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. The Title V Program has moved NPM14.1 (Percent of women who smoke during pregnancy) to a SPM in the Perinatal/Infant Health Domain, and has dropped NPM14.2 (Percent of children, ages 0 through 17, who live in households where someone smokes) and NPM15 (Percent of children who are continuously and adequately insured). Data for NPM15 are actually disconcerting as the percentage of children who were adequately insured continues to decrease in NC. The Title V Program will certainly keep monitoring these data, but will not report on them as NPMs for 2021-25. The State Action Plan is reviewed and revised every year as needed.

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.

The NC Title V Program currently manages and administers an annual budget of over $765 million and employs 956 people. This is 47% of the DPH staff, along with 47% of the budget. This of course will shift in future years with the creation of the DCFW. 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 EIB has a network of 16 Children's Developmental Service Agencies (CDSAs) serving all 100 counties.

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, 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, Interagency Coordinating Council (for Early Intervention), and the Governor's Council on Sickle Cell Syndrome. The DCFW/WCHS continues to support a full-time Family Liaison Specialist (FLS) 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 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 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 as we move forward in our ongoing response to the COVID-19 pandemic and recovery.

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. 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. With the creation of the DCFW, the Title V Office, the WICWS, and the Immunization Branch will continue to work collaboratively with Early Intervention, MIECHV, and nutrition services (including the WIC program) as well as child behavioral health services to promote the health and wellness of all people in NC. 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/cessation, substance use, breast and cervical cancer, and others.

Early childhood has been identified by the Governor as a priority of NC, and the Title V Office was directly involved in the development of the NC Early Childhood Action Plan. 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. With the ongoing response to the COVID-19 pandemic, we will all work to meet the needs of NC individuals, children and families.

III.A.3. MCH Success Story

There have been some incremental successes in the area of perinatal and reproductive health in NC over the past year. The NC General Assembly included an extension of Medicaid postpartum health care coverage from the previous 60 day time period to twelve months through the American Rescue Plan of Act of 2021 in the state budget which was approved in November 2021. Beginning April 1, 2022 (and also including coverage for eligible people who were currently pregnant or gave birth between February 1, 2022 and March 31, 2022), beneficiaries are now eligible to receive twelve months of ongoing postpartum health care coverage beginning on the date their pregnancy ends through the last day of the month twelve-months after the last date of the pregnancy, regardless of whether changes that might affect eligibility such as a change in income or household/family unit occur. In addition to this extended coverage, which is currently authorized through March 2027, most pregnant and postpartum beneficiaries will have access to full Medicaid benefits instead of the maternity-focused benefits included in the Medicaid for Pregnant Women program. During the pandemic, postpartum Medicaid benefits for people who gave birth during the pandemic were continued past the 60-day cut off due to a provision in the Families First Coronavirus Response Act, but many people were unaware of the extension and did not seek services. Lessons learned from this experience are being utilized as the NC Title V Program and other partners are working on the implementation of this new coverage to educate and inform potential recipients, providers, and the general public.

Also, during the current session of the General Assembly, the NC Senate has approved Medicaid expansion coverage for all adults. Discussions continue with the NC House with the hopes that Medicaid expansion will be approved in NC in 2022. This will have far reaching impact on improving health across the life course and improving birth outcomes in our state

In addition, a new state law went into effect on February 1, 2022, that allows North Carolinians access to self-administered oral or transdermal contraceptives and prenatal vitamins, as well as several other medications, directly from a pharmacist without a doctor's prescription by expanding pharmacists' scope of practice. The provisions in this law became operational once a standing order was issued by the State Health Director on March 14, 2022.

The NC Title V Program is collaborating with NC Medicaid, the NC Board of Pharmacy, and numerous other partners to inform both providers and the public about these changes and make sure that proper metrics are in place to monitor access and uptake of these services. It is hoped that birthing people living in rural areas of NC and health care deserts will benefit from the new pharmacy law, but this will happen only if they are made aware of it.

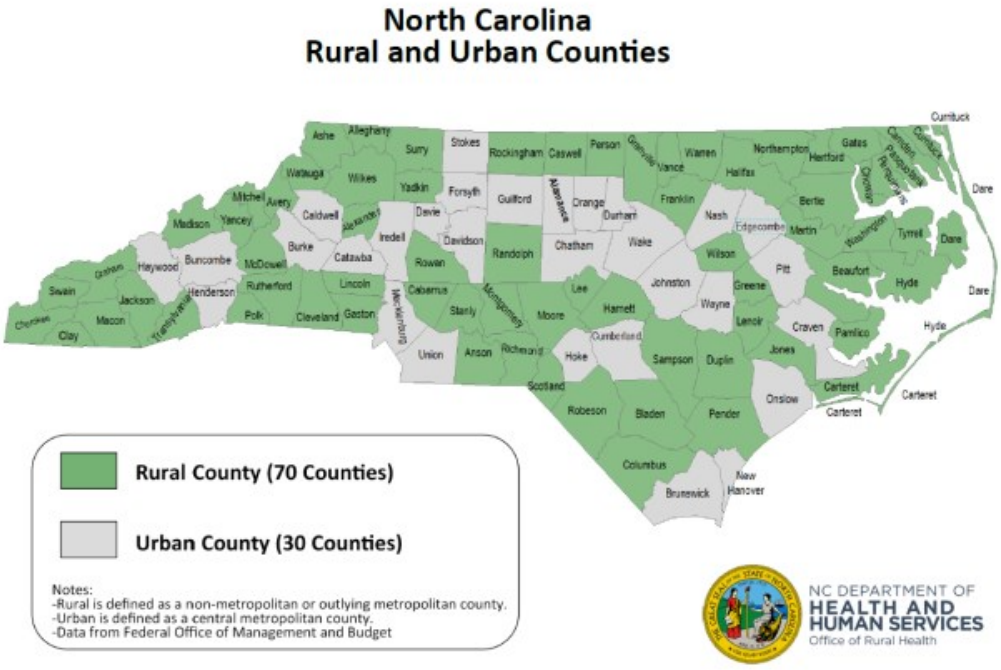
NC also recently released its first *Maternal Mortality Review Committee Report*, and the Committee is working diligently to release their next report in summer of 2023.

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 (Healthy People 2020). 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 in the map (Figure 1) below have at least one urbanized area that has a population of at least 50,000.

Figure 1



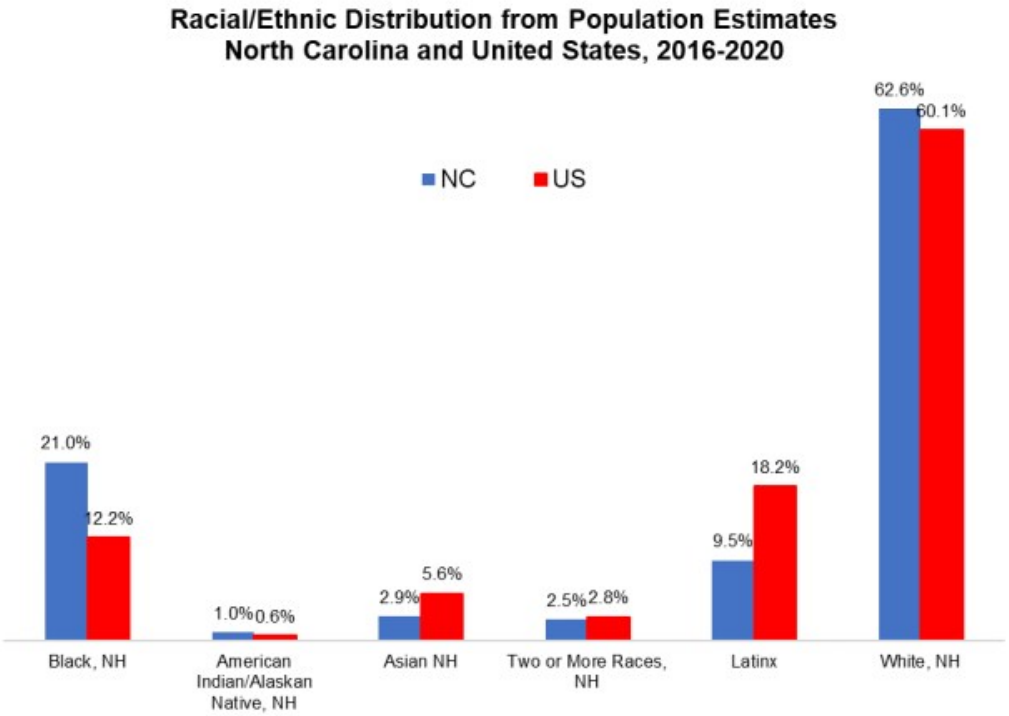
According to the US 2020 Census, NC's official population was 10,439,388 which is an increase of 903,905 or 9.5% since 2010. This was the sixth largest increase among the states and the fifteenth fastest-growing state. (Carolina Demography Blog, April 26, 2021). According to the 2016-2020 American Community Survey (ACS) 5-Year Narrative Profile, NC's official population estimate was 10,386,227 which is an increase of 540,894 or 5.2% more than the 2011-15 ACS estimates.

Per the 2016-2020 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 38.9 years; for women, it is 40.4 years. The number of women in NC in their reproductive years (ages 15-44) compose 38.3% of the total female population, and the population projections for 2025 show that the proportion of women of childbearing age will stay steady at that rate, comprising 38.4% of the total female population (NC State Data Center).

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. Based on 2016-2020 ACS population estimates, children under five years make up 5.8% of NC's population, while children under 18 years comprise 22.2%. These percentages are similar to those for the US (6% and 22.4% respectively).

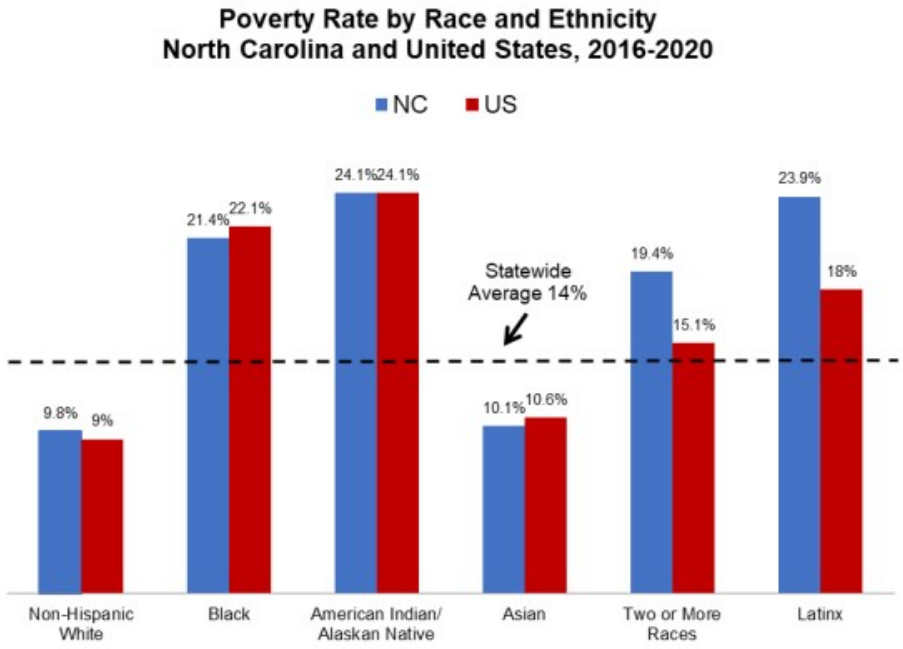
2016-2020 ACS census population estimates indicate that more than one out of every three individuals in the state is a member of a minority group. The Black population is the largest group at 21% of the population. The combined other minority groups – Latinos (9.5%), American Indian and Alaska Native (1%), Asian/Pacific Islanders (2.9%) and those reporting two or more races (2.5%) – represent a smaller proportion of the total population, but their numbers have increased significantly over the past decade. Data from the 2020 Census show that NC's Hispanic population is now greater than one million people, which is an increase of 320,000 new residents since 2010 for a percent change of 40 which is higher than that of the US at 23. (UNC Carolina Population Center Carolina Demography's blog *North Carolina's Hispanic Community: 2021 Snapshot* posted October 18, 2021). See Figure 2 for a comparison of racial/ethnic distribution in NC and the US.

Figure 2



According to single-year ACS data, 1.3 million North Carolinians (13%) lived in poverty in 2020, making NC the state with the 13th highest poverty rate. Poverty rates by race and ethnicity in NC from ACS 2016-2020 data are similar to national rates in all categories, except NC rates are higher for people of two or more races and for those of Hispanic/Latino ethnicity (Figure 3). Poverty rates for Black, American Indian, and Hispanic North Carolinians are more than twice the rates for whites. Women in NC are more likely to be in poverty (15.3%) than men (12.6%), and children under 18 in NC are at a higher rate of poverty (20%) than for the nation as a whole (17.5%).

Figure 3



Source: U.S. Census Bureau: 2016-2020 American Community Survey 5-Year Estimates

While the state's poverty rate has declined slightly over the past ten years, income levels have not changed. Per 2016-2020 ACS data, the median household income level for North Carolinians was $54,642 as compared to $64,994 for the US, and this amount has not changed much over time (2010-2014 ACS data shows the NC level at $46,693 and the US level at $53,482).

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)

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

The public health system in NC has a strong history with 85 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. Once DPH has resubmitted this documentation, PHAB will review it and will schedule interviews with key DPH staff members to take the next step in the accreditation process.

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 has been providing input to NC Medicaid and worked with the LHDs to maintain continuity for the Medicaid beneficiaries through the roll out of NC Medicaid Managed Care.

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 is working towards 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, we are establishing two new departmental agencies: 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 is bringing 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, 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.

The COVID-19 pandemic has been a common challenge for us all, and NCDHHS has been proud of how we transformed how we work as a team to serve individuals, infants, children and families during an unprecedented global pandemic and know that ongoing dedication to the COVID-19 response and recovery, both shorter and long-term, are critical.

Delivery of Title V Services within NCDHHS

With the launch of the NCDHHS' Division of Child and Family Well-Being (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, 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: Behavioral Health and Resilience, Child and Family Well-Being, and 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. 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. ClarLynda Williams-DeVane, formerly the Director of the SCHS and State Registrar of NC's Office of Vital Records, will serve as the Senior Deputy Director and Deputy State Health Official. The previous State Health Director position within 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 Title V Program currently manages and administers an annual budget of over $765 million and employs 956 people. This is 47% of the DPH staff, along with 47% of the budget. This of course will shift in future years with the creation of the DCFW. 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 EIB has a network of 16 Children's Developmental Service Agencies (CDSAs) serving all 100 counties.

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 DPH's Consolidated Agreement which is a contract between the LHD and DPH that outlines requirements of DPH 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. 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 most 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

In collaboration with our Family Partners, the following activities are planned for FY22-25 that will support the DCFW/WCHS and CYSHCN Strategic Plans and the Title V State Action Plan:

- The CYSHCN Strategic Plan will be updated to incorporate strategies from the statewide convenings and advisory committee related to the Path to Better Health for Children with Complex Needs (Path4CNC) and from the *Blueprint for Change: Guiding Principles for a System of Services for CYSHCN and their Families*.
- 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. During the coming years, the School Health Unit will be working with school health centers to integrate physical and mental health services. This also supports our partnership with Department of Public Instruction (DPI) to increase mental health services for students. The School Health Unit will also be hiring a service integration consultant as part of the InCK team to work across schools in the engaged counties. In addition, Title V is working with DPI to address behavioral and mental 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 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.

The NC Title V Program continues to participate in activities supporting implementation of goals aligned with ECAP, working to amplify the strategies included in the ECAP to collaboratively achieve the outcomes, and developing specific initiatives as part of the NCDHHS priority area of Children and Families.

Along the maternal and child health continuum with the ECAP, 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 along with four work groups (Data and Evaluation; Community and Consumer Engagement; Communications; and Policy) who meet as needed to move forward the work of the PHSP. Release of the new 2022-2026 PHSP was delayed due to the decision in March 2022 to embed the Maternal Health Strategic Plan and Task Force into the broader structure of the PHEC and PHSP.

According to data from the interactive NC Health Professions Data System, in 2019, for NC as a whole, there was an average of seven physicians with a primary care practice per 10,000 individuals. However, 32 counties have relatively few primary care physicians (less than 3 per 10,000 people) and two counties did not have any primary care physicians. NC also has an increasing shortage of health care professionals performing deliveries, and there have been seven rural hospital closures since 2010 in NC.

Per the NC Health Professions Data System, in 2019 there was an average of 1.55 physicians who specialty was general pediatrics per 10,000 population, but nineteen counties did not have any pediatricians. NC has several children's hospitals nationally ranked in pediatric specialties (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 and will be working with NCIOM on convening Action Teams starting fall 2022 to move these recommendations forward.

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, 2021, 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 does direct NCDHHS to submit and 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. All children currently eligible for NC Health Choice would then be eligible for Medicaid as of the date approved for the elimination of NC Health Choice by CMS.

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 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 is now scheduled to be launched on December 1, 2022.

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 2023 Application/FY 2021 Annual Report Update

The NC Title V Program conceives of 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, IB, DCFW/WCHS, DCFW/EIS, and DCFW/CNSS all 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 in 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 FY21 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 two years other than the ongoing effects of the COVID-19 pandemic (including potential increases in maternal morbidity/mortality that are still being investigated), the mental health crisis, and efforts to increase the percent of the population eligible for COVID-19 vaccines to become fully vaccinated and boosted.

Women/Maternal Health

Per data from the 2020 Behavioral Risk Factor Surveillance System (BRFSS), 75.6%% of women ages 18 to 44 surveyed had received a preventive medical visit in the past year which is higher than the national rate (71.2%) 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. As shown in the table below, there were no major changes over the past year in some of the other Core State Preconception Health Indicators available from BRFSS, and inequities between racial and ethnic population groups persist.

Characteristics of Women of Childbearing Age by Race/Ethnicity
North Carolina, 2018 & 2020

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
	2020	75.6	72.3-78.6	75.8	71.4-79.7	81.2	74.1-86.6	64	54.4-72.5
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
	2020	80.1	77.0-82.8	85.6	81.9-88.7	87.4	81.1-91.8	45.5	36.8-54.6
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
	2020	60.6	56.6-64.4	55.7	50.5-60.8	75.2	67.2-81.8	63.3	52.0-73.3
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
	2019	16.9	14.1-20.2	14.2	10.5-18.9	24.3	18.1-31.7	15.3	9.5-23.9
Currently smoke every day or some days	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
	2020	14.9	12.5-17.7	18.8	15.2-22.9	13.9	9.2-20.5	1.5	0.6-3.7
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
	2020	17.8	15.1-20.9	20.3	16.6-24.5	18.5	12.7-26.1	11.0	6.2-18.7

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 determine 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 2020 show that 75.1% of very low birthweight infants received care at currently designated Level III+ neonatal intensive care units (NICUs), which is lower than the 2019 percentage, but in line with data for the past five years.

In 2020, North Carolina's infant mortality rate increased slightly from a historic low of 6.8 infant deaths per 1,000 live births in 2019 to a rate of 6.9 in 2020, but that means that 803 infants (a figure equal to about 11 school buses of 72 students each) died before reaching their first birthday. While the state has experienced substantial declines in

overall infant mortality over the last two decades, reprehensible racial disparities in infant mortality persist. The disparity ratio between non-Hispanic Black and non-Hispanic white births increased slightly from 2010 to 2020, with mortality rates for infants born to non-Hispanic Black mothers more than twice as high as those born to non-Hispanic white mothers. Aggregated three year infant mortality rates for non-Hispanic American Indians were at least 1.5 times higher than non-Hispanic white infants during the same years.

Fetal death rates per 1,000 deliveries continue to tell the same story, as in 2020, the non-Hispanic Black rate (11.2) was 2.9 times that of the non-Hispanic white rate (3.9) with a total state rate of 6.1. The latest data from the National Immunization Survey (NIS) show that 85% of infants born in NC in 2018 were ever breastfed which is an increase from the previous year and is slightly higher than the national rate of 83.9%. Breastfeeding initiation data obtained from birth certificates for infants born in 2020 indicate that 80.8% of all infants were breastfed at hospital discharge. However, Latinx infants were more likely to be breastfeeding (87%) than non-Hispanic Black (69.5%), non-Hispanic white (83.9%), or non-Hispanic American Indian (53.5%) infants. While birth certificate data on mothers who reported smoking during pregnancy continues to trend down (6.8% of all live births in 2020 as opposed to 10.9% of all births in 2011), this is probably underreported, and there's still room for improvement.

Child Health

According to data from the 2019-20 National Survey of Children's Health (NSCH), 90.5% 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 (96.1%) children than Hispanic (84.7%) and non-Hispanic Black (82.3%) children. The percent 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 2019-20 NSCH show that 55.8% of children in NC between 9-35 months had received appropriate developmental screening which is an increase from 43% in the 2017-18 NSCH and higher than the national average of 36.9%. 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 2019-20 NSCH, 19.2 % down to 16.6%, the decrease is likely not significant. The immunization coverage rates for the combined 7-series for infants reported in 2020 showed significant increases over rates reported in 2019, but those reported in 2021 showed a decline which was somewhat expected as both national and NC data showed declines in rates of vaccinations and well child visits during the earlier part of the pandemic. 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 (78.7%) to 2019-20 (75.6%), and this decrease will probably continue due to the COVID-19 pandemic, particularly with School Health Centers being closed for much of SY20-21. Teen immunization rates reported in 2021 showed a statistically significant increase over 2019 reports for teens receiving the human papillomavirus series, and the rates for teens receiving meningococcal conjugate vaccine and one or more doses of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis remained about the same. According to 2019-20 NSCH data, 19.8% 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, who were low-income (<200% of the federal poverty level), or were YSHCN 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% of CYSHCN in NC per the 2019-20 NSCH, which is almost identical to the 2017-18 NSCH results of 21.2%. The 2019-20 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 (71.3% for CYSHCN v. 95.9% for non-CYSHCN), and this difference appears to be statistically significant. CYSHCN in NC age 10-17 years were more likely to be obese (27.4%) than children and youth without special health care needs (16.9%) according to the same survey. The percent of CYSHCN in NC receiving care in a medical home increased from 41% in the 2017-18 NSCH to 45.2% in the 2019-20 NSCH, but that still leaves 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 managed the work of the Immunization Branch and worked with teams spread across NCDHHS, while continuing to monitor work on the Title V State Action Plan.

Two major 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 the same 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 set to launch on December 1, 2022. 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 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 3 years.

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 by creating two positions - 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. While details are still being worked out, 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/Medical Director for Health Promotion, collaborations already in place regarding life course,

substance use, and injury and violence prevention will be strengthened.

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 opportunity 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. 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 31.5 deaths per 100,000 residents in 2020. This burden of overdose has disproportionately worsened in some historically marginalized communities. The percent 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 both during the COVID-19 response and long-term with recovery. 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. The NCDHHS organizational changes are being made in an attempt to help address these inequities. 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. NCDHHS continues to work for Medicaid expansion in North Carolina which would help close the insurance coverage gap.

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

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$17,222,472	$19,770,945	$17,424,544	$18,812,551
State Funds	$34,324,098	$39,888,265	$41,861,408	$38,249,324
Local Funds	$0	$0	$0	$0
Other Funds	$65,356,296	$58,719,041	$66,078,190	$52,819,279
Program Funds	$70,779,201	$69,967,790	$70,779,201	$73,859,576
SubTotal	$187,682,067	$188,346,041	$196,143,343	$183,740,730
Other Federal Funds	$404,992,804	$280,628,316	$403,362,999	$281,671,839
Total	$592,674,871	$468,974,357	$599,506,342	$465,412,569

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$18,806,308	$16,804,521	$18,806,308	
State Funds	$34,195,972	$35,228,731	$37,169,426	
Local Funds	$0	$0	$0	
Other Funds	$66,371,749	$57,078,391	$65,371,749	
Program Funds	$69,967,790	$67,155,895	$73,859,576	
SubTotal	$189,341,819	$176,267,538	$195,207,059	
Other Federal Funds	$393,826,669	$291,783,688	$456,342,218	
Total	$583,168,488	$468,051,226	$651,549,277	

	2023	
	Budgeted	Expended
Federal Allocation	$18,871,732	
State Funds	$45,189,526	
Local Funds	$0	
Other Funds	$65,311,808	
Program Funds	$67,155,895	
SubTotal	$196,528,961	
Other Federal Funds	$413,861,107	
Total	$610,390,068	

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. 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 FY21, federal Maternal and Child Health Block Grant expenditures were $16,804,521, which is a decrease of $2,008,029 from the previous year. This decrease can be explained by the impact of COVID-19 pandemic on programs and the April 2020 request by the NC Office of State Budget and Management (OSBM) to reduce unnecessary General Fund expenditures by implementing budget management measures such as limiting the purchase of goods and services to mission critical and COVID-19 items only; limiting travel and training requirements; limiting hiring for vacant positions; and making no reallocations (position reclassifications) or salary adjustments. This request continued until the subsequent budget memorandum dated December 21, 2020, was released stating "the COVID-19 pandemic has severely impacted our state; however, the immediate infusion of federal fiscal stimulus funds in spring 2020 helped the economy recover more quickly than earlier expected. Recently, stabilization in the stock market and optimism around vaccine development and another federal government stimulus package give us more confidence in the overall economy. North Carolina's actual FY 2020-21 General Fund revenue collections through October are approximately $2 billion above the May 2020 consensus revenue forecast estimate. Therefore, OSBM is suspending the budget management guidelines issued in our June 3, 2020 memorandum effective January 1, 2021. We must continue to be responsible with state resources." In conclusion, FY21 decrease in expenditures is directly due to the mandates on spending by our OSMB.

III.D.2. Budget

NC’s Maternal and Child Health Block Grant financial management plan assures the compliance with the Title V fiscal requirements.

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 (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.

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 FY23 as shown in Form 2 is $45,189,526. This includes state funds used for matching Title V funds, which for the FY22 application is $14,155,450.

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 at 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 DPH Strategic Plan. 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 the NC General Assembly and other partners to help us achieve its 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.

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 couple years.

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 pandemic meeting challenges, this conference has been delayed the last two years. The WICWS has begun discussions about holding the Building Bridges Conference in early 2023. Using a combination of several funding sources, topics are 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 Parenting Education Program Committee. 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 annually, with family members serving on the planning teams. During the pandemic, these trainings were put on hold, but plans have begun to restart them in FY23. Adolescent Parenting Program also holds an annual graduation and skill-building meeting which is one of the highlights of the program year, and the spring 2023 graduation is being planned as an in person event.

The WICWS has held a regular Reading Circle focused on cultural awareness for many years. The group is on a temporary hiatus with plans to restart it this fall. Books are selected representing various racial, ethnic, and cultural backgrounds; a group discussion allows for awareness building and individual experiences to be shared. In the interim, the Reproductive Health Branch/WICWS read the book *Killing the Black Body* during the fall 2021 and were then led in a facilitated discussion about the book. Staff were given several months to read the book and were paired with a colleague to have monthly debriefing discussions to help process the information. During the facilitated discussion, staff again had an opportunity to discuss the information and process how the information reflects with their current work. The rich conversations continued with a total of three discussion opportunities to process information. Staff will have an opportunity for a strategizing session in the coming months to start processing what changes can be made throughout our reproductive health programs to provide more equitable services. Staff enjoyed the opportunity to read this challenging book together and to continue the work in learning more about reproductive justice and how the information can assist in improving our programs and outcomes.

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 funding shortages. 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, Interagency Coordinating Council (for Early Intervention), 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 was to increase family-driven service provision. One response to this need was the creation of 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. Participants are compensated for time, travel, meals, and lodging according to NC state government reimbursement guidelines. More recently, the new Maternal Health Task Force was convened to enhance maternal health work in our state and the WICWS was intentional about including a person with lived experience as a co-chair along with ensuring that at least one person with lived experience from each of the six perinatal care regions was invited to participate. Each meeting agenda included time for sharing the perspective of consumers and/or community members.

The DCFW/WCHS has experienced a vacancy in the full-time Family Liaison Specialist (FLS) position. A part-time FP and other staff members have maintained training and supporting family engagement in DCFW/WCHS programs and partner organizations. Meticulous recruiting efforts have been made to reclassify and fill the position; promising prospects are on the horizon. The DCFW/WCHS continued to employ a part-time Parent Consultant, and recently added a second part-time bilingual Parent Consultant, who serve 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 nine diverse parents of CYSHCN with a full range of experience with systems of care, the of Assistant Director for the DCFW/WCHS, five Unit Managers, the FLS, and the CYSHCN Access to Care Specialist. The group size and makeup are conducive to real, intimate conversation and brainstorming. 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. In FY21, the FLS collaborated with parent trainers to convert the trainings to be deliverable virtually; the number of trainings and participants was triple that of the number in FY20. FPs are included in educational opportunities alongside staff including attending national and state conferences, planning and participating in DCFW/WCHS meetings and other trainings hosted by the DCFW/WCHS. 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 on 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. Family partners will also continue to attend the CSHCN Commission's two subcommittees – Behavioral Health and Oral Health. These groups provide feedback and recommendations on services or policies impacting Medicaid populations. Efforts to empower youth and integrating their voice throughout Title V endeavors continue to broaden, particularly through the Youth Health Advisor Team. Their accomplishments are described in the Adolescent Health Domain annual report narrative. One new parent/youth program engagement opportunity will include the development of a training cadre to explain the medical home constructs with an emphasis on cultural humility and historical inequities. The training will incorporate AAP elements of a medical home and how parents can build and maintain a successful partnership with their child's health provider, along with empowering their child to be comfortable in eventual ownership of their health care, including transition to adult health care. 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 recent 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."

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. There are twenty full-time equivalent 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. Currently there is a Public Health Epidemiologist position in the Title V Office, WICWS, IB, and DCFW/Community Nutrition Services Section (DCFW/CNSS) and 16.5 FTEs in additional data positions. 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. The table below displays the breadth of data positions across the Title V Program, listing the position title and level of education for each position that is currently filled. Active recruitment efforts are underway to fill the vacant positions.

MCH Epidemiology Workforce	
Working Title	**Education Level**
DPH/Title V Office	
Perinatal Epidemiologist	Master's
SSDI Project Coordinator/Data Analyst	Master's
DCFW/Whole Child Health Section	
Data Manager	Master's
Early Hearing & Detection Data Coordinator	Master's
Data Analyst	Vacant
DPH/Women, Infant, and Community Wellness Section	
Reproductive Health Data Manager	Master's
Teen Pregnancy Prevention Initiatives Evaluation Consultant	Master's
Evaluator Personal Responsibility Education Program (PREP) Evaluator	Master's
Maternal Health Epidemiologist	Doctorate
NC Healthy Start Baby Love Plus/Healthy Beginnings Data Manager	Bachelor's
Sickle Cell Data Manager	Master’s
Maternal Health Program Manager (.5 FTE data manager)	Master’s
DPH/Immunization Branch	
Immunization Epidemiologist	Master's
Data Coordinator	Master's
Data Analyst	Bachelor's
NC Immunization Registry Unit Manager	Bachelor's
Data Coordinator	Vacant
DCFW/Community Nutrition Services Section	
Nutrition Epidemiologist	Master's
DCFW/Early Intervention Section	
Data Manager	Vacant
Data Coordinator	Bachelor's
Data Coordinator	Vacant

Another critical piece of the MCH epidemiology workforce in NC is the existence of the NC State Center for Health Statistics (SCHS) which is responsible for data collection, health-related 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 funds several positions in 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. Funding partially supports two injury epidemiology positions (Injury Epidemiologist Supervisor and the NC Violent Death Reporting System Supervisor) as well as supporting a Suicide Prevention Program Manager position and contributing to the IVPB Head position, along with providing 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.

In addition, the WICWS has reinstituted a Data Team that meets monthly to better connect the Section's programs and data, streamlining data processes and creating better ways to disseminate data in meaningful ways within the Section. They also serve as a resource group for all WICWS data needs.

DCFW is also working across Divisions to develop a Child Behavioral Health data dashboard. Currently the goal is to have an internal dashboard launched by the end of 2022 to provide data insights that drive action and equity for child behavioral health activities.

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.

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.

During the COVID-19 pandemic, many members of the MCH epidemiology workforce described above provided countless hours to the NC DPH Epidemiology Section to provide data entry and analysis to update the NCDHHS COVID-19 Metrics Dashboard. The Perinatal Epidemiologist worked as a member of the Epi COVID Data Team in parts of FY21 and FY22, 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 Title V Office as needed. In 2021, MCH epidemiology workforce members of the WICWS were deployed to help with COVID vaccine data entry efforts, and, of course, the Immunization Epidemiologist and her coworkers have been engaged in all COVID-19 vaccination efforts along with the Title V Director.

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. Two goals of the current grant are to 1) build and expand state MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation; and 2) to advance the development and utilization of linked information systems between key MCH datasets in the state. These goals complement the work of the NC Title V Office as a whole.

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. The SCHS website houses the Tracking Maternal and Child Health Data in NC webpage which provides trend data for the Minimum/Core (M/C) Dataset for Title V MCH Block Grant programs that is compiled annually by the SSDI Project Coordinator.

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 has committed to conducting an in-house PRAMS-like survey to obtain similar data for Title V surveillance; however, as of June 2022, this survey has not been produced.

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. Having served on the Epi COVID Data Team, the Perinatal Epidemiologist is now also able to use Covid-19 case data to identify and confirm all maternal deaths due to Covid-19 and provide the MMRC with Covid case transcripts that will be used to support maternal case reviews. In addition, she makes annual presentations to the Child Fatality Task Force and relevant committees regarding infant and child deaths.

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 the WICWS, Immunization Branch, 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.

As its state-specific goal required in the SSDI grant application process, NC chose option b – Provide data support to states participating in quality improvement (QI) activities (e.g., Collaborative Improvement and Innovation Networks [CoIIN]) –for its programmatic focus over the 5-year funding period based on the SSDI Project Coordinator's ongoing involvement in the CoIIN efforts to reduce infant mortality. She continues serve as coordinator of #impactEQUITYNC, which is a partnership of the Title V Office, WICWS, DCFW/WCHS, and several non-profits. #impactEQUITYNC was initially started to create and promote the use of a Health Equity Impact Assessment tool, but in the upcoming year will also be taking on some of the work initially begun with the Social Determinants of Health CoIIN. The SSDI Project Coordinator worked with a subgroup of #impactEQUITYNC members to revise the Health Equity Impact Assessment Tool.

As needed, the SSDI Project Coordinator also provides data support to staff members across DPH and DCFW. Recent and ongoing examples of this support include serving as the chair of the Data and Evaluation Work Group of the Perinatal Health Equity Collective, assisting with ongoing evaluation of the ICO4MCH initiative, and serving as a co-coordinator of the NC DPH Epidemiology and Evaluation Team. In May 2022, the Data and Evaluation Work Group finalized a summary highlighting the accomplishments and challenges experienced with implementation of the 2016-2020 Perinatal Health Strategic Plan.

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 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 will serve as the indicator lead for infant mortality, teen births, and early prenatal care for the NC State Health Improvement Plan.

The SCHS is restructuring its current website to a platform that highlights health equity and known disparities. The new website is a suite of population health data tables, reports, infographics, fact sheets, and dashboards. The HNC 2030 component is set to go live July 2022, and additional components will go live incrementally throughout FY23. Each component has its own icon representing Lifestyle Behaviors, Health Care/Insurance, Population Demographics, Chronic Diseases, Child and Family Well Being, Environment, Communicable Disease, Injury and Violence Prevention, Social Determinant of Health, Measures of Well-Being, and the Built Environment. The Data Hub links all dashboards created or maintained by DPH to one or more of these topical icons to provide a centralized resource for population health data.

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. 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/ accessed June 16, 2022) 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 early FY23 and be publicly available in late FY23 or early FY24. The Perinatal Epidemiologist is 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. To roll out COVID-10 vaccine implementation, NCDHHS built a pandemic module that has been utilized for COVID-19 vaccine during the pandemic and the associated integrations. The COVID-19 Vaccine Management System (CVMS) is a secure, cloud-based system that enables COVID-19 vaccine management and data sharing across recipients, care providers, hospitals, agencies, and local, state, and federal governments on one common platform, in addition to the NCIR. (https://covid19.ncdhhs.gov/vaccines/info-health-care-providers/covid-19-vaccine-management-system-cvms accessed July 5, 2022). Another tool to help NC reach its goal of vaccinating as many North Carolinians as quickly and fairly as possible is an interactive web-based map application that shows census tracts in North Carolina with the highest rates of social vulnerability and the lowest rates of COVID-19 vaccination. Access to timely vaccination data disaggregated by race, ethnicity, and other social determinants of health has guided North Carolina's work to reach underserved and historically marginalized populations and deliver equitable access to COVID-19 vaccines.

During the pandemic, the Title V Program has also been 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 has continued to evolve over time with the most recent format being launched in March 2022 which includes 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. Demographic data are still available on interior dashboard pages for hospitalizations, COVID-19 cases, and vaccines.

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) 2021 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 made in August 2021 and posted in December 2021. 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 August 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 is working to build upon our strengths and the lessons learned from the pandemic to craft an even stronger, more integrated Department and is establishing 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. 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., PREP, WIC, Immunizations, etc.) is very strong and, with the Title V Director's new role as the Medical Director for Health Promotion, about to grow stronger with regard to additional federal investments regarding chronic disease and injury and 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. The NC Association of Local Health Directors (NCALHD) meets monthly, and, on the day prior to each of these meetings, committee meetings are held which include staff members from DPH/DCFW Sections which enable the Title V Program to work collaboratively with NCALHD on matters that pertain to all LHDs. NC Title V Program staff members, particularly the Regional Nurse, Social Work, Immunization, and Nutrition Services 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 even after the IMOA is established 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
- Maternal Mortality Review Committee
- NCIOM Perinatal System of Care Task Force
- NCIOM Maternal Health Task Force
- NC Public Health Genomics Plan
- Home Visiting Parent Education Collaborative
- Healthy NC 2030
- Integrated Care for Kids (InCK)
- Perinatal Health Strategic Plan
- NC Infant-Toddler Program State Systemic Improvement Plan (SSIP)
- NC Child Fatality Task Force
- Pathways to Grade Level Reading
- 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. 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 to ensure quality services and programs. NC Title V Program staff members serve on a number of 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 will be extended by NC Medicaid for another year in order to finalize the revisions.

The NC Division of Health Benefits' enrollment dashboard for Medicaid and NC Health Choice (https://medicaid.ncdhhs.gov/reports/dashboards#enroll) reflects the number of people by county and program aid category who are authorized to receive Medicaid or Health Choice services for each report month. As reported in the NC Medicaid and NC Health Choice Annual Report for State Fiscal Year 2021, in SFY21, NC Medicaid provided access to care and services to 2.3. million people in the state. Many of these people were 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. Through Health Check (Early and Periodic Screening, Diagnostic and Treatment), more than 96% of children under one year of age received all recommended preventive check-ups and more than 53% of all eligible children received periodic screenings on the schedule recommended by the American Academy of Pediatrics.

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 zero-to-five 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/Health Choice (the Children's Health Insurance Program). A description of their work is found in the CYSHCN Domain Annual Report. With the transition to managed care, the NC Title V Program will also participate in the Pediatric Advisory Group and the Maternal Health Advisory Group convened by the PQCNC to provide direct input to the Division of Health Benefits 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-9 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 will 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 will be 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 will work to improve the overall health of women and young children across the state. The Care Management for At-Risk Children (CMARC) program, provided by LHDs for at-risk children ages zero-to-five, 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 is scheduled to be launched December 1, 2022. 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 all of their needs including 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.

As part of the transition to Medicaid Managed Care, NC launched Healthy Opportunity Pilots in spring 2022. Up to $650 million in state and federal Medicaid funding was authorized for these pilots. In May 2021, NCDHHS announced the selection of three organizations to serve three regions of the state. Access East Inc. and Community Care of the Lower Cape Fear are in eastern NC, and Dogwood Health Trust is in western NC. The rollout of services occurred across all three pilot regions in 2022, with food services made available on March 15, housing and transportation services on May 1, and toxic stress and cross-domain services on June 15. 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

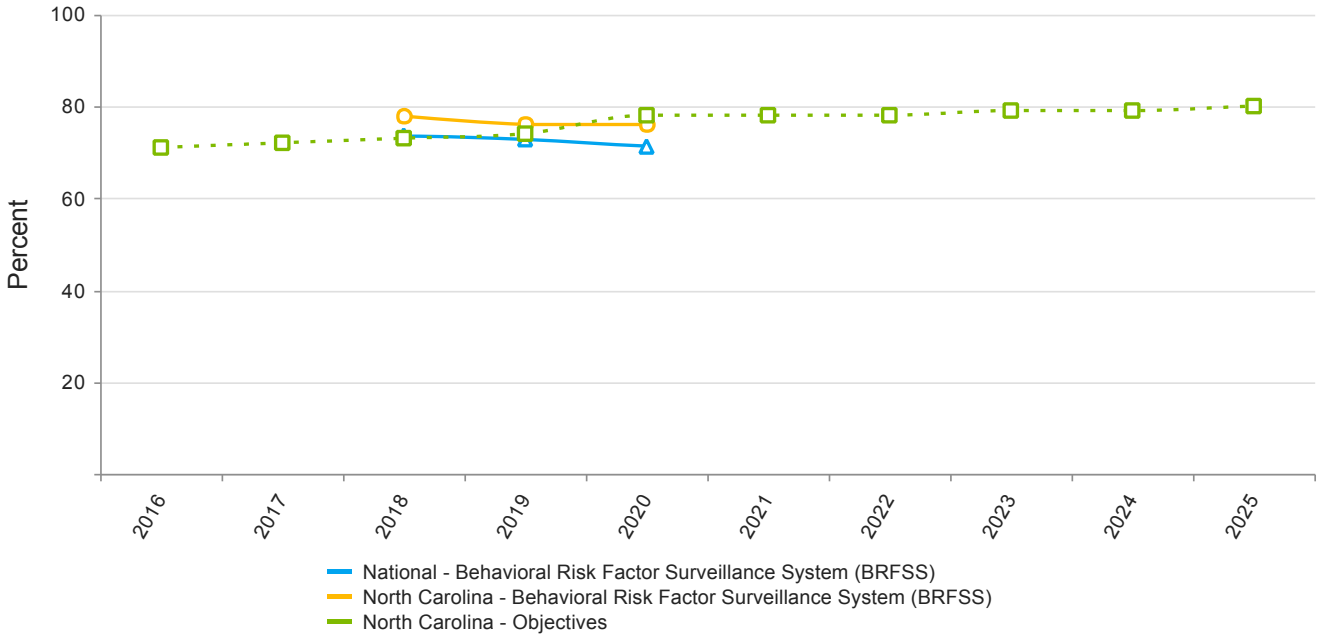
payers and providers.

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				78	78
Annual Indicator			77.6	76.1	75.8
Numerator			1,412,575	1,386,809	1,385,665
Denominator			1,820,993	1,823,266	1,827,713
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	78.0	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
Annual Objective			15
Annual Indicator	15		10
Numerator			
Denominator			
Data Source	NC FP Program Service Site Information		NC FP Program Service Site Information
Data Source Year	2020		2021
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.5	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
Annual Objective			0
Annual Indicator			0
Numerator			
Denominator			
Data Source			WICWS Internal Log
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	0.0	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
Annual Objective			30
Annual Indicator			32.9
Numerator			28
Denominator			85
Data Source			WICWS Internal Log
Data Source Year			FY20-21
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	40.0	50.0	60.0	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
Annual Objective			74
Annual Indicator			84.5
Numerator			82
Denominator			97
Data Source			NC FP LHD Clinical Practice Survey
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.0	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
Annual Objective			59.7
Annual Indicator	55.9		58.6
Numerator			
Denominator			
Data Source	NC Pregnancy Risk Assessment Monitoring System		NC Pregnancy Risk Assessment Monitoring System
Data Source Year	2019		2020
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	60.0	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, 2021.	
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 related preconception health services.	
WMH 1B.2. Increase awareness of LHDs PCH services and provider type through social media and other outreach efforts.	
WMH 1B.3. Provide education to other programs that serve similar populations such as of WIC, MIECHV, Healthy Start, Work First, and CMHRP.	
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.

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 contraceptive education utilizing telehealth services prior to the clinical appointment.

WMH 2B.4. 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 are able to 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 data from the 2020 BRFSS, 75.8%% of women ages 18 to 44 surveyed had received such a service which is higher than the national rate (71.2%), but is a bit lower than the 2019 NC rate of 76.1% (although confidence intervals overlap for the two years). Of the women who responded to the 2020 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 (81.2%) were more likely to have had a visit than Hispanic women (64%) or non-Hispanic white women (75.8%). The Affordable Care Act (ACA) has ensured that the majority of health plans offer women coverage for well-woman visits without cost-sharing, but many women and/or their providers are not aware of this coverage. 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 women giving birth in 2019. Data for 2019 indicate that non-Hispanic White women were less likely to receive a primary care visit within 12 months (14.7%) than Black non-Hispanic women (18.4%), American Indian non-Hispanic women (17.9%), and Hispanic women (19.1%).

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 FY21. According to the 2021 Family Planning Annual Report, 55,470 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.

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

During FY21, the WICWS Regional Nurse Consultants (RNCs), via monitoring and technical assistance, assured that LHDs had policies/procedures/protocols related to community engagement and community participation in determining the services offered/provided in their Family Planning clinics. Consultants also assured that the LHDs had educational materials deemed appropriate to the needs of the community by existing clients through an annual media review process.

While LHDs were responding to the ongoing COVID19 pandemic in FY21, the WICWS supported changes to their Family Planning programs to meet community needs. Services were modified through telehealth, extending birth control prescriptions when appropriate, placing condoms in convenient locations to allow for social distancing, postponing annual visits, and waiving Sexually Transmitted Infection (STI) screening for telehealth visits unless symptoms reported.

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. As of May 2018, there were 15, but that dropped to 10 according to the 2021 NC Family Planning LHD Clinical Practice Survey. During FY21, staff members conducted research by reviewing national organization information, peer reviewed articles, and published toolkits regarding offering extended hours in clinical settings. This research will be utilized to develop an information sheet for LHDs interested in offering extended hours. Additionally, research was completed about effective marketing and advertising strategies for rural and urban communities. This information will be important when working with LHDs around the best methods to communicate extended hours and other changes to increase access to services. A communication plan is critical to the success of extending hours by ensuring that the community is aware of this change.

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 at least one WICWS RNC, had plans to draft the Preconception Health Outreach and Education Toolkit to be used with LHDs, other providers, and community-based organizations to increase knowledge about preconception health in FY21 (ESM 1.2), but was unable to do so due to staff vacancies and COVID-19 priorities.

The ICHB continues to enhance the implementation of preconception efforts within NC using the NC Preconception Health Strategic Plan Supplement for 2014-2019 as a guide. 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. The ICHB hosted one PPE training virtually during the report period. Albemarle Regional Health Services-Hertford County, in collaboration with the ICHB, hosted a virtual (Zoom) PPE training on October 17 and 24, 2020. More than thirty students from Chowan and Elizabeth City State Universities attended the training. 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 FY21, 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. In FY21, forty-five outreach events on preconception and interconception health reached 2,792 women of reproductive age with information on healthy eating, active living skills, enhanced mental wellness or reproductive life planning. The Sandhills Collaborative created a preconception and interconception health survey to encourage conversations around mental health, reproductive health planning, contraception, and perinatal health. A community health worker (CHW) joined the team and provided reproductive education, including birth spacing and birth control methods, and supported the Mothers & Babies program. The CHW also focused on encouraging women to practice self-care and connected with community members around COVID-19 related stressors including housing, food and nutrition, and employment resources and provided referrals to community resources and LHD services. Through Facebook messaging, the Collaborative provided at least 1,664 people information about preconception and interconception health and perinatal mental health. Across the Sandhills Collaborative (4 LHDs), 2,111 women attended a primary care pre-pregnancy visit.

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. The Collaborative utilized Facebook, Snapchat, Instagram, and radio to reach men and women of reproductive age with content on nutrition, exercise, mental health, healthy relationships, and preconception health. Because of the COVID-19 pandemic, the Mecklenburg Collaborative was not able to establish their peer educator program in colleges.

Both Collaboratives launched the Mothers & Babies program in FY21. Seventy-nine staff members from both Collaboratives were trained to facilitate Mothers & Babies and they delivered thirteen sessions of the program to thirty women and two men. Attendees received eight referrals and four of those were completed. Sandhills Collaborative overcame barriers to getting staff trained by holding trainings as Lunch and Learns and were able to train an additional twenty staff. They also held weekly program group sessions at the Richmond County Housing Authority which reached five participants. Because of the COVID-19 pandemic, the program was delivered virtually in Mecklenburg and Union counties. This presented barriers in referring and confirming patient interest and connecting with patients over email and virtual platforms for depression screenings and delivery of program materials.

During FY21, 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. They conducted outreach and recruit program participants through health department family planning clinics. Due to the pandemic, FOWs provided outreach by taking materials and/or supplies to the front doors of clients. NC BLP sites utilized web conferencing tools to reach program participants and/or telephone outreach during the pandemic. The NC BLP program engaged participants through 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 FY21, 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.

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 if 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.

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 during FY21. Thirty-three percent of LHDs had staff complete such trainings.

During FY21, the WICWS sponsored several trainings for LHD staff. In September 2020, the WICWS's partnership with the NC DMH/DD/SAS continued in inviting LHDs to attend a training along with opioid treatment programs in their communities around Reproductive Life Planning for Substance Use Disorders (RLP SUD) Training programs. This training was moved to a virtual platform and three different webinars were held to accommodate individuals. Ten LHDs and 24 opioid treatment programs participated with a total of 85 individuals trained across the three trainings. The trainings 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.

Through the RLP SUD trainings held over the last few years, partnerships were made, and resources shared, between substance use treatment programs and LHDs. After the trainings in September, monthly webinars were hosted for substance use treatment programs and LHDs to share resources/skill training/etc. During these webinars participants were able to learn from one another how agencies are implementing this work with substance use clients, received an overview on the Family Planning Medicaid program, discussed condom use and negotiation skills, and did some troubleshooting to assist agencies having challenges in this work.

In October 2020, a WICWS Medical Consultant hosted a webinar, *Reproductive Health Services in the Age of Telehealth*, to assist LHDs in determining what services can be provided via telehealth, examine their agency

readiness and capacity, and explain how telehealth may affect patient access. There were 135 participants during the live webinar and additional participants have viewed the archived webinar.

The reproductive justice framework is also critical to the work happening around teen pregnancy prevention. In FY21, the Teen Pregnancy Prevention Initiatives (TPPI) program offered several relevant trainings for locally funded projects to further their understanding around the work. In December 2020, a Sexuality for Communities of Color Training was held virtually with 46 attendees. In February and April 2021, TPPI sponsored two Racial Equity Institute Groundwater Trainings with 51 attendees and 54 attendees respectively. Finally, in June 2021, TPPI sponsored a Disability Justice Training, Part I with 34 attendees and a Creating Safe Spaces Training with 23 attendees.

In March 2020, TPPI hosted a networking conference for local funded agencies, where local program coordinators participated in a reproductive justice workshop and prioritized updating existing evidenced-based curricula utilized for program implementation. In response, during the summer of 2020, TPPI collaborated with content experts and certified trainers at the North Carolina School Health Training Center to review curricula with a reproductive justice and inclusivity lens. Each curriculum (Making Proud Choices, Draw the Line/Respect the Line, Reducing the Risk, and Be Proud! Responsible! Be Protective!) was carefully reviewed for cultural and inclusivity adaptations. The reviewers also prioritized removing ableist language from curriculum activities to increase accessibility for all participants. The timing of the adaptation recommendations coincided with COVID-19 response efforts, which necessitated the transition to virtual program delivery. TPPI convened four multi-disciplinary workgroups of local program coordinators, many of which participated in the initial reproductive justice workshop and/or other equity training; certified curriculum trainers; and TPPI Program Consultants to incorporate adaptations and develop interactive virtual curriculum activities and materials. A supplemental handout, *Supporting a Culturally Sensitive Approach to Sexuality Education*, was created to support evidenced-based program implementation and focuses on trauma informed education (including racism, poverty, community violence and bullying) and consent.

To further advance teen pregnancy prevention, the WICWS continued to partner with Sexual Health Initiatives For Teens NC (SHIFT NC) as they nurtured a youth leadership council for NC. During FY21, the youth council was created. Young people applied to be a part of the Council, were interviewed, and seven youth were selected to be on the Council. Five meetings were held throughout the year, and the youth attended five different workshops on various adolescent health topics, including contraception, minor's rights, healthy relationships and consent, LGBTQ+ inclusion, and mental health. The Council also served as the keynote presentation during the annual teen pregnancy prevention conference that SHIFT NC hosted in May 2021.

Another objective is to increase access to highly effective contraceptive methods. During FY21, 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, FQHC, nonprofits, private funders, hospital systems, universities, consumers, Medicaid, and substance use disorder treatment programs. The group met virtually in September 2020 with 12 people attending; met in January 2021 with 12 people attending; and met again in April 2021 with 14 attending. During the September meeting, NC Medicaid provided an overview on Medicaid Transformation and how telehealth was rolling out to assist during the COVID-19 pandemic. The group received updates from different agencies on how services had been affected by the pandemic. During the January and April meetings, the group discussed state COVID-19 vaccination plans and heard an overview of the Perinatal Health Strategic Plan and the MCHBG State Action Plan and items related to this group.

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 FY21, Upstream started consulting with a tribal liaison to bolster recruitment efforts and ensure including the tribal communities in NC. Starting in February 2021, due to the focus on COVID-19, Upstream paused their work with eight of the eleven LHDs partnering with them. Three LHDs decided to continue their project. One of the LHDs completed the virtual training and 89% of support staff and 100% of clinicians reported they would recommend the training to others. Upstream went through some organizational changes and restructuring during this time and reworked their program model to provide technical assistance to agencies more efficiently.

During FY21, requests from LHDs around same day insertion were limited, due to the focus on COVID-19. 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. Additionally, staff continued to partner with Upstream to assist agencies in need of more intensive technical assistance around provision of same day LARC insertion. Many LHDs, due to COVID-19, were not at a place where they could focus on changing policies and practices to fit same day insertion protocols. However, even given these challenges, the percent of LHDS offering same day insertion of both contraceptive implants and intrauterine devices (ESM 1.4) rose from the 2019 baseline of 74% to 85% according to results of the 2021 NC Family Planning LHD Clinical Practice Survey. Research was completed regarding barriers and mitigation strategies for same day insertion of long-acting reversible contraceptives in FY21. This information was compiled and will be used in the future to help staff provide consultation and technical support to LHD’s for same day insertion.

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. Priorities, strategies, and measures for this domain have been reviewed and work on them will continue in FY23.

Provide Guidance and Support to Offer Family Friendly Clinical Services

To offer family friendly clinical services, the LHDs must be a safe, inclusive space for adolescents to seek services. The Reproductive Health Branch (RHB) has created a youth friendly services project to assist local agencies, including LHDs, by working on a youth friendly services toolkit. In FY23, the RHB will illicit feedback from local agencies and youth to create a toolkit to assist in providing information to all agencies in the community about youth friendly services. The toolkit will include a training that agencies can utilize to educate the community on appropriate services to meet the needs of young people in an inclusive, equitable manner.

Extended Hours for FP Services

Over the next year, the WICWS will continue to work with the LHDs interested in working towards extended hours for family planning services to provide an opportunity for more individuals to access a preventive medical visit. The WICWS plans to host a webinar for LHDs to share with one another successes and challenges in implementing extended hours. This will allow for a space for LHDs to learn from one another and may prompt additional LHDs to work towards making extended hours an option for their community.

Improving Preconception Health and Creation of Outreach and Education Toolkit

The PCH Team, in collaboration with at least one RNC, will finalize 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 by July 2022 (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, 2022. 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 FY23 efforts supporting this priority need, NPM#1, and ESM#2 include that three out of the five funded ICO4MCH sites will implement a strategy focused on improving preconception and interconception health among women and men. They will develop a 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 also 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 FY23 as described in the WMH Domain Annual Report.

Priority 2 – Increase Pregnancy Intendedness Within a Reproductive Justice Framework

In one effort to increase pregnancy intendedness within a reproductive justice framework, over the next year, a training will be made available to LHDs around offering all methods of contraception, including some methods via prescription or referral, if necessary, and how to ensure referral sources are providing quality care to clients. This training will include sharing a guide, developed by the Reproductive Health National Training Center, around how to appropriately stock all methods of contraception. In addition, the RHB will update an existing training around Reproductive Life Planning to assist staff turnover within LHDs and assure that clinics are offering Reproductive Life Planning (RLP) to all clients.

The reproductive justice framework is also critical to the work happening around teen pregnancy prevention. In FY23, TPPI will continue to introduce more equitable and inclusive primary prevention curriculum to funded sites, which will be included as implementation options in the primary prevention Request for Applications (RFAs) projected for release in fall of 2022. Two curricula previously identified are Rights, Respect and Responsibility (3Rs) and FLASH. TPPI will provide additional curriculum overview sessions for individuals that were unable to attend previous sessions in January and February of 2022. TPPI Program Consultants will conduct individual interviews with local program coordinators and supervisors to collect feedback and evaluate how the new curricula meet youth and community level needs as well as identify potential gaps. TPPI will identify workgroup topics based on feedback provided during the interviews. Workgroup members will participate in Racial Equity Institute Phase I and reproductive justice trainings to guide this work toward equitable outcomes. Additionally, members of the North Carolina School Health Training Center training cadre will be trained as certified trainers for both the 3Rs and FLASH. In FY23, TPPI plans to offer a series of trainings focused on racial equity, reproductive justice, and inclusivity for funded agencies. TPPI will again offer a workshop on “Sexuality for Communities of Color” in partnership with the North Carolina Sexual Health Conference (NCSEXCON). This workshop will be led by a diverse panel of facilitators which will focus on Black, Indigenous, and Latinx communities. TPPI will also partner with expert trainers to coordinate a reproductive justice introductory training, identify program improvement objectives, and conduct supplementary workgroups to support the aforementioned.

To further advance teen pregnancy prevention, the WICWS will continue to nurture a youth leadership council for North Carolina. WICWS partnered with SHIFT NC to create a youth leadership council over the last few years.

Recently, SHIFT NC closed their doors, but this work will continue. During FY23, WICWS will continue to maintain a statewide youth advisory council. At least eight youth leaders will serve on the council and meet at least five times during the year. The council will provide direct feedback on strategies on working with young people in North Carolina. The youth council will also develop an annual project such as: developing a media campaign, creating a toolkit for local programs to develop a youth council, or bringing other youth advisory council's together for shared learning, skill building, etc.

Another objective is to increase access to highly effective contraceptive methods. Over the next year, the RHB will survey LHDs to find out which agencies are interested as serving as mentors to other LHDs that are working towards offering all methods of contraception. The LHDs that currently do offer the full array of methods will share their lessons learned and provide advice and guidance to assist agencies that do not. The WICWS will continue to partner with Upstream NC to ensure the technical assistance provided are based on evidence and allow for health department clinical staff to learn how to best meet the needs of their communities while respecting their decisions about having children and, when desired, how they choose to prevent pregnancies. The RHB will work with LHDs and Upstream to provide sample policies and clinic flows around contraception same day availability for LHDs needing this information. Resources from the Reproductive Health National Training Center will be shared along with technical assistance on how to utilize this information to enhance clinical services provided to clients.

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					
	2017	2018	2019	2020	2021
Annual Objective	90	90	90	90	90
Annual Indicator	76.1	77.3	76.7	80.1	75.1
Numerator	1,502	1,560	1,269	1,375	1,253
Denominator	1,974	2,017	1,654	1,717	1,668
Data Source	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	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
Annual Objective			50
Annual Indicator	33.7	37.2	70.9
Numerator	29	32	61
Denominator	86	86	86
Data Source	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year	FY18-19	FY19-20	FY20-21
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	100.0	100.0	100.0

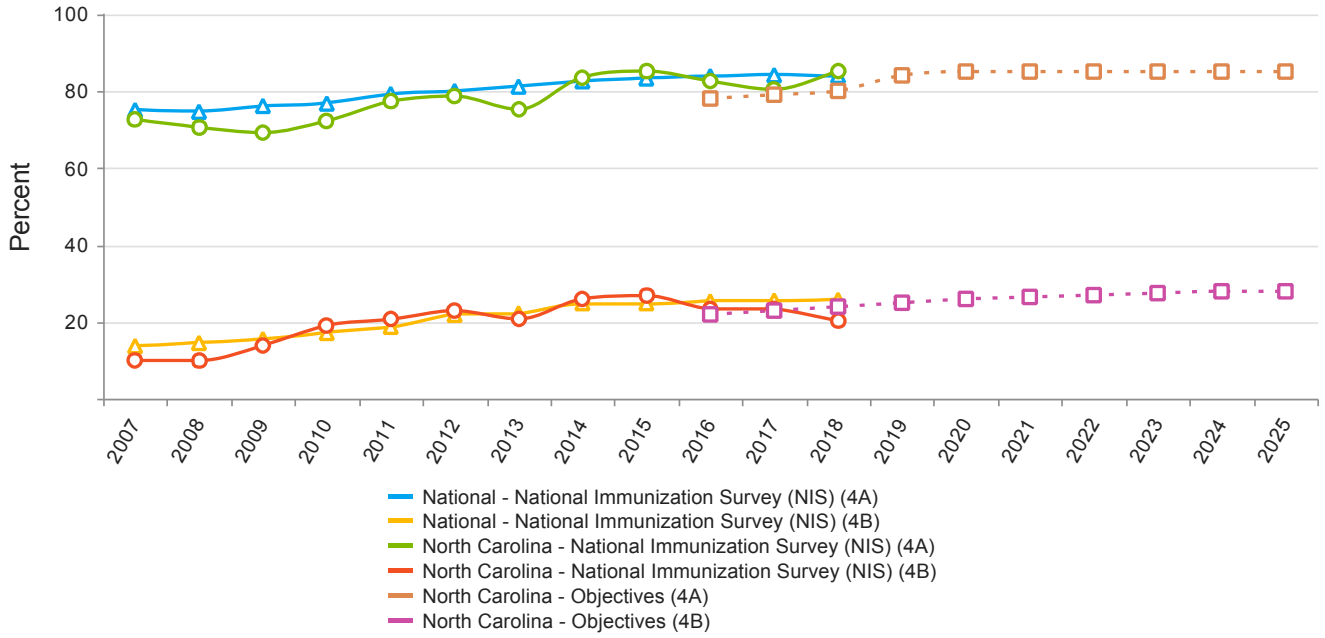
ESM 3.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL)

Measure Status:	Active

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

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	79	80	84	85	85
Annual Indicator	83.5	84.9	82.5	80.3	85.0
Numerator	90,633	103,683	88,249	90,222	91,471
Denominator	108,563	122,165	106,953	112,365	107,553
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	85.0	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	23	24	25	26	26.5
Annual Indicator	26.1	27.0	23.4	23.3	20.2
Numerator	27,283	31,775	24,051	25,865	21,416
Denominator	104,660	117,705	102,887	111,143	106,047
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	27.0	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
Annual Objective			28,350
Annual Indicator	27,587	25,020	22,263
Numerator			
Denominator			
Data Source	NC Crossroads WIC System	NC Crossroads WIC System	NC Crossroads WIC System
Data Source Year	SFY18-19	SFY19-20	SFY20-21
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	29,120.0	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
Annual Objective			8.1
Annual Indicator	7.6		6.8
Numerator	8,991		7,923
Denominator	118,725		116,755
Data Source	NC Vital Statistics/SCHS		NC Vital Statistics/SCHS
Data Source Year	2019		2020
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	7.0	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 genetic/metabolic 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 health and behavioral health combined trainings for LHDs/LMEs 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.
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 Pregnancy Care Managers inclusive of behavioral health.
PIH 1B.7. WICWS LCSW will develop webinars related to behavioral health that will be archived for repeat viewing.
PIH 1C.1. The Newborn Screening Follow-Up Team will continue to ensure 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.

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 - 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.

PIH 3A.3. Support strategies in the following strategic plans to improve breastfeeding rates: - NC Perinatal Health Strategic Plan - NC Early Childhood Action Plan - 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 North Carolina Division of Public Health 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 development and 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 to Maternal and Child Health care managers, local health department employees, home visitors, etc., though 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 newly revised NC Making It Work Tool Kit created by the CDIS Community and Clinical Connections for Prevention and Health (CCCPH) to help breastfeeding mothers return to work.

PIH 3A.11. Promote the WIC Breastfeeding Peer Counselor Program to all women receiving services in local health departments/WIC clinics and increase the number of women who sign the Breastfeeding Peer Counselor 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 mothers are receiving care in a risk-appropriate level of care facility. In FY21, a state-focused Maternal Health Task Force led and continued work on the development of a Maternal Health Strategic Plan with the goal of addressing disparities in maternal health and improving maternal health outcomes, inclusive of preventing maternal mortality and reducing severe maternal morbidities. The development of the Maternal Health Strategic Plan was informed by the work of the Maternal Health Innovation Program which included the Statewide Provider Support Network (SPSN). The SPSN works throughout the six Perinatal Care Regions (PCRs) in the state and is inclusive of Perinatal Nurse Champions, Obstetric Champions, Family Medicine Champions, and Pediatric Champions. Together, they have continued to work with birthing facilities across NC to determine the neonatal and maternal levels of care through the completion of the Centers for Disease Control and Prevention (CDC) Levels of Care Assessment Tool℠ (LOCATe℠).

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 2020 show that 75.1% of VLBW infants received care at currently designated Level III+ NICUs, which is similar to data for the past three years. 2020 rates were higher for Hispanic (81.4%) births than for Black, non-Hispanic (74.8%) and white, non-Hispanic (75%) 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 has delayed some of our process as providers have needed to prioritize other efforts.

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 LOCATe℠ 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 FY19, twenty-nine hospitals completed the LOCATe℠ tool, thus establishing the baseline total for ESM 3.1 (% of birth facilities [86 total] with level of care documented using the CDC LOCATe℠ tool) to 34%. In FY21, twenty-nine additional birthing facilities completed the CDC LOCATe℠ assessment tool for the first time bringing the cumulative total to 61 hospitals (71%). By FY23, the Perinatal Nurse Champions will engage with the

remaining birthing facilities to complete the LOCATe[SM] tool and work with facilities to complete reassessments if it has been greater than two years since the initial assessment. The work of this program will ensure that all birthing facilities will have completed the LOCATe[SM] tool at least once 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. 2019 baseline data for this measure was 1.2% as only one LHD (Granville/Vance District) was using NC-PAL, but in FY21, Alamance County Health Department began using the service as well. The NC MATTERS team conducted two trainings for locally funded Healthy Start Projects and for CMHRP, which consists of LHD staff. Due to the pandemic, continued efforts to engage LHDs were paused until after the demand of COVID-19 duties.

As part of the NC MATTERS program including NC-PAL, in FY21 staff members offered informational and educational webinars to NC LHDs and Local Management Entities/Managed Care Organizations (LME/MCOs). The NC MATTTERS program has perinatal psychiatrists and perinatal mental health specialists who served as the subject matter experts for the educational webinars. During FY21, the NC MATTERS team conducted three orientations via webinar to three LHDs. Additional orientations/informational sessions were provided to staff from various programs, such as Women's Health Nurse Consultants, subcontractors on the Maternal Health Innovation Program, WIC nutrition and breastfeeding staff, and the Maternal, Infant and Early Childhood Home Visiting (MIECHV) staff.

In FY21, the NC MATTERS program pursued opportunities to strengthen its relationship with the LME/MCOs. Representatives from LME/MCOs were invited to serve on the Implementation Team. Also, NC MATTERS worked on meeting efficiencies by merging their leadership team with the leadership team of the NC Pediatric Access Line. In FY21, two leadership meetings were held (in August and December) with 40 to 50 attendees at each meeting.

In FY21, the WICWS Licensed Clinical Social Worker and Maternal Health Nurse Consultant co-facilitated an educational webinar titled *Perinatal Mental Health for Local Health Departments: Awareness, Assessment, Action*. The intended audience for the webinar was nursing staff, social workers, and OB/Family Medicine providers that care for pregnant and postpartum clients in local health departments. The focus of the webinar was to address concerns from our local agencies related to screening and referral for mental health issues. Local agencies had questions about how to distinguish between the typical hormonal and mood changes in pregnancy from symptoms associated with perinatal mood and anxiety disorders. Additional questions related to the prevalence and symptoms of perinatal mood and anxiety disorders and how to administer and score validated screening tools to determine when further assessment was needed. The webinar also explored special considerations such as being pregnant during the COVID pandemic, pregnancy loss, and the impact of trauma on pregnancy. With the help of NC MATTERS Program Consultant, the State Social Work Consultant and the Maternal Health Nurse Consultant, resources for referral and follow-up were compiled and made available to local agencies. Eighty-five individuals participated in the webinar, and 74 participants completed the evaluation survey to receive 1.25 nursing continuing professional development (NCPD) contact hours. Fifty-two out of the 74 participants who completed the survey

(70%) were Registered Nurses, and 97% of respondents agreed or strongly agreed that the educational activity was "presented in an organized and engaging manner." This webinar is archived on the WICWS website for repeat viewing.

During FY21, the Regional Social Work Consultants (RSWCs) provided on-going support around behavioral health to CMHRP Care Managers in several ways. First, behavioral health education was provided during the face-to-face portion of the program's new hire orientation training for new staff with emphasis on the importance of awareness, accessing services and closing the loop on behavioral health referrals. Mental Health First Aid (MHFA) was and is a required component of the new hire orientation process. RSWCs provide resources for this and other available behavioral trainings to CMHRP Care Managers.

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

RSWCs also provided case conferencing and consultation to CMHRP Care Managers. RSWCs were available to care managers to brainstorm strategies to address behavioral health issues that were solution-focused and resourceful. When applicable, the RSWCs connected Care Managers to the WICWS Licensed Clinical Social Worker.

Using the CMHRP Common and Postpartum Care Management Pathways, guidance and technical assistance is provided on how to assess behavioral health needs. Consultation is provided on behavioral health resources, as well as screening tools such as the Patient Health Questionnaire-9 (PHQ-9) and the Edinburgh Postnatal Depression Scale.

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 and later for galactosemia, congenital adrenal hyperplasia, 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 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 NBSs with abnormal 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 FY21, the NBS Follow-Up Team provided services for 886 infants with abnormal NBS results for CH, CAH, galactosemia, biotinidase deficiency, and CF, 116 of whom were confirmed to be affected and are receiving treatment as determined by the appropriate subspecialist. Additionally, active follow-up was provided to 64 abnormal SCID results, which identified no confirmed cases of SCID, and 16 infants were identified with and treated for other conditions detected by a low T-cell count. The NBS Follow-Up Team developed follow-up protocols and educational materials for SMA, and screening was implemented early in 2021. The NBS Follow-Up team began similar work for X-ALD and will work to develop follow-up protocols, educational and outreach materials relevant to new conditions being added to the NC Newborn Screening Panel in FY22 (MPS-1 and Pompe).

The DCFW/WCHS maintains a contract with UNC-Chapel Hill for follow-up and management of infants identified by tandem mass spectrometry (MS/MS). The team at UNC continued to provide clinical genetic services, genetic counseling services, and genetic testing for approximately 2000 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 at least 2,478 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 460 infants identified through NBS and consultation to referring healthcare providers regarding patient diagnosis, care, and management. There were 28 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 5800 phone encounters with all their metabolic patients regarding ongoing management.
NCSLPH NBS completed validation of a Laboratory Developed Test (LDT) for SMA via real-time polymerase chain reaction that allows for simultaneous identification of Severe Combined Immunodeficiency (SCID) and SMA. The NBS Follow-Up Team began receiving notification of potential SMA cases and began providing timely interpretation, confirmation of suspected diagnoses, and coordination of care. Since launching of SMA screening on May 1, 2021, five confirmed-positive SMA cases have been identified. Verification of the FDA-Cleared NeoBase™2 MSMS kit assay for the measurement of amino acids and acylcarnitines was completed. This method replaced the previously utilized LDT for the measurement of 29 biomarkers in the detection of Fatty Acid Oxidation, Amino Acid, and Organic Acid disorders. Procurement, installation, and optimization of two SCIEX Citrine™ QTRAP MS/MS *in vitro* diagnostic medical devices for the validation of an LDT to detect X-ALD via a second-tier LC-MS/MS was completed. A new nitrogen generation system was also installed to serve the NBS MS/MS Lab. This system replaced the individual nitrogen generators in the lab, resulting in reduced noise and space usage, and provided a redundant source of nitrogen and dry air delivered to the Lab by stainless steel lines. Requests for Proposals (RFPs) were processed for First, Second, and Third Tier Testing for MPS-1 and Pompe.

The DCFW/WCHS State Public Health Genetic Counselor (SPHGC) provided additional training and technical assistance about children and youth with and at risk for genetic conditions in FY21. The state genetic advisory

committee, made up of professionals, families, and other stakeholders 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 86 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 2020, a total of 117,658 (99.2% of 118,637 occurrent live births) were screened for hearing, with 114,629 (96.6% 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 align with the PHSP using an environmental scan survey. The PHSP has continued to support and foster new partnerships. For example, the intersection of substance use and tobacco, as well as perinatal incarceration, has created the opportunity to work with new partners. Regular PHSP 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, PHSP partners can turn to the plan to ensure that the work we are doing addresses the larger goals:
Goal 1 – Addressing Social and Economic Inequities
Goal 2 – Strengthening Families and Communities
Goal 3 – Improving Health Care for Women and Men

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. A new 2022-2026 PHSP, to be released in 2022, is aligned with the Perinatal Systems of Care (PSOC) Task Force recommendations with a continued 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 (63% of the 1279 child deaths in 2020), 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 is one of North Carolina's minority infant mortality reduction programs with goals that include 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-child care. All Healthy Beginnings staff are required to complete training and/or utilize educational materials identified by the Women, Infant and Community Wellness Section for each program component.

The Healthy Beginnings program served 494 minority pregnant and postpartum/interconception women and their children in FY21. During FY21, there were 443 live births with one infant death (2.5 infant death rate). Among all pregnant program participants, 82% 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 FY21, BLP was focused in four counties with higher infant mortality rates within the state. 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. The ICO4MCH initiative provided funding to five lead LHDs (which totals 14 health departments) in FY21. The LHDs implement one evidence-based strategy in each of the three aims. The evidence-based strategies to be implemented include: using a Reproductive Justice framework to improve the utilization of RLP and access to LARC, Ten Steps for Successful Breastfeeding, with a Focus on Steps 3 and 10; Tobacco Cessation and Prevention, Triple P (Positive Parenting Program), Family Connects Newborn Home Visiting Program, and Clinical Efforts to Address Secondhand Smoke Exposure (CEASE). 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.

The Infant Mortality Reduction Program provided Title V funding to 21 LHDs in counties that have experienced some

of the highest infant mortality rates in the state in FY21. This program implements 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 include the provision of 17P injections to help prevent repeated preterm births; Centering Pregnancy; doula services; infant safe sleep practices; Nurse Family Partnership program; reproductive life planning and increased access to long acting reversible contraception; and tobacco cessation and prevention.

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

Increasing the percent 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 2018 reported that 85% of infants were ever breastfed, yet by 6 months of age only 20.2% of infants were exclusively breastfed, below the national average of 25.8%. Additionally, breastfeeding initiation data obtained from birth certificates for infants born in 2020 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 (87%) and non-Hispanic white (83.9%) more likely to initiate breastfeeding than non-Hispanic Black (69.5%) or non-Hispanic American Indian (53.5%) infants. These disparities are also present for babies born 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.

The continuation of COVID-19 pandemic continued to impact the gaps in breastfeeding support across NC. At the onset of the COVID-19, NC maternity centers reported decreased staff position in lactation support and closure of maternity centers particular in rural communities. The continuation of the COVID-19 pandemic through FY21 has stagnated the rebound and growth of North Carolina's breastfeeding support referral network. The NC Breastfeeding Coalition's (NCBC) statewide database for breastfeeding support further highlights the limited resources available to breastfeeding women in both rural as well as urban communities. This inequitable access to and availability of resources and support is a known contributor to racial and ethnic disparities. Research is emerging evaluating the negative impact of the COVID-19 pandemic on breastfeeding, particularly among under resourced populations. Multiple factors are believed to contribute to the disruption in breastfeeding support resulting in decreased breastfeeding rates, including, but not limited to the disruption in breastfeeding friendly hospital practices, insufficient professional support, decreased in-person appointments, mixed messaging received by parents across professional organizations about safety of COVID-19 and breastfeeding. While the COVID-19 pandemic has been credited with positively impacting the expansion of telehealth services, the utilization of telehealth and the lack of in-person appointments during the early weeks of postpartum has been identified as a contributor to decreased breastfeeding rates. In-person breastfeeding support is more likely to provide the emotional care and warmth of peers and professional support that women value, lactation support providers can provide more than just practical breastfeeding support, clear up any mixed messaging pertaining to the COVID-19 and breastfeeding, and screen for depression.

FY21 continued to be a learning curve in how to adapt delivery of services in the COVID-19 pandemic to balance individual safety with optimal prenatal and postpartum breastfeeding support. The DCFW/CNSS 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. The DCFW/CNSS investigated new paths to improve individual access to breastfeeding support the development of the North Carolina Breastfeeding Hotline. In FY21, the DCFW/CNSS in partnership with external organizations, outlined a proposed plan for a Statewide hotline and identified a promising funding source through NC Medicaid.

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 continue to be 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 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 breastfeeding coordinators and lactation consultants. 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 of 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 25 hours 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 Counselor (BFPC) Program funds were made available to local agencies in 2005, the program has grown from four local WIC agencies to 84 local WIC agencies. In FY19, Breastfeeding 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. However, in FY21, participation in the BFPC program continued to decrease despite increased participation in the WIC Program. In FY21, there were 22,263 participants who received BFPC Program services, an 11% decrease from the 25,020 participants who received services in FY20. The COVID-19 pandemic resulted in a swift shift of WIC services from in-person to telehealth primarily phone based contact resulting in a disruption in local WIC agency operational and referral processes and, similar to all fields, turnover. the FY21 resulted in gaps in BFPC Program services within agencies. Despite the emerging issues the COVID-19 pandemic has brought to the operation and sustainability of the BFPC Program, the BFPC Program has been identified as one of the most effective interventions improving breastfeeding rates, and the NC WIC Program has increased their state-wide breastfeeding initiation rates from 57.6% in FY05 to 72% in FY21.

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 1,700 healthcare staff members in all 100 counties in NC with 103 healthcare staff members completing the training in FY21. 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 DPH. Since its implementation in 2010, over 68% of NC maternity centers have achieved at least one or more stars and currently over 49% 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 19 hospitals in NC who have achieved the Baby-Friendly designation from Baby Friendly USA. As 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 FY21, NCDHHS also updated the NC Breastfeeding Friendly Child Care Designation 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*. The revised application was released during the FY22. 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.

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. By 2021 a total of 7 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 to implemented breastfeeding friendly practices within their clinic. In August 2020, the NCBC updated it's award application criteria and between August and October 2020, the PNC worked with NCBC and internal staff to update the Award Online Pre-Application Assessment and provided updated links to Child Health Consultant Staff and Clinical Connections for Prevention and Health (CCCPH) Branch and Healthy Communities staff. Only one LHD Child Health Program chose to work on this Award for FY21 (Swain County) and their efforts to work on this were delayed due to COVID-19 prioritization of work.

During FY21, 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:

- On June 25, 2020, the training titled *Making a Difference: Supporting Breastfeeding Families* was co-delivered by three DCFW staff members. The target audience for this 90 minute webinar was Child Health Enhanced Role Nurses, Family Nurse Practitioners, Physician Assistants, MD's working in Child Health clinics, CMARC Care Managers, and nurse practitioners throughout NC. Approximately 55 people attended the live webinar which was recorded and is available online for 1.75 NCPD Contact Hours and CPH Recertification Credits upon successful completion.
- In FY21, DPH along with NCBC, CGBI, and MomsRising developed and implemented a dissemination, training, and use plan for the *NC Making It Work Tool Kit*, a breastfeeding support tool kit which consists of five different tools targeted to breastfeeding moms, employers, family members, and advocates Spanish versions of all these materials are also now available and funding for the Spanish translation was provided by the Community and CCCPH Branch of the NC CDIS.
- Other hoped or planned for breastfeeding coordination activities for FY21 were put on hold as staff had to prioritize COVID-19 work.

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

CYSHCNs.

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 (PSE) 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. Staff from WCHS and CDIS work together to coordinate and share information across programs to help focus technical assistance (TA) and training, reduce duplication of effort and increase outcomes.

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

One NC SPAN Grant activity was the creation of the NC Breastfeeding Advisory Group (BAG) whose purpose is to be a sharing forum for North Carolina breastfeeding stakeholders to explore challenges and opportunities, share expertise, provide guidance and identify potential collaborations to increase breastfeeding among families in North Carolina. The PNC is a member of the group along with staff members from DPH/DCFW, the NCBC, Mom's Rising, and the Carolina Global Breastfeeding Institute. The NCDHHS Senior Early Childhood Policy Advisor is also a member.

The CCCPH Branch is also providing direct technical assistance and support to local community organizations awarded funding through RFA #A359 (PAN Funding). Part of the funding supports the NC Title V Program's work to increase breastfeeding initiation and duration. 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.

Care Managers for the CMHRP program assessed each of their patients prenatally and in the postpartum period for breastfeeding support needs and provided on-going education and information during FY21 as part of their care management services. 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 FY21, 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 and 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 FY21, 78.3% initiated breastfeeding, and 30% 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 FY21, 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 FY21, 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 the lower rates. The top reason reported from 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 will be discussed.

In FY21, ICO4MCH sites hired CHWs to assist with implementation of the breastfeeding strategy. The CHWs attended the NC Lactation Educator training and are now certified as Breastfeeding Peer Counselors to provide breastfeeding support. The CHWs contributed to writing a policy for the new Mamava lactation pod and other related breastfeeding policies and reached out to businesses as part of the Breastfeeding Friendly Cities Initiative. The CHWs also worked with students from Duke University and the University of North Carolina on breastfeeding-friendly provider designations and trainings. The CHWs have specifically worked to prioritize reaching underserved populations and young families unaware of the available resources, often educating them on their reproductive life planning options and breastfeeding while employed, including focusing on self-care for mothers, pregnancy spacing, and continued conversations around reproductive life planning. During FY21, a new partner relationship was established with one organization, 223 outreach and educational events were held, and 5,310 individuals were reached with breastfeeding education. ICO4MCH sites also provided general lactation education to 168 individuals; organized lactation training for 260 individuals; and provided peer support for 63 individuals.

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 FY19, 23% of MIECHV participants reported any breastfeeding at 6 months of age, while non-MIECHV NFP sites were at 38.6%. In FY21, these percentages were 18.1% for MIECHV participants and 26.2% for participants of non-MIECHV NFP.

Both NFP and HFA programs practice a number of 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. Other strategies include incentives for breastfeeding, developing a breastfeeding success plan, disseminating breastfeeding educational materials, and ongoing trainings for the home visitors throughout the year. One MIECHV site developed a curriculum to share with male partners educating them

about the benefits of breastfeeding, how to support mothers with their decision to breastfeed, and how to participate in breastfeeding. Additionally, there is a focus on increasing breastfeeding at 6 months.

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 2020, this percentage decreased to 6.8%. Hispanic women (1.4%) were least likely to smoke during pregnancy and non-Hispanic American Indian women were most likely to smoke (18.2%) in 2020. Non-Hispanic Black women (6.6%) were less likely to smoke than non-Hispanic White women (8.8%). 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 125 pregnant women during FY21. Of those pregnant, 88.9% reported abstaining from tobacco during pregnancy with 96.6% 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 80.4% and 80.6% 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 FY21, 96.8% of pregnant program participants and 92.3% of postpartum/interconception program participants do not smoke. During FY21, 95.7% of pregnant program participants and 97.4% of postpartum/interconception program participants did not use other tobacco products/ENDS. During FY21, 88.2% of pregnant program participants and 96.8% of postpartum/interconception program participants did not allow smoking in the home to avoid secondhand smoke exposure.
Because tobacco use during pregnancy is a driving factor for preterm birth and low birth weight, CMHRP Care Managers continued to employ interventions to assist pregnant persons with tobacco cessation in FY 20-21. Medicaid recipients, as well as low income individuals who did not qualify for Medicaid coverage, that reported tobacco use during pregnancy at the same level as before pregnancy, were eligible for CMHRP services. Tobacco use is the most common risk factor associated with eligibility for CMHRP services. All pregnant and postpartum individuals who are eligible for CMHRP services were assessed by a CMHRP Care Manager, received the 5As and

the appropriate level of tobacco cessation intervention according to the 5As modality. Harm reduction, postpartum relapse prevention, as well as the dangers of infant exposure to second-hand smoke were emphasized. The CMHRP Program updated its Tobacco Cessation Pathway resource for care managers in collaboration with UNC Collaborative for Maternal & Infant Health and the You Quit, Two Quit initiative. This Tobacco Cessation Pathway provides guidance for screening, counseling and documentation of care management activity related to tobacco use in pregnancy and postpartum. This Pathway, along with the most updated version of the You Quit, Two Quit Tobacco Cessation Practice Bulletin, which encompasses several other educational resources for care managers and patients continued to be a resource for CMHRP Care Managers.

The CMHRP Program also partnered with the Pregnancy Medical Home (PMH) program, implemented by Community Care Of North Carolina (CCNC) to align on tobacco cessation strategies for dually served pregnant and postpartum individuals. The PMH has a companion pathway for prenatal care providers that aligns with the Tobacco Cessation Pathway for care managers that continued to serve as a resource for prenatal care providers and care managers.

In FY21, the Tobacco Cessation and Prevention evidence based strategy for ICO4MCH sites worked to decrease primary tobacco use as well as second-and third-hand smoke exposure to reduce the risk of infant mortality. To accomplish this, LHDs provided direct clinical support around tobacco use, screening, and counseling; educated community members through worksite cessation classes; conducted outreach to promote the use of Quitline NC resources; advocated for and helped to enforce smoke-free/tobacco-free policies in public spaces throughout their service areas; and trained practitioners in the 5As method of counseling and/or as Certified Tobacco Treatment Specialists (CTTS), which is a more intensive method for those who deliver moderate to intense tobacco treatment services in a healthcare or community setting.

In FY21, ICO4MCH sites held vaping education presentation via Zoom for Alleghany County Schools faculty and staff to share basic vaping education and prevention resources with seven faculty members. Additionally, some sites implemented a marketing campaign, *Every Try Counts,* in partnership with iHeartMedia. This campaign targeted audiences in several counties and was broadcasted on social media platforms, streaming networks, and radio. The ads directed audiences to the QuitlineNC for additional resources for quitting tobacco use.

ICO4MCH site connected with Blue Ridge Healthy Families, an intensive home-visiting service for families with newborns in Avery County. Virtual meetings were held to showcase tobacco cessation services offered through the program and to work with the agency to develop a tobacco use screening tool to be used during home visits. In addition, the ICO4MCH LHD site provided QuitlineNC resources to a local restaurant in Boone to be distributed in the employee break room as well as the restaurant's weekly employee newsletter.

Preconception Health and Tobacco Cessation Activities

NC has a robust partnership of state and LHD partners, universities, and community-based organizations involved 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) shares and disseminates information associated with women's health and tobacco use prevention and treatment across the lifespan. Healthcare providers, including LHDs, are the major partners in the tobacco cessation effort for pregnant women. Support provided to program partners includes training, technical assistance, strategic planning, and educational materials development and dissemination around tobacco cessation treatment. WATCH assisted in the latest development and update of the *You Quit Two Quit* Practice Bulletin. This 2019 update included a focus on perinatal substance use. This is one of several provider and patient

tobacco cessation materials developed and distributed to health care partners throughout the state. All materials are distributed free of charge.

During FY21, the WHB 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.

In concert with the ICHB Head and the WICWS Nutrition Consultant, the Preconception Health and Wellness (PHW) Program Manager provides leadership and guidance for the Preconception Health Advisory Council. This Council is responsible for updating the existing preconception health strategic plan and moving it into implementation. The current plan includes a focus on pregnancy intendedness, mental health, obesity, access to care, and substance use. This position also is responsible for implementing the state's Preconception Peer Education (PPE) Program. With tobacco use being a critical focus area for preconception health, the PHW Program Manager also manages this effort within the WHB, including coordinating WATCH. This position was vacant for much of FY21 due to staff retirement, but the new Program Manager, hired in April 2021, engaged in planning discussions with WICWS leadership and initiated efforts to revitalize WATCH. Email correspondence was sent to former and prospective WATCH members to ascertain their interest and availability to attend future meetings. An initial WATCH meeting was scheduled for early 2022 with others to follow quarterly.

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 FY23. 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 FY23, the state-focused Maternal Health Task Force will have joined efforts with the Perinatal Health Equity Collective (PHEC). Strategies developed by the Maternal Health Task Force will be merged into the statewide PHSP that is led by the PHEC. The goals of the PHSP are already inclusive of improving maternal health and reducing maternal morbidity and mortality.

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 Maternal Health Action Team of the PHEC will lead the work in the development of the maternal levels of care to include collaboration with the DHSR. The Perinatal Nurse Champions will continue to engage birthing facilities who have not yet completed the CDC LOCATe^{SM} to do so in FY23.

Providing Behavioral Health Support to Maternal Health Providers

To increase awareness of the NC MATTERS program and NC-PAL in FY23, 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.

By FY23, the MATTERS program will refine the strategy and workplan for engaging North Carolina LHDs in use of the NC-PAL, aiming to enroll at least fifteen pilot LHDs to establish protocols that include integration of the NC-PAL consultation services into the agency's clinic flow. Upon enrollment, each LHD will receive: (1) continuing education resources on Perinatal Mood and Anxiety Disorders via online learning services around substance use, mental health care planning and community based resources, (2) clinical guidance on mental health care plans algorithms for routine screening using MATTERS clinical and mental health wellness plan toolkits, and (3) provider efficacy training opportunities. After services are established, the perinatal telepsychiatry clinic will be accessible for each enrolled LHD to receive special psychiatry care for their patients. While working with the pilot counties is the main emphasis of the MATTERS program, providers from any county in NC can call NC-PAL, and WHB staff members will be encouraging all LHDs to do so.

NC currently has seven LME/MCOs, which are public managed care organizations that manage Medicaid, federal, state and local funding for services and supports related to mental health, substance use and intellectual/developmental disabilities. The NC MATTERS program plans to strengthen its relationship with the LME/MCOs, to include inviting a representative to serve on the Implementation Team. It is anticipated that LME/MCOs can be instrumental in advising the NC MATTERS Implementation Team on ways to best integrate health care/maternal mental health services via resource sharing, provider trainings and other coordinated efforts. Now that Medicaid Transformation has been restarted, discussions with the Prepaid Health Plans will also be critical.

In FY23, the Maternal Health Branch (MHB) Licensed Clinical Social Worker (LCSW) will continue to develop and conduct webinars on behavioral health topics that may impact pregnant and postpartum individuals. The LCSW will conduct an assessment of additional professional development topics that LHD staff and others working for maternal health programs. By the end of FY23, the MHB LSCW will produce a series of recorded webinars that will focus on

behavioral health as it pertains to reproductive life planning. Additional webinar topics being considered for FY23, based on the results of an assessment, include interpersonal violence, motivational interviewing, grief counseling, compassion fatigue, finding mental health resources, and cultural differences in maternal care from the client's perspective.

In FY23, the WICWS nurse consultants will support LHDs providing maternal health services by reviewing the psychosocial component of the Agreement Addendum during monitoring visits. This review serves as an opportunity for the WICWS nurse consultants provide TA in areas that need improvement, such as documentation and follow-up. 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 determining whether to incorporate Health Behavior Intervention Services.

The WICWS RSWCs will continue to provide on-going support around behavioral health to CMHRP in the methods described in the P/IH Domain Annual Report. Behavioral Health will continue to be addressed in an on-going way in CMHRP Programmatic documents:

- RSWCs ensure it is an area addressed on the Pregnancy Risk Screening Form
- Resources are included in "CMHRP Resources and References" document
- Education and guidance are included in CMHRP Common Pathway and will be updated include best practice for Depression screening
- Information on Depression and Post-Partum Depression is included in the CMHRP Patient Education Pathway

RSWC's will partner with the MHB LCSW to provide at least one behavioral health training during the year and develop a Behavioral Health Pathway as a resource for CMHRP care managers. RSWCs will continue to bring a behavioral health perspective to their work with CMHRP care managers to ensure a holistic approach is taken to patient care. RSWCs will continue to advocate for addressing whole person care inclusive of behavioral health with care managers and program stakeholders.

Newborn Screening Follow-Up Team

In FY23, 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 FY23 (MPS-1, and Pompe).

The NC MAPS project, a CDC funded collaboration between the NCSLPH and RTI, started in September 2020 and will extend through 2022. It is primarily designed to support laboratory and follow-up activities in the onboarding processes for the four new conditions recently added to NC NBS panel: Mucopolysaccharidosis – Type I (MPS-I), X-Linked Adrenoleukodystrophy (X-ALD), Pompe Disease, and Spinal Muscular Atrophy (SMA). These processes have been completed for SMA and X-ALD, but will continue in 2022 for MPS-1 and Pompe Disease. To date this initiative has worked to enhance the Laboratory Information Management System at the SLPH, improve the Case Management Information System for the NBS follow-up program, and to develop and implement standard operating procedures, educational materials, and project management tools to map our progress towards reaching our

onboarding goals.

In early 2022, a contract was awarded for First, Second Tier, and Third Tier Testing for MPS-1 and Pompe. Plans for July 2022 through June 2023 include the verification of screening for MPS-1 and Pompe via the FDA-cleared NeoLSD™ MSMS kit assay as the First-Tier method at NCSLPH. This verification will include tests of assay performance and corresponding data analysis to establish reporting algorithms and cut-offs. Specimens identified by First-Tier screening will be screened by LC-MS/MS and Next Generation Sequency by PerkinElmer Genomics in a tiered approach. In addition to verification of NeoLSD™ at NCSLPH, preparation for screening for Pompe and MPS-1 will require the establishment of laboratory operating procedures, organization of specimen submission for confirmation, validation of LIMS functionality and reporting, training of testing personnel, and the creation of Follow-Up Programs for MPS-1 (UNC) and Pompe (Duke).

The team at UNC will continue to provide clinical genetic services, genetic counseling services, and genetic testing for approximately 2500 unduplicated patients in FY23. Metabolic services will be provided to at least 2700 newborns and patients with a potential diagnosis for an inborn error of metabolism identified through MS/MS through the NCDHHS. Services have been expanded to reflect the NBS program expansion through the State Laboratory and will include infants screened for SMA, X-ALD and MPSI. 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 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 FY23. All 85 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 addition of a Spanish bilingual parent consultant and the continuation of the Parent Support Team. The EHDI program will also continue quality improvement work with the goals of increasing the percentage of infants rescreened by 1 month of age, increasing the percentage of children who receive a diagnostic evaluation by age 3 months and increasing the percentage of infants enrolled in early intervention services by age 6 months.

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

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, will continue in FY23 through a variety of methods. The PHSP's adapted framework is designed to focus on equity and social determinants of health to address infant mortality, maternal health, and the health status of individuals of reproductive age. A new 2022-2026 PHSP will be released in summer 2022.

In addition, work to support the NC CFTF will continue. As historically, about two-thirds of all child deaths in NC are

infant deaths (803 of the 1,279 total child deaths to children under 18 in 2020 were infant deaths – 63%), the NC Title V Office works closely with the NC CFTF. Specific priorities for FY23 include continuing to work on legislation to strengthen the statewide Child Fatality Prevention System, youth suicide prevention, firearm safety, nicotine use prevention, infant safe sleep, and motor vehicle safety. For 2022, the CFTF made nine legislative recommendations, most of which are being repeated from prior years, including recommending increased funding (from $45,000 annually to $250,000) for programs to prevent deaths associated with unsafe sleep environments or Sudden Infant Death Syndrome (SIDS) (NC CFTF Annual Report, May 2022).

Infant Mortality Reduction Programs/Initiatives

In FY23, Healthy Beginnings will serve a minimum of 400 minority women during pregnancy, the postpartum period, and up to two years interconceptionally as described in the P/IH Domain Annual Report.

The Healthy Start NC BLP program will continue to provide the services described earlier in the P/IH Domain Annual Report, and the program will have an enhanced focus on mental health, breastfeeding, co-parenting and improving self-sufficiency for FY23. NC BLP plans to re-engage in community events and outreach where permitted and appropriate in order to increase awareness of the program and increase enrollment efforts. NC BLP program received additional funding to provide mental/behavioral health services for 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 spring 2022, five sites representing nine counties received two-year ICO4MCH funding through a request for application process. In this round of funding, the six choices of evidence-based strategies to be selected were: 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 FY23, the Infant Mortality Reduction Program will provide funds to 22 local health departments to implement evidence-based programs in the counties that have experienced the highest infant mortality rates during the five-year period of 2010-2014.

Strategic Plans Prioritizing Breast/Chest and Human Milk Feeding

As reported in the P/IH 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 FY23 under the leadership of the NC DPH/DCFW Breastfeeding Coordination Team.

WIC Breastfeeding Peer Counselor Program

In FY23, the NC WIC Program will implement a new regional model for the Lactation Training Centers outlined below as WIC Lactation Area Training Centers for Health (WIC LATCH). The WIC LATCH will provide greater support to local WIC agencies in the development of standardized internal and external referral system to increase referrals by health departments and WIC staff to the Breastfeeding Peer Counselor Program. Additionally, the NC WIC Program will implement the WIC Breastfeeding Support Curriculum from the United States Department of Agriculture to

provide greater support through peer counselors having timely access to experts in lactation care and greater guidance expectations of charting through the development of trainings. These two factors have been identified as an indicator for retention of peer counselors. The emphasis being greater retention will lead to more consistency in the acceptance of referrals and local WIC agencies being able to operate the BFPC Program.

Regional Lactation Training Centers and NC Lactation Educator Training Program

NCDHHS, through the NSB, launched the Regional Lactation Training Centers (RLTCs) in 2005 to enhance the statewide infrastructure to support breastfeeding across the state. The COVID-19 pandemic served as an opportunity to assess the needs of the public health agency staff and medical providers serving the WIC eligible population in the provision of breastfeeding support, leading to a rebranding of the RLTCs into the Regional WIC LATCH. The Regional WIC LATCH will continue to ensure that public health agency staff and medical providers have routine and ready access to accurate, standardized, evidenced-based clinical lactation management information through answering questions and free in-service and continuing education opportunities. Additionally, the WIC LATCH will be tasked with bridging the gap between private and public providers to ensure consistency of messaging and increasing the network of support for prenatal and postpartum families in breastfeeding support. For FY23, the DFCW will seek to award the WIC LATCH contract in each of the three regions to offer state-wide coverage and harness the support of the NC DHHS partners to promote ability and utilization of this resource through completion of in-services in lactation and increased enrollment in WIC's BFPC Program.

Breastfeeding Friendly Designations

DCFW/CNSS will update the NC Maternity Center Breastfeeding Friendly Hospital Designation application to align with the World Health Organization's updated *Ten Steps to Successful Breastfeeding* and updated Baby-Friendly, USA guideline evaluation criterion for implementation in FY23. CNSS will coordinate endorsement of application with the North Carolina Hospital Association, NC Pediatric Society, Child Fatality Task Force, NC Institute of Medicine and other pertinent professional organizations.

Also, in FY23, 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 FY23, 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 FY23, 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 FY23, the NC BLP staff will prioritize the relationship with WIC, particularly the Breastfeeding Peer Educators within the health department. BLP staff will focus on making early referrals to breastfeeding peer educators to strengthen the bond with participants prenatally. It is anticipated that connection during prenatal period will build a network of support during the postpartum period. In FY23, additional BLP staff will be trained as lactation counselors through funding from the federal Healthy Start initiative. This training will provide the tools needed to assist families early and during home visits. Familial support is also a critical component of breastfeeding initiation and impacts duration. The NC BLP Program Coordinator, who also assists with supporting fathers/male partners of the program, is a Certified Lactation Counselor. In this role, the BLP

staff person will 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 also participate on the Local Action Networks (LANs) to elevate the community's responsibility in supporting breastfeeding families. The LAN will create action plans to promote schools and businesses adopting policies to support breastfeeding families.
ICO4MCH grantees focus on Steps 3 and 10 of the Ten Steps for Successful Breastfeeding. FY23 strategies for ICO4MCH will include the following: 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 FY23, ICO4MCH projects will also work with LHDs to establish public lactation rooms.

The MIECHV Program will continue to implement HFA and NFP models in NC in FY23 and support their ongoing strategies to promote breastfeeding. One MIECHV NFP site is participating in a CQI Practicum with a focus on the continuation of breastfeeding at six months and will be teaching breastfeeding classes and creating a breastfeeding support video to test with clients in FY23.

Additional Strategies to Increase Breastfeeding Rates

Additional strategies to increase breastfeeding rates include:

- 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.

In addition, the WICWS Nutrition Consultant, in collaboration with the DPH/DCFW Breastfeeding Coordination Team, is planning to develop and host a webinar on breastfeeding promotion in August 2023 along with creating emails that will be shared with WICWS and DCFW staff and programs as appropriate. Also, DPH/DCFW staff members and their partners will continue to work with the combining of the NCIOM Maternal Health Task Force with the Perinatal Health Equity Collective to ensure breastfeeding strategies and resources are highlighted when efforts are

integrated into the Perinatal Health Strategic Plan.

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 Infant/Toddler Quality Enhancement 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 P/IH Annual Report will continue in FY23. A new round of 5As training will also be provided to CMHRP Care Managers during this timeframe. 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. All new Healthy Beginnings program staff will be trained to provide evidence-based tobacco use screening and cessation counseling through You Quit, Two Quit or Northwest AHEC's online tobacco cessation course. In FY23, all program participants will receive education and monthly tobacco use assessments and cessation counseling when needed.

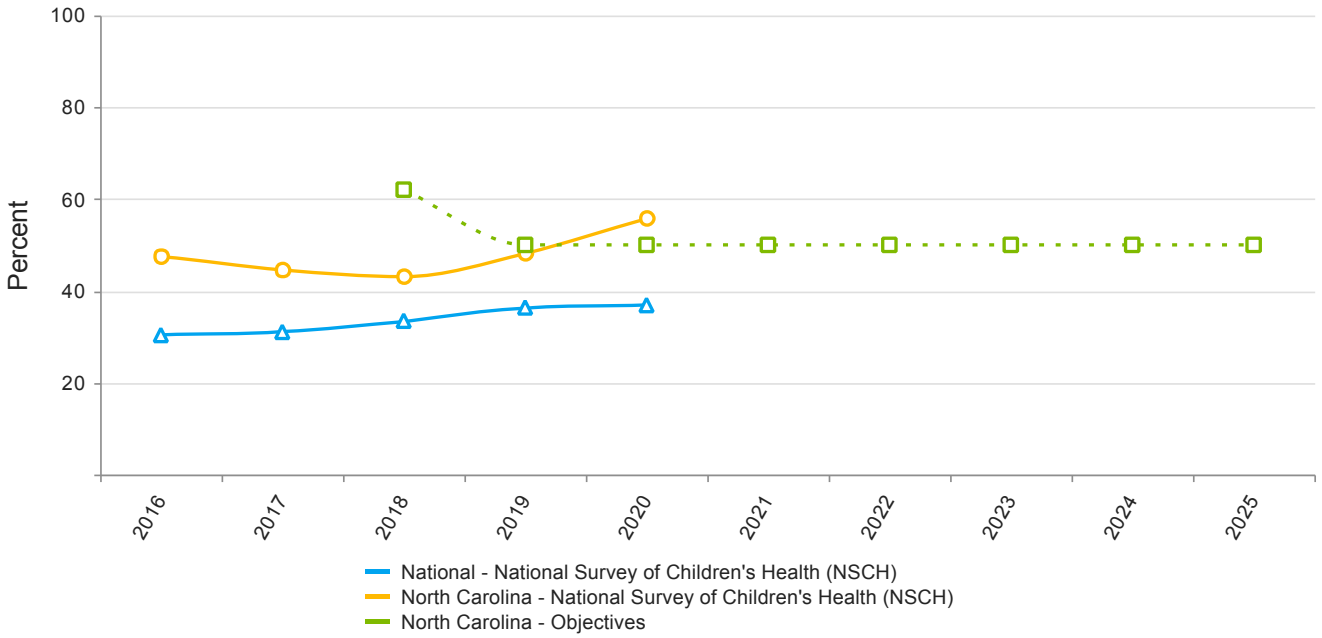
Preconception Health and Tobacco Cessation Activities

In collaboration with the ICHB Head, the PHW Program Manager will continue efforts to revitalize WATCH during FY23. Action steps to be completed include reviewing and updating the WATCH listserv as needed, 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*. WATCH members will also review an updated *You Quit Two Quit* Practice Bulletin in FY23. The PHW Program Manager 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 PHW Program Manager 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 Collaborative for Maternal and Infant Health (CMIH) and other WATCH members and provided to WICWS and DCFW staff members on the 5As of tobacco cessation, women's health, QuitlineNC, and e-cigarettes in FY23.

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		62	50	50	50
Annual Indicator	47.6	44.4	43.0	48.1	55.8
Numerator	132,477	120,289	112,720	119,658	123,695
Denominator	278,073	270,809	261,906	249,001	221,849
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.0	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
Annual Objective			80
Annual Indicator		75	80.9
Numerator		51	55
Denominator		68	68
Data Source		DCFW/WCHS staff internal log	DCFW/WCHS staff internal log
Data Source Year		FY19-20	FY20-21
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.0	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
Annual Objective			15
Annual Indicator	15.3		16.6
Numerator			
Denominator			
Data Source	2018-19 NSCH		2019-20 NSCH
Data Source Year	2018-19		2019-20
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	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
Annual Objective			90
Annual Indicator	80.1		75.9
Numerator			
Denominator			
Data Source	2017-19 National Immunization Survey		2018-20 National Immunization Survey
Data Source Year	2019		2020
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	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 percent.	
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 to LHD child health clinical staff, child care providers (through CCHCs), CMARC and MIECHV home visitors, Innovative Approaches, Triple P trained providers, and private providers.	
CH 4A.3. DCFW/WCHS staff members will provide statewide trainings on preventive, screening, assessment, diagnostic and treatment health and well-being services that impact infant, children, youth and their families to LHD child health clinical staff, child care providers (through CCHCs), CMARC and MIECHV home visitors, Innovative Approaches, 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 18%.

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 non-medical drivers of health such as food insecurity.

CH 4B.3. Continue to participate in the Home Visiting and Parenting Education (HVPE) System to strengthen the system of care through home visiting and family support services.

CH 4B.4. Support and participate in several initiatives to align efforts, including, but not limited to, the following: - New Initiative on Young Child Social-Emotional Health (with NC Child) - NC Telehealth Program for Child and Adolescent Psychiatric access (NCTP-CAPA) - Navigating Pathways to Coordinated Care for Children with Autism Spectrum Disorder and Developmental Disabilities (with Carolina Institute for Developmental Disabilities)

CH 4.B.5. Continue to support the implementation and use of NCCARE360 care management to support children, birth to five years, needing community-based supports to address health and social determinants of health issues.

CH 4B.6. Continue to collaborate with external partners to improve safe, stable and nurturing environments for children, birth to 21 years (ECAC, B-3, NC Partnership for Children, Prevent Child Abuse NC, NC Child, NC Pediatric Society, NC Academy of Family Physicians, NC DMH/DD/SAS, NC DSS, NC DECEE, NC DPI, CFTF, 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 stakeholders.

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 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, human services agencies, schools, child care, and other stakeholders and 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 successful 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 stakeholders, 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 stakeholders 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 the 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.

Also, during FY21, the Interim Title V CYSHCN Director/Pediatric Medical Consultant (PMC) and other DCFW/WCHS and Title V Office staff members continued to participate with efforts to help with the implementation of strategies developed and supported by many early childhood leaders as part of the Pathways to Grade-Level Reading efforts which helped to form the NC ECAP. NC ECAP goals include healthy babies (infant mortality and especially disparities), preventive health services, safe and nurturing relationships, food security, safe and secure housing, and social emotional health and resilience. The Pathways to Grade-Level Reading committees continued to identify and coordinate strategies to support children's optimal development beginning at birth through age eight with efforts with adding to a statewide Pathways Action Map; and align policies and practices that are rooted in how children develop.

In addition, the Interim Title V CYSHCN Director and other staff members participated on the EarlyWell Initiative (which was formerly the NC Initiative on Young Children's Social Emotional Health) advisory committee and participated on several work groups which developed and reviewed recommendations and strategies that used an equity lens, acknowledged the impact of racism and poverty, and included changes in how providers and systems engage families and provide TA to medical homes. This initiative continued to be led by NC Child, in collaboration with early childhood leaders including the NC Early Childhood Foundation, 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 goal of Pathways was modified to be more inclusive of children with all abilities and is not that NC children, regardless of race, ethnicity or socioeconomic status, are reading on grade level by the end of third grade, and all children with disabilities achieve expressive and receptive communication skills commensurate with their developmental ages to that they have the greatest opportunity for life success.

Due to priorities having to shift because of COVID-19 needs, during FY21, the Early Childhood Matrix Team, which was previously convened as part of the Early Childhood Comprehensive Systems grant and comprised of program staff across the DCFW and DPH, was not able to meet.

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, and in particular, the DCFW/WCHS, 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. materials), and ensuring that families can access appropriate care for further assessment. Per the 2019-20 NSCH, 55.8% of children in NC between 9-35 months had received appropriate developmental screening which is an increase from 48.1% in the 2018-19 NSCH and higher than the national average of 36.9%. While this makes NC the leading state in the nation, there is always room for improvement. 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 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 FY20, 75% of the 68 LHDs providing clinical services for children had staff members who had been trained on appropriate use of screening tools (ESM 6.1). This increased to 81% in FY21.

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

The DCFW/WCHS Regional Child Health Nurse Consultants (RCHNCs) and the PMC 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 PMC also provided one presentation to the NC Pediatric Society members and also to pediatric providers in the western area of the state served by one of the hospital systems about developmental surveillance and screening and the use of CDC's *Learn the Signs. Act Early.* (LTSAE) during FY21. Presentations included data on drop in well visits and need to continue to provide care which includes developmental screenings. The presentation to NC pediatric providers also 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.

DCFW/WCHS RCHNCs did not conduct in person individual site visits to review child health services and but did continue to provide technical assistance and education about best practices to LHD staff virtually during FY21 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 an essential component of health supervision visits and clinical care. The PMC participated in a CDC grant with other pediatricians across the country and CDC staff led by the AAP to identify best practices that providers were using with telehealth, hybrid, and

in-person/alternative systems for care across the country. In addition, the grant used key informant interviews to identify strategies that promote cross collaboration with multiple agencies and providers such as home visitors, Early Head Start/Head Start, child care and early intervention.

The RCHNCs continued to provide technical assistance 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 PMC, continued to update LHD staff members on minor changes to the Medicaid requirements in 2021 and reinforced the need for ongoing developmental screenings using validated tools. Additionally, the NC ITP continued to explore implementing the ASQ-SE statewide.

Due to the impacts of the COVID-19 pandemic response, several training opportunities were postponed until fall 2020 to LHD nursing providers participating in the Child Health Training Program (CHTP). Four training opportunities were presented during the CHTP which included information on developmental, psychosocial, and behavioral screening and were provided by utilizing the Microsoft Teams Virtual platform.

A statewide webinar was held in the summer of 2020 for all LHD child health clinical staff and CMARC care managers. This webinar was provided in partnership with the two developmental and behavioral pediatricians who were authors of the recent 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 webinar with LHDs and CHTP students to increase knowledge, skills and abilities related to developmental surveillance and screening

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 PMC revised and 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 PMC 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 FY21, the CMARC program continued collaboration with other agencies and programs, such as EI and Pregnancy Care Managers, 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 in the transition to Virtual Health/ Care Impact Platform documentation system. The program also continued the current performance assessment and improvement processes to ensure program expectations were met.

The CMARC program was expected to transition from the current Medicaid fee-for-service system to Medicaid managed care beginning with rollout in November 2019, but managed care was put on hold the lack of a budget from the NCGA to complete. NC Medicaid Managed Care went live on July 1, 2021, and during FY21, CMARC state staff worked with NC Medicaid to assure that care management services for the birth to five population are maintained

and enhanced. The CMARC program staff are assisting DHB and the LHDs on an opt out process if the health department decides not to move forward with the CMARC program after Medicaid Transformation.

The CMARC program manager and several other Title V staff (PMC, 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 also has a component that focuses on providing training to pediatric practices to facilitate screening and referral and increasing family navigation services and resources. A steering committee made up of key early childhood stakeholders which included Title V staff reviewed family navigation services and resources in NC and determined that an online resource to guide families through the early identification process was useful for both families and professionals. The steering committee worked to create a decision tree model to engage families in developmental monitoring (using LTSAE materials), encourage them to participate in developmental and autism screening, and then seek early intervention services if warranted.

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. The NC Triple P Model Scale-up Plan was 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 FY21, LIAs developed their Year One Plan as part of the Model Scale-Up Five-Year Plan. 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 FY21, 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 received 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 FY21, 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 FY21, 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.

With the addition of state appropriations transferred from DSS, the DPH has been able to expand coverage to all 100 counties in NC. The focus for FY21 was 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" was implemented during FY21 that requires 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 seven counties) selected Triple P as one of their evidence-based strategies to improve health among children ages zero to five during FY21. An additional site chose to expand their 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 efforts in FY21. 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 education settings through child care health consultation. The Resource Center is jointly funded through Title V and the Child Care and Development Block Grant. The Resource Center and the SCCNC offered training, technical assistance, and coaching services supporting 64 Child Care Health Consultants (CCHCs) providing local and regional coverage.

The SCCNC and Regional CCHC Coach, serving as subject matter experts, worked collaboratively with DCDEE and DHHS to develop and maintain the *NC DHHS ChildCareStrongNC Public Health Toolkit* which provides COVID-19 guidance for child care settings. Additionally, the SCCNC and CCHSRC staff participated in collaborative calls with DCDEE licensing consultants, Child Care Resource & Referral agencies, and facilities to provide updates on Governors' orders, toolkits, and the new TA referral process. The SCCNC also contributed content to the PMC and the State Child Health Nurse Consultant (SCHNC) for the monthly webinars for child health clinical staff in LHDs related to information regarding COVID-19 guidance and response in child care settings.

In addition to the regional coaching services provided by the SCCNC and existing regional coaching position at the Resource Center, with funding from the Child Development Block Grant and Title V, the Resource Center expanded their coaching staff to three Regional CCHC Coaches. The SCCNC and the Regional CCHC Coaches provided COVID-19 coverage to 53 counties without a local CCHC. Additionally, the Regional Coaches provided technical assistance and training opportunities for CCHCs across the state in FY21 primarily on the COVID-19 response.

Specifically, nine webinars were held on the *NC DHHS ChildCareStrong Public Health Toolkit* as it was updated periodically. The SCCNC and the Resource Center partnered with DCDEE to offer statewide webinars for child care providers on the COVID-19 guidance and vaccine promotion.

In FY21, a CCHC Systems Building for Statewide Expansion Planning workgroup consisting of representatives from DCFW, DPH, CCHSRC, DCDEE, NCPC, LHDs and local Smart Start agencies contributed to the development of a strategic plan to address a governance structure and coordinated, sustainable funding efforts. DCDEE committed an additional $2M from the Child Development Block Grant to support a state infrastructure and additional local child care health consultants with the goal being that every county in NC would have access to a local or regional CCHC. The *NC CCHC Service Model and Hiring Agency Guide*, guiding documents for CCHCs, were updated in FY21. The SCCNC and CCHSRC provided extensive outreach to hiring and funding agencies in CCHC expansion counties and held multiple regional meetings for Executive Directors of local partnerships for children.

In FY21, the Resource Center offered the NC CCHC course for ten new CCHCs virtually in September 2020 and February 2021. The four CCHC coaches served as course instructors. Medication Administration train the trainer was offered within the course. 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 revised and offered multiple times to CCHCs and other technical assistance providers across the state, resulting in 41 individuals trained as trainers for ITS-SIDS and fifteen newly trained EPR trainers. The CCHSRC maintained a CCHC Resource Library providing information on COVID-19 guidance, current health and safety requirements, including recommendations for meeting best practice standards for child care facilities.

During FY21, the SCCHC and the CCHSRC also began planning for CCHC Learning Collaboratives for FY22. These are professional development activities for CCHCs on general health and safety topics addressing young children in child care settings.

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 North Carolina 2030 indicators and is part of the Early Childhood Action Plan. Results from the 2019-20 NCSH indicate that 16.6% 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 less than the 18.1% 2019-20 national rate, but again, probably not significantly different.

In FY21, 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. One statewide effort was promoted by Medicaid which allowed providers to paid for positive screens that required referral for resources through NC CARE 360 using the NC DHHS screening tool from January 2021 through June 2021. 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 FY21. 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 FY21, 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. The CMARC program has incorporated Reach Out and Read and the Dolly Parton Imagination Library in their new hire orientation and it is also listed as resources in the CMARC Resource Directory.

Also, in FY21, the MIECHV Professional Development coordinator met with Dr. Pretzel at UNC LEND program to collect new LTSAE resources for MIECHV site staff and the NC Home Visiting Consortium hosted a presentation with ROR campaign staff members.

North Carolina is fortunate to have two CDC Act Early Ambassadors (Rebecca Pretzel, PhD and Sharon Loza, PhD) representing the University of North Carolina at Chapel Hill and its LEND program and the Early Intervention Section, respectively. Through an Act Early COVID-19 grant in 2021, the NC Act Early State Team was revitalized, and included the PMC/Interim CYSHCN Title V director; this team is now part of the NC Interagency Coordinating Council's (ICC's) Local Interagency Coordinating Council (LICC) subcommittee. This grant also supported close collaboration with Child Care Services Association to print and disseminate thousands of LTSAE materials to families served through child care centers across the state. Both Act Early Ambassadors were able to provide ongoing training and LTSAE materials to numerous MCH-related agencies including Home Visiting, NC Partnership for Children/Smart Start, Exceptional Children Advocacy Center, LICCs, and Early Head Start/Head Start agencies.

The SCHNC, RCHNCs, and PMC continue to promote the value of reading and the ROR during the CHTP for CHERRNs and during a couple of monthly webinars for child health staff related to care of children during COVID-19. During FY21, seven 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 FY21 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 the 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 FY21 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. Classes for families in LHD and in school settings on nutrition and physical activity 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 PMC and SCHNC developed and offered a new option child health service 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 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. Two rural LHDs applied during FY21 with proposals to use funding to address firearm storage during FY22.

Home Visiting and Parenting Education (HVPE) System

Given the complexities of the current home visiting and parenting education landscape and the multiple invested stakeholders 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 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. Throughout FY21, 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 FY21, the DCFW/WCHS continued working with the NFP sites to strengthen their Community Advisory Boards (CABs). The CABs focused on referrals for the NFP program in past years. Having developed good referral systems in each county, staff provided technical assistance to local CABs to focus on marketing the NFP program in the community to increase awareness, interest, and ownership within the community and developing sustainability plans that include applications for local and philanthropic funding. In addition, CABs encouraged including more parents, especially parents who have graduated from the NFP program. Families were engaged with the planning and implementation of the NFP program at the state and local levels. Families served on the state stakeholders' group and are represented on local NFP CABs. Many of the parents who became involved at the local level as mentors to parents and members of local CABs are graduates of their NFP home visiting program.

Retention continues to be a focus of NFP, and it is tracked monthly. Sites are now challenged to keep their early attrition (clients who received 3 or fewer visits before disenrolling) to below 7%. NFP is working as a program to initiate what is called the First 5 Home Visits approach. This allows for the Nurse Home Visitor to develop a rapport with the client/family and deep dive into what the client is needing out of the program during those first five home visits.

In FY21, the NFP National Service Office (NSO) hired a Government Affairs Manager to work at the state level to identify sustainability opportunities at existing sites. All NFP sites in NC are now documenting on standardized assessment forms. This was developed in collaboration with the State Nurse Consultants and the NFP NSO.

MIECHV will continue working to integrate MIECHV data into the NC Early Childhood Integrated Data System (ECIDS). MIECHV Regional Meetings are held quarterly for the professional development of home visitors. The

topics for FY21 included lead poisoning, the EHDI program, children of incarcerated parents, NC Infant-Toddler Program & Early Intervention, and child support resources. Additionally, a monthly email is sent out to home visitors with professional development opportunities which include webinars, journal articles, and local 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 WHB Head 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: http://www.ncleg.net/DocumentSites/Committees/NCCFTF/Homepage/.

During its 2020-2021 study cycle, the CFTF had a total of twelve meetings, including nine committee meetings and three full CFTF meetings where attendees heard more than 65 presentations. Experts and leaders presenting to the Task Force and its committees represented academic institutions and state and local agencies, as well as state and community programs. The CFTF was successful in 2020 in advancing a law to require suicide prevention training for school personnel and a risk referral protocol in schools. Through non-legislative efforts that involved collaboration with various partners, the CFTF was successful in strengthening some tools and resources related to education and awareness surrounding child abuse and neglect reporting. Although there was no legislation in 2020 addressing CFTF recommendations to strengthen the statewide Child Fatality Prevention System, progress was made toward advancing these recommendations as DHHS continued its study and planning related to these recommendations which included input from various stakeholders and DHHS leaders.

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. The state CFPT Coordinator and PMC 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.

All NC counties have one or more local teams who review the county's 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. Approximately eighty percent of local CFPTs and CCPTs are blended. Each quarter, local CFPTs are provided data on the number of child deaths for each county which include the child's name, date of birth, date, and cause of death, among other information. These data are provided through the SCHS and the Office of the Chief Medical Examiner (OCME). Local CFPTs identify system problems and make recommendations for prevention of future fatalities and how to act on those recommendations. The local CFPTs provide education to their communities on ways to keep children alive and safe. The state CFPT Coordinator monitors the activities of the local teams to ensure compliance with the NC CFP System's statutory requirements. The CFPT Coordinator makes site visits to local CFPTs and provides statewide webinars to increase the local teams' knowledge about current health, data, and child safety issues. The CFPT Coordinator position was vacant in late 2020 and an interim Coordinator conducted consultation and technical assistance via email and telephone (due to COVID-19 travel restrictions) to 40 local CFPTs in FY21. While managing multiple COVID-related priorities, the counties increased the volume of reviews submitted by 23 percent, which is reflective of the dedication of staff and CFPTs to continue this vital work.

The interim state CFPT Coordinator created and implemented four virtual mini-trainings presented up to three times each, between March 1-June 30, 2021. The topics were chosen based on a needs assessment survey of the counties conducted during March/April, and the trainings covered the nuts-and-bolts of complying with the CFPT state requirements. Sixty-five people attended the trainings which received an 87% satisfaction rating. The webinars were then posted on the updated CFPT Resource page for review by counties as needed. All new personnel (seven in FY21) have been directed to review these trainings until training specifically suitable to new personnel can be developed.

Additional Strategies to Promote Child Health and Decrease ACEs

The DCFW/WCHS and the EIB 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 FY21, they also supported and participated in initiatives such as Early Well (formerly the Initiative on Young Child Social-Emotional Health) and Navigating Pathways to Coordinated Care for Children with Autism Spectrum Disorder and Developmental Disabilities.

In addition, there was ongoing technical assistance and outreach provided to LHD staff in child health clinics and CMARC care managers about the use of NCCARE360 care management to assist children, birth to five years, needing community-based resources to address health and social determinants of health (i.e., food, housing, interpersonal safety and transportation). The Title V Office 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 was created using Medicaid claims data from 2017-18 and was shared with NC PA advisory committee. The dashboard can be found at: https://ncpal.org/nc-youth-mental-health-care-data. The PMC 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 FY21 related to child and perinatal mental health (NC MATTERS).

In FY21, 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.

In FY21, the NC Title V Program continued to collaborate with the NC Childhood Lead Poisoning Prevention Program to help eliminate childhood lead poisoning. Strategies to promote elimination include the testing of water in schools and child care facilities statewide; a renewed emphasis on current testing and surveillance of children exposed to lead paint; and regulatory requirements for lead-free certification to be part of house transfers and apartment rentals. In fall of 2020, the PMC presented to a statewide group of environmental health specialists across the state about pediatric perspectives on lead screening and held and discussion about best practices for working with medical homes to address lead screening, testing, follow up of children with elevated lead levels which includes the need for ongoing developmental surveillance and screening.

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

compliance with NC immunization laws.

Overall, the NC Immunization Program (NCIP) distributed a total of 2,194,994 doses of vaccine, including 391,270 doses of influenza vaccine in FY21.

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 2018-2020 National Immunization Survey (NIS) results (for children born 2017-18) were released in the fall of 2021. 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 75.9%, which was higher than the national estimate of 70.5% but lower than the previous year NIS results of 80.1%. Results of the 2020 NIS-Teen, also released in the fall of 2021, showed that the rate of NC teens aged 13 through 17 years who have received one or more doses of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) since the age of ten years was 92.5%, slightly higher than the national estimate of 90.1%. Regarding the percent of teens up to date on the HPV series, the NC estimate was higher than the national estimate (60.7% v. 58.6%) and showed a statistically significant percentage point increase from 2019. The meningococcal conjugate coverage estimate in NC was higher than the national estimate (94.4% v. 89.3%). It is important to note that the national and state confidence intervals for each of these estimates are overlapping, so there is probably no significant difference between them.

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 FY20, the IB initiated 426 IQIP visits. In March 2020, all IB staff were instructed to telework in response to the COVID-19 pandemic. This directive essentially halted all new IQIP visits since it is a requirement that the initial visit be done in person. Due to the ongoing pandemic, CDC introduced Tele-IQIP, allowing IQIP visits to be temporarily conducted virtually. In FY21, IB initiated 113 IQIP visits.

Additional Title V Immunization Activities

The PMC 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. There were fewer requests for medical exemptions, and requests were received later in the fall due to COVID-19 and two extensions of the deadline for individuals enrolled in childcare, school, colleges and universities having required immunizations completed in order to attend the facilities. The PMC continued to work with the attorney general's office on appeals to medical exemption requests.

The PMC provided weekly webinars to child health clinic staff in LHDs from March to May 2020 that included highlighting the need for well visits and immunizations and the decreasing immunizations rates due to COVID-19.

Child Health - Application Year

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 NGO partners in one of the largest efforts to promote safe, stable, and nurturing relationships for children. In FY23, 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 CYSHCN Director, PMC and other DCFW/WCHS staff members will continue to help with the implementation of strategies developed and supported by NC ECAP and Pathways to Grade Level Reading. NC ECAP goals include healthy babies (infant mortality and especially disparities), preventive health services (which also include developmental screening and surveillance), safe and nurturing relationships, food security, safe and secure housing, and social emotional health and resilience. Title V staff will continue to work on creating an action map 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, PMC. SCCNC, and other WCHS staff in the efforts to address Infant Early Childhood Mental Health Consultation to 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.

Several Title V staff will continue to partner with Dr. Pretzel and Dr. Crais (UNC-CH) on the HRSA funded *Navigating Pathways for Coordinated Care for Children with ASD/DD* grant to increase early identification of young children with special developmental needs. The decision tree model to engage families in developmental monitoring (using LTSAE materials) will be posted on the NC Act Early web site. In addition, family navigators across the state will be trained through the grant to use the online developmental monitoring guide with families, including those from Title V, CMARC, ASNC, FSN and ECAC.

In FY23, the Early Childhood Matrix Team plans to reform and determine a meeting cadence to share ideas, sponsor training events, align with the other early childhood efforts such as NC ECAP, Think Babies, IHOPE (Integrating Healthy Opportunities for Play and Eating), and coordinate work to support child well-being, making sure the structure supports ongoing partnership with the proposed reorganization. Program topics for FY23 will align with priorities of DPH, DCFW, and NCDHHS related to and/or impacting early childhood. Potential topics include Medicaid Transformation, NCCARE360, impact of COVID-19, engaging in the Perinatal Health Strategic Plan, updates from other early childhood efforts across the state, and supporting implementation of the ECAP.

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

The DCFW/WCHS SCHNC, RCHNCs, and the PMC will continue to include at updates and 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 arrangement due to the pandemic.

The DCFW/WCHS SCHNC and RCHNCs have not been able to go onsite to LHDs 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 in order to provide consultation and technical assistance. The plan is to restart individual site visits in spring of 2022 and DCFW/WCHS staff members will continue to review child health services and provide technical assistance and education regarding best practices to LHD staff about well child visits which include developmental surveillance, screening, identification, management and referral. The PMC 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 PMC, 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. 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 PMC, 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 a holding a statewide Annual Child Health Conference will also be explored in FY23. In the meantime, the PMC, SCHNC, and RCHNCs will continue to 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 PMC, 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 FY23, 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

CAPTA 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 FY 23 to promote the Healthy Opportunities Pilot. We will continue to participate in 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 PMC will authorize targeted case management, evaluation and management services offered by service providers at several CDSAs. The PMC 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. The PMC will also help with recruitment of a state level pediatrician to help with consultation and TA for the CDSAs and outreach and trainings to health care providers serving young children about general development and social emotional health. NC ITP management, CDSA leadership, the remaining physicians and advanced practice providers and the PMC will also review 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 FY23, 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 FY23, 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 FY23. 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 FY23, the SCCNC will continue to work collaboratively with programs within the DCFW/WCHS, as well as with local and state partners, to establish and maintain links to promote health and safety 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 both 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 child care facilities. The Resource Center, 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. The three Regional CCHC coaches from the NC CCHSRC in addition to the SCCNC will continue to provide coaching services to CCHCs in FY23 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 CCHC Systems Building for Statewide Expansion Planning workgroup was established in FY21 and is continuing its work in FY23. 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 FY23, the PMC will work with the SCCNC and the NC CCHSRC to enhance professional development activities and resources for CCHC's 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 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. The CDC Act Early grant's second year will focus in having ITP provide training of selected Part C staff on a Level II screening tool for ASD. In addition, the PMC, 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 Reach Out and Read with families and medical home providers. In addition, in FY23, 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 FY23 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

A central priority at this time is investing in and further developing the critical infrastructure to support the HVPE

System, including expansion of staff. In addition, the four committees (Assessment and Planning; Communications; Finance; and Programs) will develop work plans in the remainder of 2022, aligned with the HVPE State Action Plan, to attach specific tasks and potential resource needs to goals in service of the plan, and will move to implementation in 2023. Several community-based pilots (including technical assistance around assessment and planning for introduction and expansion of HVPE services; communications strategies; and fiscal modeling to determine costs of implementing a mix of HVPE models) are planned for 2023-2024. Family and community engagement and racial equity remain central to the HVPE System work, and expanded supports for these areas are planned.

NC Child Fatality Prevention System

In FY23, the state CFPT Coordinator will continue to:

1. Provide live and archived webinars with partners to local CFPTs on topics such as gun safety, recruitment of new members and meeting facilitation.
2. Conduct training needs assessments with all 100 local CFPTs.
3. Accept quarterly reports from local CFPT and submit an annual report to the State Child Fatality Prevent Team and the CFTF.
4. Provide individualized trainings to new CFPT Chairpersons and support staff.
5. Conduct monitoring activities for 33 local teams via telephone conferencing and site visits.
6. Collaborate with local partners such as the OCME and UNC CMIH to provide training on gun safety and storage issues and the impact of COVID-19.
7. Provide training on the Identification of Problems causing child deaths, Recommendations to solve these problems and Actions taken to work to solve the problems.

Additional Strategies to Promote Child Health

In FY23, 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 insurances will also be provided.

In FY23, 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 share the revised guidelines for lead screening with a lower blood reference level.

As with previous action plans, the PNC will continue in FY23 to integrate breastfeeding 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 CYSHCNs. The PNC will also continue her active involvement in the Association of State Public Health Nutritionists (ASPHN) through the MCH Nutrition Council and the Fruit and Vegetable Nutrition Council. In FY21, the PNC and other Steering Workgroup members of the NC Farm to Preschool Network, applied for and were awarded a one-year $91,000 ASPHN/CDC Farm to Early Childhood and Education Implementation Grant (FIG) that began November 1, 2020 and was slated to end on October 31, 2021 (https://asphn.org/farm-to-ece-grantees-programs/). With continued funding from CDC, ASPHN offered FIG funding to NC and other states and that funding (91K) will end October 31, 2022 (unless more continuation funding from CDC/ASPHN is available). The Network has local and state level Policy, Systems, and Environmental (PSE) changes included in the FIG grant along with a racial equity focus. For FY23, the PNC and Network partners will wrap up their Year 2 grant deliverables, complete end of grant year reports, generate success stories and investigate other funding opportunities to expand their work. The PNC

also serves on the Farm to School (FTS) Coalition of NC Steering Committee, a statewide coalition she helped form in 2014. In FY23, the PNC will continue to lead or serve on workgroups to expand FTS in NC and continue to promote the accomplishments of the Coalition.

The PNC will also continue collaborative partnerships with the NC Partnership for Children, GoNAPSACC, the CDIS SPAN grant staff, the State Child Care Health Consultant, the NSB (WIC and Child and Adult Care Food Program [CACFP]), 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 FY23 and beyond 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. A new strategy for FY22 and continuing into FY23 that the PNC is involved with is advising and providing technical nutrition expertise to DHB, on food and nutrition services being offered to address food insecurity and improve nutrition among high-risk “members” (which includes infants, children, adolescents, pregnant women and adults with chronic health conditions) as part of the Healthy Opportunities Pilots.

Other worked for FY23 includes work planned by the PNC for FY22 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 nutrition needs identified during preventive dental visits.

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

Vaccines for Children Program Strategies

In FY23, 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 FY23. Although Tele-IQIP Visits may still be needed, the IB plans to gradually return to in-person visits if COVID-19 cases remain at a safe level. 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 optional strategies as defined by the needs of state and local communities) 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 Title V 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.

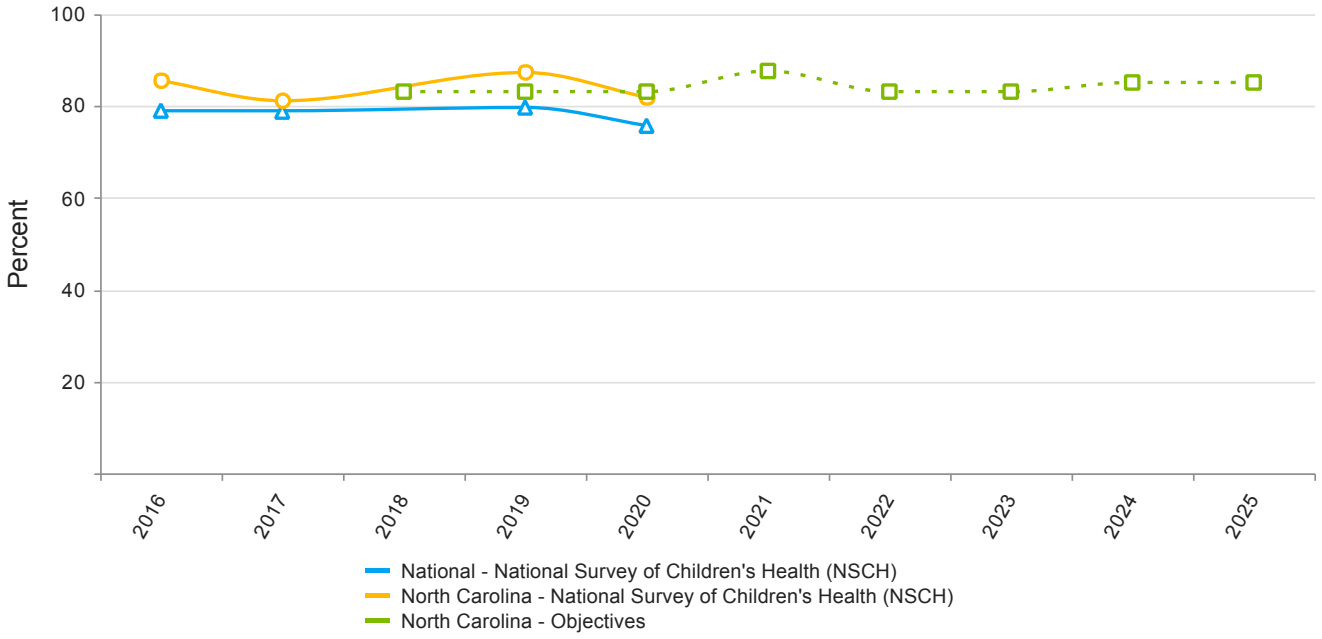
Among the many impacts of COVID-19 on NC is a marked decrease in the rates of well child visits and childhood vaccinations. In FY23, the Title V Office will continue to monitor vaccination rates closely and work with partners on outreach and sharing of best practices to increase vaccination rates. The Title V Office and DCFW/WCHS worked with NC Medicaid, NC AHEC and Community Care of North Carolina (CCNC) on the *Keeping Kids Well* initiative to work with practices experiencing greater care gaps to increase well child visits and immunization rates across the state. NCDHHS will continue to work on an expanded influenza media campaign to ensure maximum coverage this year during the COVID-19 pandemic and leverage COVID-19 messaging and the importance of "layering up this winter" with both COVID-19 and influenza vaccines. NCDHHS will also continue to engage with diverse state and community partners who interact with and care for children and adolescents to implement COVID-19 vaccination in NC, ensuring fast and fair vaccination that is easy and everywhere, especially in anticipation of the availability of booster doses.

The PMC 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 increasing COVID-19 vaccination rates in children and adolescents.

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		83	83	83	87.5
Annual Indicator	85.5	81.0	81.0	87.3	81.6
Numerator	643,711	638,902	638,902	786,182	698,073
Denominator	752,936	788,733	788,733	900,582	855,558
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	83.0	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
Annual Objective			24,225
Annual Indicator		16,676	7,656
Numerator			
Denominator			
Data Source		LHD/HSA and NC SHC Annual Report	LHD/HSA and NC SHC Annual Report
Data Source Year		2020	2021
Provisional or Final ?		Provisional	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	8,000.0	8,500.0	9,000.0	9,500.0

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
Annual Objective			66.3
Annual Indicator			71.6
Numerator			4,334
Denominator			6,054
Data Source			LHD/HSA
Data Source Year			SFY20-21
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	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 about the importance and required components of the annual well adolescent visit with an emphasis on confidentiality, 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 will continue to be credentialed to assure they are providing primary & preventive adolescent health services in line with national SHC performance measures including behavioral health when BH 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 Telehealth Partnership for Child and Adolescent Psychiatric Access (NCTP-CAPA) Implementation Team in support of grant objectives.
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.
AH 6A.10. Promote the importance of adolescent preventive care through the Triple P Learning Collaborative.
AH 6A.11. Educate statewide stakeholders on the importance of adolescent preventive care and all components including behavioral health risk assessment through outreach education.

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

Adolescent Health - Annual Report

While there is not currently a stand-alone Adolescent Health Program in the DCFW/WCHS, those services and attention to adolescents are present in many programs in the Section and especially the School Health Unit (SHU). 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 all the 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 WCHS uses NPM#10 (percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year) to monitor improvement with regard to 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 regional nurse consultants 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 2019-20 NSCH indicate that parents report that 81.6% of adolescents in NC received a preventive medical visit in the past year which is almost identical to data from the 2016-17 survey (81%). NC did have a higher percentage that the nation in both the 2016-17 (78.7%) and 2019-20 (75.6%) surveys, although the confidence intervals overlap, so there is probably not a significant difference. In NC in 2019-20, YSHCN were more likely to have received a visit than those youth without a special health care need (YSCHN – 84.5% v. non-YSHCN – 80.4%).

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 FY21 was 6,054 which is a 17% decrease from the number receiving visits in FY20 (7,332) and a 52% 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 20-21 indicate that 1,602 preventive medical visits occurred at the NC School Health Centers (SHCs). For FY and SY21, there was a combined total of 7,656 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). 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 SY21, SHCs also completed 3,811 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

CHNCs continued to encourage LHDs to choose to allocate Title V/351 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 FY21, the SCHNC, RCHNCs and the PMC 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 which is used by the Medicaid program as the standard for preventive health care for children up to 21 years of age. During FY21, the PMC, 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 PMC and the SCHNC finalized the guidance for coding for sport physicals (Preparticipation Physical Evaluations) with the NC DPH Public Health Nursing and Professional Development Unit (PHNPDU) and 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 PMC continued to use a self-assessment tool with new providers to LHDs about their knowledge, skills, and abilities related to all of 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 FY21 it assisted the PMC 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 of the requirements for an adolescent visit continued to be included in the most current NC Health Check Billing Guide 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/WCHS PMC, SCHNC and RCHNCS provided TA and training as needed to new LHD providers about the annual well adolescent visit. The Consultants and PMC provided specific TA with LHDs to improve confidentiality and share best practice strategies for interactions with adolescents and with use of LHD 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 also 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. Continuing Professional Development to CHERRNs were provided for four of these webinars, but were not able to be provided for the remaining monthly webinars due to COVID-19 related and other commitments for the RCHNCs who served as nurse planners.

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 five months. Due to COVID-19 restrictions, the CHTP which started in FY20 was extended three months into FY21. A total of five students completed their training in FY21. Course content covered in FY21 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.

Annual School Nurse Conference

The Annual School Nurse Conference has been provided for the past 36 years and is attended by at least 50% of the state's more than 1,300 school nurses. Participant evaluations and input from adolescents and parents support the planning and topics to be covered at the next year's conference. Due to the ongoing COVID response and mitigation from NC school nurses, 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 decided to reschedule the 37th Annual North Carolina School Nurse Conference which was originally planned for December 2020 to 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 FY21, school nurses were largely dedicated to COVID-19 mitigation and response efforts. Although FY21 did bring an improvement in the average NC school nurse to student ratio, moving from 1:1,007 to 1:890, these positions are largely supported through temporary COVID-related funds and sometimes difficult to fill during the pandemic. Any sustainable impact on school nurse ratios and FTEs will require a permanent funding response.

The School Health Nurse Consultant team did hold Regional Lead School Nurse Office Hours meetings bimonthly during FY21 to provide technical assistance for school nurses and school staff that provided care to adolescent students. The office hours provided a forum for discussion related to a variety of emerging local adolescent needs and issues. Specific topics covered during office hours 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.

School Nurse Chronic Conditions Case Management

An average 17% to 19% of the North Carolina student population receives services in school each year related to a chronic health condition 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 in standards-based case management programs in NC LEAs continued progressively throughout FY21.

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 FY21, the pandemic continued to affect school openings. Many SHCs remained closed as the schools in which they were located remained closed. Towards the end of FY21 some schools began experimenting with a hybrid schedule enabling some students to begin a slow transition to full-time attendance in the fall. SHC staff members continued to show creativity by providing virtual support as telehealth remained available for students attending virtual classes, and SHCs were appropriately staffed to support the needs of children opting to attend school. SHCs also worked to assist their host schools in planning and managing activities in regard to students' potential return to school during the pandemic.

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 FY21, SHCs received support/technical assistance as they planned and implemented an appropriate COVID-19 prevention response with the schools where they are located. 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.

While credentialing was paused due to the COVID circumstance, the ability to credential has increased as students have returned to school and COVID restrictions have lifted. There has been continuous monitoring assistance for all SHC's. The inability to provide services due to SHC closings had an effect on service provision, however mental

health services remained relatively consistent with a minimal reduction in the number of behavioral/mental health procedures. SHCs reported 13,175 behavioral health procedures during in FY21. This reduction was minimal in comparison to years past despite the disruptions in service due the commitment of SHC's alternative means to provide services and ability to implement telehealth services in spite of closures due to the challenges that COVID presented.

NC Youth Health Advisor (YHA) Team

During FY21, the Youth Health Advisor (YHA) Team convened virtually twice monthly to provide support to programs in the DCFW/WCHS that serve adolescents. Driven by a passion to identify the health needs of their peers statewide, the advisory team conducted their own adolescent health needs assessment to evaluate the impact of the pandemic on NC youth's health. To achieve this, the YHA Team developed a 37-question survey seeking information from middle and high school age youth in NC on the impact of the pandemic on the learning and education experience, physical health and well-being, behavioral health and well-being, and access and utilization of heath care services. This survey was completed by over 1,200 NC youth. Data from this survey was used by the YHA team to research recommendations for supporting NC youth. Both the data from this survey and youth-initiated recommendations are detailed in a 14-page report authored by the YHA team titled, *One-Year of COVID-19: North Carolina Youth Peer Survey Findings*. Youth team members also presented their findings and recommendations with stakeholders statewide in virtual meetings.

The YHA Team also extended their expertise to DCFW/WCHS partners in DPI, DMH, and other divisions in NCDHHS throughout FY21 in matters of social and emotional learning, adolescent preventive care and education, reproductive health programming, effective youth engagement, and youth COVID-19 vaccination strategy. In addition, two NC youth and the Adolescent Health Coordinator were selected to serve on AMCHP's inaugural Youth Voice Amplified Committee, committing to one year of service to ensure the inclusion of diverse and inclusive youth experiences in AMCHPs programs and policies as well as the broader MCH field.

Findings from the YHA Team end-of-year evaluation show that:

- 100% of respondents agree that they have an increased interest in public health.
- 90% agree that they have a better understanding of what health equity and health disparities are.
- 90% agree that they have learned more about adolescent health and that they feel more prepared to improve adolescent health.

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, PMC and other CYB 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 FY21 are described in the CYSHCN Domain Annual Report.

NC Telehealth Partnership for Child and Adolescent Psychiatric Access

The NC Title V Director, Adolescent/Behavioral Health Coordinator, PMC and other DCFW/WCHS staff continued to advise and participate in the NC Telehealth Partnership for Child and Adolescent Psychiatric Access (NCTP-CAPA) implementation work during FY21. The purpose of the NCTP-CAPA is to support pediatric primary care providers with the timely identification, diagnosis, management, treatment, and referral as appropriate of children and youth with behavioral health concerns and conditions, with an emphasis on rural and underserved areas of the state. The four key objectives of the NCTP-CAPA 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 the Duke NCTP-CAPA and HRSA teams to provide updates. During FY21 the NC Psychiatric Access Line (NC-PAL) as part of the NCTP-CAPA project expanded to become 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 consults. Early implementation showed that NC PAL consultations resulted in 34% fewer children requiring visits with specialists and 10% fewer children going to emergency departments.

In addition, the NCTP-CAPA advisory committee met three times with stakeholders from public health, mental health, academic centers, pediatrics, family medicine, psychiatry, rural health, and other disciplines during FY 21. REACH Trainings were held three times which trained 73 clinicians serving youth in North Carolina. Sixteen pediatric and family medicine residents were trained at Duke through a curriculum adapted by the NCTP-CAPA program called Behavioral Health Expansion in Pediatric Residency Training (Be ExPeRT). The NC Youth Mental Health dashboard map of counties by diagnoses, treatments and prescriptions for NC youth was also created and released in FY 21.

School Mental Health Initiative 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 in FY21. These efforts include engagement on the statewide implementation team for social and emotional learning standards. During FY21, the Adolescent Health Coordinator in partnership with the Youth Health Advisor Team assisted DPI in the development of a statewide vision for social and emotional learning in NC public schools as well as messaging for partners in health and human services. 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 continued to support local school nurses as part of the School Resource Team to address behavioral issues, suicide and bullying in schools.

Triple P (Positive Parenting Program)

Triple P has been implemented in all 100 counties in NC, and an adolescent component to help families manage behavioral problems is now available on-line for free 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 FY21.

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 FY21, the PMC and Title V Director worked with Fostering Health NC and DSS to develop 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.

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 FY23 deliverable for DCFW will be the creation of a children's mental health dashboard for the state.

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 FY23, 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 FY23 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 FY23, HCPG and Health Choice Guidance 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 be made available to LHDs.

The DCFW/WCHS Child Health Nurse Consultants (state and regional) and the PMC will continue to provide TA and training as needed to new LHD providers about the annual well adolescent visit based on the NC HCPG and Health Choice Guidance. 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 and Health Choice Guidance. 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 PMC will continue to use the 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 FY23 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 2022 conference began in fall 2021. In addition to the Regional School Health Nurse Consultants, local school nurses and representatives from the NC Youth Health Advisory Council will participate on the planning committee. 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, vaccine hesitancy, vaping, and substance abuse prevention.

School Health Centers

Specific plans for SHCs in FY23 include continuation of funding for 31 of the state's >90 SHCs. While many SHCs experienced pandemic related staffing changes over the past couple of years, SHCs managed to remain appropriately staffed to support the needs of children. In FY23, SHCs will continue to strengthen their workforce and explore ways to improve, increase, and provide ongoing quality services to students. Nutrition and mental health services will also continue to be prioritized. The monitoring process for SHCs will be ongoing to assure resources, guidance and technical assistance is readily available. Assistance and resources may be provided in the form of suggested trainings, contract development and revision, processes, budget assistance or data collection. SHCs are expected to be fully functional and rebuilding capacity as the schools will be back to normal operation.

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 Program 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 Family Liaison Specialist (FLS) and Family Partners (FPs) and increase external collaborations with youth, families, and school health center staff.

School Health Center Credentialing

In FY23, 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 re-convened, and during FY23 the plan is to complete all remaining credentialing that was delayed due to the pandemic. A required submission of Medical Record Audits will occur by the SHCs for review of all applicable medical services provided. Policy 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 FY23. The team will complete and present their Youth Participatory Action Research Projects at the beginning of FY23. These projects involve data collection, research, and intervention on an area of youth health including mental health, physical health, nutrition, school engagement, and more. The YHA team will release their second annual report on the impact of COVID-19 on the heath of young people during FY23. In addition, during FY23, the team will focus on redeveloping website content for youth and parents/guardians to promote the adolescent well visit. The team plans to engage both youth and parents in focus groups for feedback for these web additions. The YHA team will continue to use social media networking platforms to feature the Youth Advisors sharing pertinent and timely messages for teens. The YHA team has made a proposal to NCDHHS Communications to establish a standalone social media account for youth-focused communication, with plans to engage other NCDHHS youth councils and organizations in sharing important messaging. 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 in order to reduce weight bias especially for kids in larger bodies who can be at greater risk for bullying and other trauma that can affect their mental health. The PNC will also continue to share nutrition and physical activity resources with the Adolescent Health Coordinator, Regional School Nurse Consultants, and the SHC Coordinator.

Outreach Efforts to Medicaid and Health Choice Enrollees

Title V staff will continue to do outreach under the IMOA with DHB to increase enrollment in Medicaid of CYSHCN into Medicaid and Health Choice 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 NC DHHS (i.e., DPH, DSS, DMH/DD/SAS), will continue to promote shared decision making and informed consent with adolescents during adolescent well visits about different services. The PMC will co-chair the Fostering Health NC Transition Age Youth Work Group with a youth co-chair and will 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, SCHNC, PMC 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.

NC Telehealth Partnership for Child and Adolescent Psychiatric Access

The NCTP-CAPA program has become even more critical with the mental health crisis for children and adolescents that has been exacerbated by the pandemic. NCTP-CAPA 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. In FY 23 the NCTP-CAPA advisory committee will plan to convene three times. NCTP-CAPA will continue to target specific strategies to work with primary care providers: 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 primary care providers in counties experiencing increased cases of mental health crises in youth. In addition, REACH trainings will continue to be offered to primary care

providers to increase competencies of primary care providers 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. NCTP-CAPA will start to provide telehealth consultation supports to local CDSAs. NCTP-CAPA will also explore providing support to the schools by piloting consultation services for school support staff and/or developing pediatric mental health training for low-resource counties in the state.

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 with DPI's mental health initiatives for planning and implementation at the local level. In FY23, regional school nurse consultants 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 in order to collaborate on the statewide vision and implementation of social and emotional learning in NC schools. The Adolescent Health Coordinator is also a planning member for a Youth Suicide Prevention Academy for youth-serving professionals/school personnel in early FY23.

The DCFW/WCHS will also continue to participate in a TA process with the Association of State and Territorial Health Officials that began in FY22 to establish a Unified School Behavioral Health Plan to address youth mental health needs with partners from DPI, DMH/DD/SAS, DPS, and more.

Triple P (Positive Parenting Program)

During FY23, 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

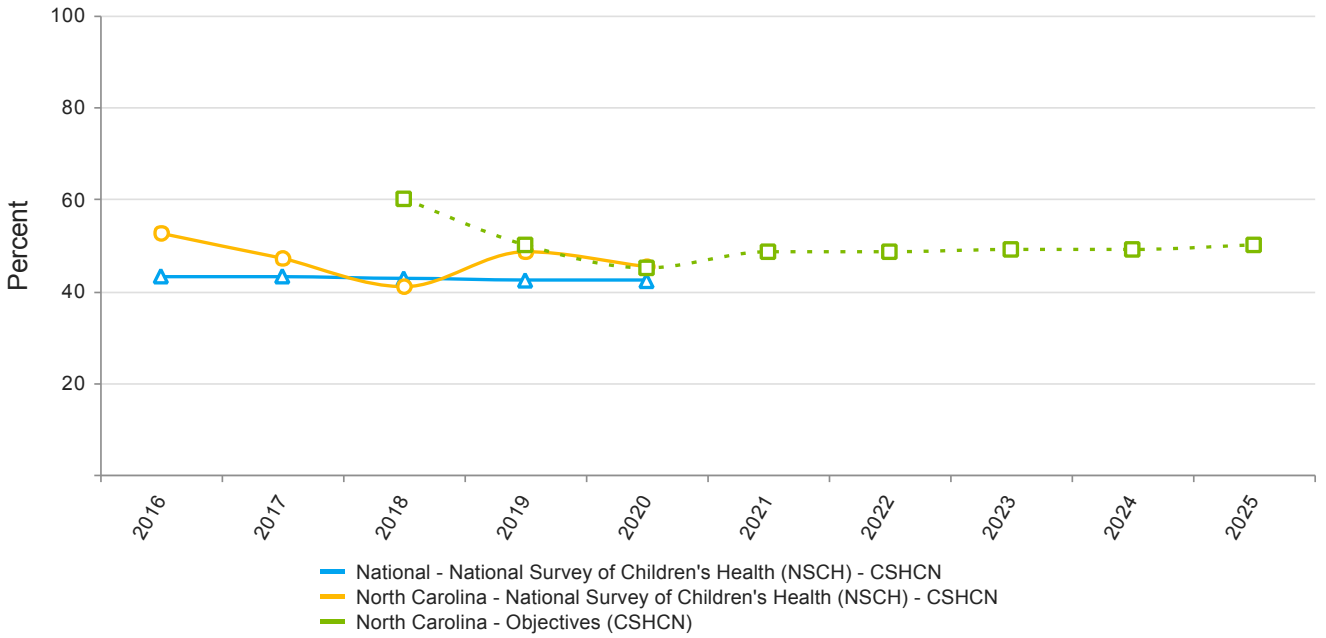
The PMC and CYSHCN outreach staff will continue to promote the importance of adolescent preventive care including behavioral health risk assessment in policies and processes and during meetings, presentations, and discussions with state and community agency partners. These partners include but are not 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 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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		60	50	45	48.5
Annual Indicator	52.6	46.9	41.0	48.4	45.2
Numerator	257,575	225,282	199,181	241,421	227,867
Denominator	489,644	480,138	485,743	498,468	504,402
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	48.5	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
Annual Objective			88.7
Annual Indicator	85		80.8
Numerator			
Denominator			
Data Source	2018-19 NSCH		2019-20 NSCH
Data Source Year	2018-19		2019-20
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.0	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
Annual Objective			10
Annual Indicator		8	9
Numerator			
Denominator			
Data Source		DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	12.0	12.0	14.0	16.0

State Action Plan Table

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

Priority Need

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

NPM

NPM 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. Continue the Innovative Approaches (IA) Initiative and replicate best practices.

CYSHCN 7A.6 . Continue to train parents and dentists in best oral health practices in serving CYSHCN.

CYSHCN 7A.7. Continue to partner with internal and external stakeholders 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 stakeholders 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 10% from 24.1% (NSCH 2017-18 baseline) to 26.5%.

Strategies

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

CYSHCN 7B.2 Utilize pilot projects from IA sites to expand adolescent to adulthood transition activities (i.e., Educational materials; replication of Adolescents Transition to Leadership and Success (ATLAS), etc.).

CYSHCN 7B.3 Collaborate with DSS to support health care transition for youth in foster care.

CYSHCN 7B.4 Explore modifying language in the agreement addenda for LHDs and school health centers to include a requirement to implement a strategy to support health care transition.

CYSHCN 7B.5 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

State Action Plan Table (North Carolina) - Children with Special Health Care Needs - Entry 4

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 7D. By 2025, the percent of children enrolled in the Infant-Toddler Program who increased their rate of growth in Positive Social-Emotional skill will increase from 74.3% (FFY19 baseline) to 85%.(This represents the average score needed to reach the top 10% of all states and territories for this indicator using nation-wide data from FFY14 through FFY18).

Strategies

CYSHCN 7D.1. NC ITP will implement universal social-emotional screening statewide utilizing the ASQ-SE.

CYSHCN 7D.2. NC ITP will implement Alliance for Infant Mental Health Association Competency Guidelines, including crosswalk with the Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children (Pyramid Model).

CYSHCN 7D.3. NC ITP will enhance and expand use of evidence-based social-emotional assessment tools and interventions.

CYSHCN 7D.4. NC ITP will enhance the capacity of the program to provide targeted social-emotional interventions by increasing the number of Infant Mental Health Specialists available as staff and contract providers.

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 5

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 7E.1 By 2025, NC ITP will achieve statewide implementation of Coaching and Natural Learning Environment Practices. Staff and providers will receive training and attain proficiency using the Coaching and Natural Learning Environment Practices approach.

CYSHCN 7E.2. By 2025, NC ITP staff and providers will receive training in Pyramid Model implementation.

Strategies

CYSHCN 7E.1 NC ITP will provide training and follow-up support for program staff and contract providers to achieve and maintain proficiency with Coaching and Natural Learning Environment Practices as outlined in the NC ITP Coaching and Natural Learning Environment Practices Toolkit.

CYSHCN 7E.2. NC ITP will maintain a cadre of certified Master Coaches and establish and maintain a cadre of certified Fidelity Coaches to ensure capacity to support full statewide implementation and proficiency with Coaching and Natural Learning Environment Practices.

CYSHCN 7E.3. NC ITP will partner with the Family Infant and Preschool Program to provide training and certification opportunities for staff and providers while building internal program capacity to sustain Coaching and Natural Learning Environment Practices statewide.

CYSHCN 7E.4. NC ITP will develop a plan, utilizing the principles of implementation science, for staff and provider Pyramid Model training and implementation.

CYSHCN 7E.5. NC ITP will access resources and apply for technical assistance opportunities from the National Center for Pyramid Model Innovations and other TA partners.

CYSHCN 7E.6. NC ITP will establish a cadre of trainers for Pyramid Model implementation, leveraging and building upon Master Coach and Fidelity Coach capacity within the program.

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 WCHS 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 FY21 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 2019-20 NSCH indicate that 45.2% of CYSHCN had a medical home as compared to 52.7% of children and youth without special health care needs (non-CYSHCN). National rates for this measure are 42.2% for CYSHCN and 47.9% for non-CYSHCN. State rates for both CYSHCN and non-CSHCN have decreased from the 2016 rates of 52.6% and 54.4%.

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 stakeholder meetings 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 80.8% in 2019-20. 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 83.1% in the most recent 2019-20 NCSH. Baseline data for ESM 11.2 was obtained in FY21 based on what occurred in FY20 when there were eight relevant stakeholder meetings with an agenda item related to medical home promotion. A goal of increasing this to sixteen meetings by 2025 was set.

Several DCFW/WCHS staff members and FPs participated in the Children's Complex Care Coalition of NC (C4NC) advisory committee supported by a grant from the National Center for Complex Health and Social Needs. This effort was 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 rallied around its vision to have family-centered, integrated systems of care that enable all children with complex health needs to thrive. The Advisory Committee met monthly to examine national CYSHCN priorities (including medical home and health care transition) and to survey different disciplines of stakeholders across NC and rank the priorities using Delphi methodology. Next, the priorities were used for broad discussion at a 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 goal of the convenings was to generate key priorities and actionable recommendations to address scope and scale of care for children with complex needs in NC. The convenings used gallery walks led by facilitators from the C4NC,

including the PMC, that addressed a range of topics which included medical home and health care transition. 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. Challenges, strengths, and opportunities in current systems of care and recommendations for improvement were generated for each of the seven themes. More information can be found in the resulting white paper *Improving Systems of Care for Children with Complex Health Needs in North Carolina*.

Several of the C4NC meetings of the advisory group and all three of the PATH4CNC convenings included discussions about medical home. In total, there were nine meetings in FY21 which included medical home promotion on their agenda.

Education, Training, and Support for Providers Regarding Medical Home

In FY21, 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 2020 Child Health Training Program that extended into FY21. The PMC and SCHNC worked with NC DPH PHNPDU 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 PMC use 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 PMC stayed up to date on Medicaid policies related to telehealth in order to provide TA and consultation to providers in LHDs and other practices in order to increase access to care in the medical home for children via in person and telehealth options. The PMC also continued to solicit interest from providers and agencies about having the 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 Title V Director and PMC regularly updated COVID-19 related NCDHHS guidance and resources for medical home providers related to care of children during the COVID-19 pandemic. The PMC provided 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 CSHCN who report that their children receive family-centered care, the DCFW/WCHS continued several programs and activities during FY21. 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 DHHS Healthy Opportunities 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 medical homes to care for children with a variety of conditions such as asthma, sickle cell, foster care, and neonatal abstinence syndrome.

Title V funds continued to be used to support CMARC services for children, birth to 5 years of age, ineligible for Medicaid. 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 the majority of FY21 requiring work to be maintained by other staff. Recruiting efforts were made to fill this important role with a bi-lingual, bi-cultural staff member who was hired in August 2021. The person hired previously worked at the local level to ensure families' access to affordable health insurance through the ACA.

DCFW/WCHS staff members continued to provide support to the NC Commission on CSHCN and its workgroups (Oral Health and Behavioral Health) in FY21. 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.

During FY21, the Commission was engaged in Medicaid Transformation policy recommendations. and provided feedback and recommendations on the development of the Medicaid's Standard Plan, which covers the majority of Medicaid children, including CSHCN. 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. The Commission formed an ad hoc committee to further discuss key concerns of providers and family members regarding Medicaid Transformation. Quality care management for CSHCN was a key issue among stakeholders. The Commission will invite the Prepaid Health Plans to join future Commission meetings to discuss their care management services and provide feedback from families and providers. The Commission continued to monitor the anticipated renewal of the CAP-C Waiver in FY22. Commission members shared concerns with NCDHHS leadership on issues ranging from the complex application process to the availability and quality of care management services available through waiver. The Commission continued to support telehealth to ensure access to key health services and supported efforts by NCDHHS efforts to expand its use in rural areas. In addition, the Commission recommended that providers utilizing telehealth adhere to the Americans with Disabilities Act standard for effective communication when utilizing telehealth. The Oral Health Workgroup's initiative to provide education about the importance of a dental home resulted in 14trainings reaching 262 oral health providers in FY21.

The CYSHCN Help Line Coordinator and PMC began to work with a large pediatric medical home with several locations in a rural county and several community 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. Expanding the Help Line outreach into medical practices across the state is beneficial and encourages new partnerships for all those working with CYSHCN.

The PMC served on the Medical Home Work Group with the Family to Family Health Information Center agency in NC as part of the statewide Early Well 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.

Education for Families Regarding Medical Home

As a result of the CYSHCN strategic planning sessions in FY20, the DCFW/WCHS, in collaboration with FPs, developed a CYSHCN web page geared toward families. The web page maintains current information and resources that address several key topics including: Diagnosis and Healthcare, Insurance and Financial Support; Family Support; Education Resources; Transition to Adulthood; and Advocacy/Legal. The web page is updated by the Help Line Coordinator, who receives ongoing feedback from families. FY21 updates to the web page included the new Medicaid/Health Choice flyer, Parents as Collaborative Leaders flyer, Hurricane Preparedness webinars, information on COVID19/Sports & Return to School, Dental Home Checklist, IA Family Photo Voice Exhibit, and Disaster Preparedness Video. Links and content were updated for CMARC, guardianship, and the Carolina Institute for Developmental Disabilities.

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 FY21. The Help Line is staffed by a 1.0 FTE with backup provided by the CYSHCN Access to Care Specialist. The CYSHCN Help Line contact volume for FY21 was 403 calls and emails. Families/caregivers of CYSHCN reflect 73% of the call/email volume. While callers can use the email link (CYSHCN.helpline@dhhs.nc.gov), 76% of callers utilized the direct phone contact which allows callers to talk directly with staff. Calls/emails originated from 65 of NC's 100 counties. Ninety-four percent of callers reported English as their primary language. Sixty-eight percent of callers reported Medicaid (Health Check) or Health Choice (CHIP) as their child's primary insurance which was consistent with FY20 reporting. The number of private insurance callers was 24% and the number of callers without any insurance was 10% of all calls/email, both about 2% higher than the prior FY. Sixty-eight percent of the calls were for children birth to age eleven, while 22% were for ages 12-18. Sixty-four percent of calls/emails requested assistance in accessing specific community services and resources which included: accessing public school's Exceptional Children Services, financial assistance, relocation to NC, and Social Security Disability Insurance. Additionally, 21% of call categories reflected health insurance specific inquiries. Callers to the Help Line indicated they learned about the Help Line via various methods: 38% via the website, 23% via their previous experience with the Help Line, and 18% as a referral from a state/local agency.

The Help Line continued to employ a CQI approach regarding its service provision to families and professionals. Help Line callers were sent a weblink for a services satisfaction survey. The Help Line services continually receive ratings between 90-100% on service indicators including: timeliness of response from the Help Line Consultant, how well questions/concerns were addressed, and respect shown for caller's opinions/feelings. Help Line survey respondents' comments reinforce the Help Line's purpose and value to families and the professionals caring for CYSHCN via the following quotes:

- "Help Line staff was amazing and provided the exact information I was looking for!"
- "Help Line staff was very helpful and offered a listening ear. It is nice to know that this service exists"
- " Help Line staff was the first person today that was able to send me information and clearly explain what I needed to hear"

- “Prompt and thorough response! Super helpful and friendly”

Outreach efforts to promote the awareness and access of the Help Line 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 FY21 reflected 1,021 families. Promotional materials including the *Help Line Information Card* (available in English and Spanish) and *Help Line Referral Flow Chart Guide* are available electronically and in hard copy. A total of 1,685 Help Line info cards were distributed in FY21.

A third outreach strategy involves direct promotion via collaborative opportunities (e.g., networking with or attending State or local stakeholder meetings), presentations to potential beneficiaries or professionals who work with these beneficiaries, or exhibits at professional conferences or local community events.

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 “lived vs. learned” 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, implementation and evaluation. Fifty-six FPs contributed 779 documented hours in FY21(an 18% increase over last fiscal year) towards DCFW/WCHS program and activity development, implementation, and evaluation efforts. The DCFW/WCHS continued to employ a staff FLS who worked to support staff and families in a broad array of family engagement efforts. In addition, the DCFW/WCHS continued to employ a part-time Parent Consultant who served the EHDI Program. The Access to Care Specialist for CYSHCN 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 six times in FY21 and participated in bidirectional communication regarding topics including parent training cadre updates, the AMCHP scholarship application process, proposed NC Medicaid/Health Choice outreach materials, 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 in English and Spanish at no cost to parents, either as a series or as individual modules according to the parents’ needs. Due to COVID 19 travel restrictions, the PACL training was offered in a virtual format. FPs consulted with the FLS to convert the training to a parent friendly virtual format that minimized technical barriers. Additionally, FPs and the FLS collaborated to offer the training in Spanish. Removing the time and cost barriers associated with travel, and adding the Spanish option, led to a participation surge in parent trainings resulting in 59 modules (38 in English and 21 in Spanish) presented to 370 parents and caregivers of CYSHCN across the state during FY21, almost triple the amount from the prior fiscal year. Ninety-eight percent of attendees felt the training contributed to their knowledge and skills for leadership. Participants reported:

- “I expect this training to help me apply the knowledge that was provided in this module and cultivate an

effective, positive impact in my community."

- "The facilitator created an environment that felt safe and allowed me to step out of my comfort zone and share my experiences and the impacts they've had on my family."
- "Cuando se me presente un conf licto sabre manejarlo de una mejor manera" (when a conflict arises I will know how to handle it in a better way).
- • "Lo usar para buscar mejores opciones de servicios para mi hijo" (I will use the training to find better service options for my child).

A second training curriculum addressing how a dental home has equal importance as a medical home continued to be offered as part of the DCFW/WCHS Parent Leadership Training cadre. The training discusses practical accommodations and strategies that can be used in the dental care setting, in addition to ways families can partner with their dental providers so CYSHCN have positive dental experiences. The presentation used the *Finding the Right Dental Home for Your Child or Youth with Special Needs* checklist (available electronically in English and Spanish) to categorize strategies via anxiety, communication, sensory, and mobility concerns. A trained family partner co-presented (with the contract dental hygienist/program consultant) at twelve virtual presentations to 138 parents and caregivers across the state in FY21. One hundred percent of attending family partners reported that their knowledge regarding oral health for CYSCHN and strategies for working with dental providers had increased as a result of the information learned in this training. The evaluation also used a 10-point scale to assess participants' confidence levels regarding the topic prior to and after the training. Sixty-seven percent reported more confidence in advocating for accommodations, similar to the prior fiscal year. Sixty-two percent reported more confidence in sharing [dental home] information, resources and ideas for accommodations with other families of CYSHCN as compared to 24% before the training.

The DCFW/WCHS continued to invest in Title V family leadership development by sponsoring family partners to attend national conferences, specifically AMCHP (seven attendees) and the National EHDI (1 attendee) conferences in FY21. 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. AMCHP scholarships represent two categories of attendees: AMCHP *Ambassadors* are family partners who have direct experience in NC's state system of care, including DCFW/WCHS sponsored local activities/initiatives, have documented local leadership experiences, and are interested in further developing their leadership potential. AMCHP *Scholars* are those family partners who have maintained ongoing leadership commitments by serving on the DCFW/WCHS BFP Steering Committee, the Parent Leadership Training cadre, or other DCFW/WCHS sponsored committee representation to further their state level leadership opportunities. Additionally, selected AMCHP scholars serve as a resource to help the *Ambassadors* navigate the conference.

One Family Partner presented information to the Steering Committee about a Medical Home Portal that she had learned about while attending the AMCHP conference. Branching from her presentation, a small subcommittee was formed to explore integrating information specific to NC into the national Medical Home Portal website. The subcommittee (which included the FLS, CYSHCN Access to Care Specialist, and led by the Family Partner), engaged in a series of meetings with the Medical Home Portal developers to discern the possibilities and benefits. Ultimately the partnership was not consummated due to funding and infrastructure limitations.

Other BFP engagement opportunities during FY21 included:

- Co-developing a three module parent training series called *Teaching your Child with Disabilities about Sexual Health*, incorporating input from youth and fathers
- Networking at FLS facilitated monthly BFP meetings to share updates about their communities and learn from staff presenters about mental health topics including Triple P, substance disorders, human trafficking, and resilience;
- Participating on the NC Triple P Partnership for Strategy and Governance (PSG) /NC Learning Collaborative (NCLC);
- Contributing to the MCH Block Grant review process;
- Leading quarterly Branch Journal Club meetings;
- Sharing their lived experience and input on issues related to COVID and school aged children on The Testing Project advisory group;
- Attending DCFW/WCHS Meetings and Town Halls. Informing and adding value to the work of the Behavioral Health and Oral Health Subcommittees of the NC Commission on CSHCN; and
- Co-chairing the NC Genetics Steering Committee whose purpose was to implement the leadership structure and guiding organizational framework for the State Genetics Advisory Council.

Additionally, the FLS partnered with the Adolescent Health Coordinator and the CYSHCN Access to Care Specialist to present *Leading with Lived Experience: North Carolina's Strategies in Engaging Families and Youth* at the Family Voices conference. The presentation highlighted successful strategies used to facilitate family and youth engagement, including pathways for recruitment, compensation, and methods to track and evaluate engagement. The presentation was shared with the intention of inspiring and supporting family engagement in other programs' efforts across North Carolina.

Outreach Efforts

The DCFW/WCHSoutreach 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.

As partnering agencies and communities acclimated to in-person restrictions due to the COVID pandemic, outreach staff developed revised strategies to continue promoting the value of NC Medicaid/Health Choice. Despite the vacancy in the Minority Outreach Coordinator position during most of FY21 and the travel restrictions and social distancing required as a result of COVID19, many outreach efforts (restyled to virtual methods) were maintained. The pandemic highlighted the need and led to increased internet connectivity options in rural, low-resource communities allowing the outreach staff to expand their virtual reach to these communities by increasing their proportion of virtual presentations and collaborations in the absence of face-to-face activities or events. Staff members reached out to various partner organizations or agencies to participate and present in their virtual community meetings. Examples included: refugee stakeholder meetings, Local Interagency Coordinating Councils, military families, emergency preparation for vulnerable populations, and transition/medical home for special populations (foster care youth). The number of outreach events more than doubled from 88 in FY20 to 186 in FY21 impacting over 4,614 participants. During the pandemic travel curtailment, outreach staff also prepared information packets which were mailed to site contacts for inclusion in their distribution efforts (e.g., food distribution to rural or Latino populations and back to school events). A total of 2,184 English/Spanish NC Medicaid/NC Health Choice informational flyers were distributed

in FY21.

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 partner 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 NC Project via the NC Pediatric Society, 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 NC's Medicaid transformation, the Child Tax Credit, and legislative updates on Build Back Better.

Innovative Approaches Initiative

FY21 marked the second 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 officially received a Best Practices designation from AMCHP in November 2018. To continue to build the evidence for IA, the initiative will enter year three of a three year plan to undergo a rigorous process of 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 will present their final report in May 2022. Furthermore, IA continued to produce and share Snapshot of Success stories which highlight IA strategies at work and serve as a reference point for replication of IA projects. In addition, IA sites continued to leverage external funds to support the goals of Title V.

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 FY21 the Parent Outreach Coordinators were challenged with maintaining parent participation in pandemic conditions. The coordinators transitioned meetings from in-person to virtual meetings and provided communications through multiple platforms (Facebook pages, websites, communication portals, etc.) to increase awareness about educational opportunities, meetings, and IA projects. The IA Parent Outreach Coordinators partnered with the FLS to offer PACL trainings to bolster the leadership skills of the parents involved in their IA Initiatives and recruit additional parents.

Each IA site has a Parent Advisory Council (PAC) which is a diverse group of parents and guardians of CYSHCN. The PAC is committed to advocacy and educating other families, agencies, and health care professionals on issues that effect CYSHCN. PAC members met monthly with service providers and agencies to promote collaboration and make recommendations to the IA Steering Committee.

In FY21, the Cabarrus, Gaston, Rowan, and Union County IA site recognized the importance of utilizing advocacy and leadership skills in youth with special health care needs. The site collaborated with Amazing Grace Advocacy and the Exceptional Children's Assistance Center (ECAC) to identify interests, content, and accessible language for YSHCN to participate in advocacy and leadership training; the training was piloted with small group of youth with intellectual and developmental disabilities. A texting platform to address health care transition for youth and young adults with intellectual and developmental disabilities was also piloted and identified as a strategy to address youth feeling unprepared to successfully transition to from pediatric to adult medical care. Other community improvement projects for this IA site in FY21 included participating in a 90 Day Quality Improvement Challenge to use Results

Based Strategic Planning for CYSHCN and leveraging funds through community partners to translate the Health Care Financing Guide (created in FY20) into Spanish. Furthermore, the PAC members participated in a virtual Photo Voice project titled *Our Family, Our Journey* to "educate others about issues impacting families of CYSHCN" as well as the impact of COVID during the pandemic.

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. Each review offered recommendations for improvements and help to secure partners for these projects, as well as to work with partners to find ways to modify outdoor spaces to increase inclusivity for CYSHCN. School nurses were trained in January 2021 to use the TRACK Rx program and given materials and "prescription pads" to use with their students.

The Henderson IA also focused on improving resource materials for parents of CYSHCN. Work groups reviewed both promotion and prevention focused parent outreach strategies, as well as provider-focused strategies, to determine which would be best for a Triple P Online campaign. Two parent flyers and a provider flyer were created and disseminated into the community, including to all foster care licensing social workers and foster families and teams. Additionally, after surveying child care centers and preschools about interest in materials for supporting CYSHCN, the IA site promoted the CDC's LTSAE materials among childcare subsidy, early learning programs, preschools, care management, and nurse visiting programs.

Oral Health Care for CYSHCN

The Commission's Oral Health Workgroup continued to focus on education and outreach to families and providers and is also charged with providing the Commission with recommendations to promote access to dental providers accepting Medicaid for children and youth with physical or intellectual disabilities.

Two retired dental hygienists of DPH's Oral Health Section were hired in FY20 to promote the importance of a dental home for CYSHCN and the use of the Dental Home Checklist for CYSHCN among family organizations and oral health providers. Presentations were conducted virtually to reach families and oral health providers throughout the state during FY21. In addition to the presentations for families mentioned earlier, a total of 262 oral health care providers participated in thirteen presentations, titled *Dental Home for CYSHCN* which emphasizes the providers' role in providing a dental home for CYSHCN by addressing access needs and clinical strategies.

Additional Strategies to Support CYSHCN

The SCCNC working collaboratively with the NC CCHSRC, continued to provide training, technical assistance, and support for 64 local CCHCs to develop strategies for the inclusion of CSHCN in the state's 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 infants and children with special health care needs. The PMC and SCCNC worked with Our Children's Place of Coastal Horizons Center to work on developing strategies and tools for CCHCs, child care providers, and local re-entry councils to help support children and their families with incarcerated or returning parents who have children in child care. Our Children's Plan serves as NC's leading advocate and education resource focused on children of incarcerated parents. The workgroup engaged with state partners to do focus discussions on applying the equity and trauma informed lens to the development of resources.

The SCCNC participated in the Early Care and Education Workgroup as part of the Early Well Initiative to address

the social and emotional health of children birth to third grade attending child care settings. The workgroup developed strategies around addressing equitable and accessible child care and adequate support and compensation for the early education workforce.

During FY21 the SCCHC and the NC CCHSRC began planning for CCHC Learning Collaboratives for FY22. These will be professional development activities for CCHCs on topics addressing the inclusion of CSHCN ages 0-5 yrs. in child care 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.

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. The pandemic limited in-person event during most of this FY. NC-EHDI sponsored three one-day virtual learning experiences for families and one in-person Family Fun Day. The in-person event offered families time to enjoy being together, making connections and participating in fun activities. NC-EHDI co-sponsored a new CARE Project activity, CARE Connect, a Facebook Live monthly program that focuses on timely topics that are of interest to DHH families.

NC-EHDI launched a new Family Focus Email in May 2021. The email is sent to parents and highlights resources, community events, points of interest and personal stories.

PACL training continues to be offered to families across the state in collaboration with family support groups and agencies. The Children's Cochlear Implant Center at the University of North Carolina hosted an online zoom PACL monthly training series from October 2020- May 2021. A parent of a child with hearing loss and EHDI parent partner conducted the trainings.

The EHDI Parent Consultant established an EHDI Parent Support Team to offer parent-to-parent support for families of children who are Deaf/Hard of Hearing (D/HH). The team included six mothers of children who are D/HH and is diverse in race/ethnicity, communication mode, language (American Sign Language [ASL], Spanish), geographical location, and type of hearing technology used (hearing aids, cochlear implants, no technology). The EHDI program partnered with the Early Learning Sensory Support Program for Children with Hearing Impairment to enroll families in this support program. During this reporting period, eight parents opted into the Parent Support Team.

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 Early Childhood Integrated Data System (ECIDS) Governance Council has 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 EHDI program continued to facilitate a "Common Ground Initiative" with key educational and health partners to engage in critical conversations to address conflicts that have arisen affecting schools and programs serving children and youth who are D/HH and their families over time. The goal of this initiative is for Schools for the Deaf,

OPTION Schools (Spoken Language), and health professionals to be able to continue collaboration on behalf of the education and whole person development of all deaf and hard of hearing infants, children, and youth so that all of these children reach their full potential. Fourteen “Shared Understandings” were developed by the NC Common Ground Workgroup. During FY21, these Shared Understandings were broadly disseminated to stakeholder groups to facilitate discussion on proposed policy changes to decrease disparities in educational opportunities and outcomes for deaf and hard of hearing children in NC. Early identification of hearing loss in children, followed by appropriate and timely intervention, are key contributors to goal 8 (high quality early learning), goal 9 (on track for school success) and goal 10 (reading at grade level) of the NC ECAP.

The AAP named a new NC EHDI Chapter Champion, who is deaf, to work closely with the EHDI Program. The developmental pediatrician: 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 Consultant 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, made up of newborn screening stakeholders, families, audiologists, laboratorians, researchers, infectious disease specialists, otolaryngologists, pediatricians, and other medical providers. This workgroup provided education to healthcare providers and the general public on CMV in efforts to increase awareness. They also explored current screening protocols in NC and made recommendations for change as needed.

The EHDI Program also continued to work collaboratively with the Division of Services for the Deaf and Hard of Hearing to implement the recommendations made by the Task Force on Access to Health Services for the D/HH. This Task Force was convened in partnership with the NCIOM, and the recommendations are found in the Assuring Accessible Communication for Deaf, Hard of Hearing, and DeafBlind Individuals in Health Settings report. Since the onset of the COVID-19 pandemic, the need for communication access has risen to a new level of importance, especially in light of mandates and recommendations for the wearing of masks.

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 FY21. 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 to collaborate 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, but worked within the COVID-19 response to address the access needs of CYSHCN and those with disabilities. NCODH led the development of the "COVID-19 Accessibility Checklist for Testing Sites" which was shared with LHDs and other COVID-19 testing providers. NCODH continued to provide TA virtually as a subject matter expert on statewide calls with LHDs discussing equity in the COVID-19 response.

Involvement in emergency preparedness efforts continued in FY21 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 FY21, NCODH continued to serve as a FAST Coordinator and trained additional FAST members.

In partnership with NCEM, NCODH planned a webinar series for families of CYSHCN in preparation for hurricane season during COVID-19 which was held in July 2021. The series titled *Hurricane Season and COVID-19: How Families of CYSHCN Can Be Prepared* brought together state and local emergency managers, first responders, families of CYSHCN and non-profit agencies to address the most pressing topics and questions related to how individual preparedness, hurricane response, and recovery was different due to COVID-19. Approximately 340 family members, caregivers, disability organizations, and emergency preparedness professionals attended at least one of three sessions to discuss how to meet the needs of children and youth with special health care needs and those with disabilities in the event of a hurricane. The webinars consisted of a panel of experts on each of the following topics and included presentations by BFPs sharing their personal experience as it related to each topic area:

1. Personal and Family Preparedness During COVID-19
2. How State and Local Officials are Preparing During COVID-19
3. Recovery, Resources and Questions Answered about Preparing During COVID-19

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 virtual presentations for dental providers, specifically addressing accessibility needs and ADA compliance within dental practices.

NCODH continued collaboration with the NC Office of Minority Health and Health Disparities to address inclusion of people with disabilities and CYSHCN in efforts to address health equity. With the shift to COVID-19 response efforts, NCODH collaborated with NCDHHS Historically Marginalized Population (HMP) Workstreams to ensure the needs of people with disabilities and CYSHCN who are also part of racial and ethnic minorities were addressed during the COVID-19 response. In FY21, NCODH expanded involvement in HMP workstreams working to promote access and inclusion of people with disabilities and CYSHCN in COVID-19 response. As a result, 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. The accessibility needs of people with disabilities and CYSHCN were promoted through the development of the *COVID-19 Accessibility Checklist for Testing Sites*. Specific equity issues related to CYSHCN were discussed in HMP workstream meetings and NCODH was given a leadership position within an HMP workstream.

Ensuring Health Care Transition Services

One component of improving access to coordinated, comprehensive, ongoing medical care for CYSHCN is to ensure that YSHCN receive 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 10% from a 2017-18 baseline of 24.1% to 26.5% by 2025, although it should be noted that the 2017-18 data should be interpreted with caution as the 95% confidence interval exceeded 20 percentage points. Percentages from the 2018-19 and 2019-20 NSCH were more reliable and show lower rates of 16.5% and 16.3%, respectively, so the 2025 goal may be too ambitious. 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 year of survey results, rates for subgroups by race/ethnicity are not reliable.

Transition Work Group and CYSHCN Strategic Plan Health Care Transition Recommendations

During FY21, 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 CDCFW/WCHS 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 PMC continued to try to promote communication among academic and community providers working on HCT efforts for YSHCN and with Branch programs to share best practices. 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. 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.

IA Transition Activities

There were several health care transition efforts in the IA program led by Cabarrus Health Alliance which is in four counties: Cabarrus, Rowan, Gaston and Union. A Roadmap (available in English and Spanish) was created and disseminated to multiple agencies that addresses health care transition in addition to transition to employment, post-

secondary education and independent living/health (essential areas on IEP transition plan). A Health Care Transition Checklist was adapted and shared with medical providers and families/youth to use as a guide for talking with their doctor during visits in the four counties. In FY 21, Cabarrus IA also developed and piloted materials for a Text4YourHealth initiative for youth/young adults with ID/DD from racial/ethnic minorities in English. Materials for a Spanish Text4YourHealth (TextoSalud) were created with a plan to pilot that texting service in FY22 for youth/young adults having ID/DD.

Regular meetings continued in each of the IA projects that focused on transition provided opportunities for IA sites to share educational materials, policy changes and events focused on transition in their communities. The IA Director developed a menu of options that can be replicated in other communities and this information was posted on the CYSHCN web page.

The Robeson County IA initiated the (Adolescents' Transition to Leadership and Success) ATLAS project continued to provide guidance and updates to other IA sites and to explore if a version of ATLAS could be replicated in any of the remaining IA counties. The ATLAS model pairs adolescents with chronic illness with mentors who are college students as well as youth from the community to provide social support for adolescents with chronic medical conditions and a forum to discuss and improve the experience of being an adolescent with a chronic illness. The goal of the group is to explore personal experience and reach out to others to try to improve the experience of being a teen with a chronic illness through monthly meetings, social activities, and service projects.

Health Care Transition for Youth in Foster Care

IA efforts led by Cabarrus Health Alliance related to Text4YourHealth included developing resources and materials for youth/young adults in foster care which will be piloted in FY22.

The PMC continued to co-chair the Transition Age Work Group with staff members from Fostering Health NC in FY21. 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 reviewing and enhancing DSS protocol and guidance on informed and shared decision-making regarding health care for youth in foster care and aging out of foster care based on one focus group held with youth currently in and formerly in care and two focus groups held with providers (mental health, community and health care providers serving youth and young adults in foster care). The work group was successful in being able to develop a job description and find funding to be able to begin recruitment for young adult co-chair for the work group with the PMC. The group also reviewed the survey completed by about 110 young adults formerly in foster care from ages 18 years and older throughout the state to ask about their health priorities, including some questions related to transition. 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 of discussion for this work group included beginning 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.

Modifications to Agreement Addenda and Contracts

In FY21, the Transition Work Group reviewed the current literature and tools (GOT TRANSITION, etc.) related to transition of youth from pediatric to adult health services. However, due to COVID-19 restrictions and other tasks required by staff, the Transition Work Group was not able to be incorporate the use of transition tools into LHD and pediatric practices to assist parents, youth and practitioners in the transition process and was not able to explore

ways to incorporate transition recommendations into agreement addenda and contracts for the FY22 contract year. The Child Health Program continued to provide TA related to incorporating health care transition into LHD agency policies and included transition information in several training opportunities with LHD staff and CHTP students.

Prophylactic Antibiotics for Children with Sickle Cell Disease

The North Carolina Sickle Cell Syndrome Program provided services to 1,903 clients with sickle cell disease, age 0-21, during FY21. 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. Patient education is provided one-on-one to clients and families regarding preventative health care measures including education about 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.

The Sickle Cell Education Consultant collaborated with UNC's Comprehensive Sickle Cell Center to host five virtual education sessions from September 2020-November 2020. Sickle Cell Educator Counselors, community-based organization (CBO) staff, sickle cell medical center staff and clients and families affected by sickle cell disease participated in the virtual sessions facilitated by UNC clinicians. Sessions were held during the evenings to meet the needs of clients and families. Session topics included an overview of sickle cell disease and COVID-19, non-opioid ways to manage pain and suboxone, blood transfusions and hydroxyurea, coping strategies for patients with sickle cell disease, and research efforts/new drug therapies.

Additionally, the Sickle Cell Education Consultant collaborated with Wake County Health Education Center to coordinate and host a School Nurses Conference held virtually on October 22, 2020. The purpose of the conference entitled *Sickle Cell Disease: Updates and Interventions* was to educate school nurses across Wake County. The 3.5-hour virtual conference was recorded and attended by 95 school nurses. Conference content was presented by the Sickle Cell Education Consultant, a CBO staff representative, and physicians and psychologists from Duke University and UNC Comprehensive Sickle Cell Medical Center. The topics presented include clinical complications, interventions and psychosocial implications experienced by children living with SCD, and the importance of the role of school nurses.

Finally, Piedmont Health Services and Sickle Cell Agency, in collaboration with Atrium Health's Comprehensive Sickle Cell Program conducted virtual sessions during fall 2020 for clients, families, and teachers of children with sickle cell disease to educate them about the medical and psychosocial problems a child with sickle cell disease may experience that could interfere with learning.

Social Emotional Health of Children Served Through the CDSAs

The NC ITP continued its efforts to provide timely and comprehensive early intervention services for children with special developmental needs and their families during FY21. One specific area in which the NC ITP goals overlap with those of the MCHBG is in improving the social emotional health of the children served through the CDSAs. The EIB would like to increase the percentage of children enrolled in the ITP who increased their rate of growth in positive social-emotional skill from 74.3% (FFY19 baseline) to 76.11% by 2025. This target was established as part of a

larger process of setting required targets through FFY 2026 for the NC ITP's Annual Performance Report to the Office of Special Education Programs. This process involved input from stakeholders including the state's Interagency Coordinating Council, NC ITP leadership, parents, and representative from other community partners. This specific target represents a statistically significant increase every two years in the percent of children who increase their rate of growth in this outcome area. In FFY21, 74.1% of children enrolled in the ITP had increased their rate of growth in positive social-emotional skill, leaving much room for improvement. This indicator also aligns with Goals 7 (Social-Emotional Health and Resilience) and 9 (On Track for School Success) of the ECAP. Specific NC ITP strategies toward reaching this goal include implementing statewide universal social-emotional screening using the ASQ-SE as well as enhancing and expanding the use of other evidence-based social-emotional assessment tools. In addition, the NC ITP will increase the number of Infant Mental health Specialists available as staff and contract providers.

In FY21, NC ITP purchased ASQ-SEs in English and Spanish for all sixteen CDSAs across the state. Depending on the staffing pattern, each CDSA has the ability to integrate the tool into their initial or ongoing assessment process. In addition to screening and assessment tools, NC ITP has also supported the CDSAs in having additional staff members trained in multiple evidence based practices such as Circle of Security, Child Parent Psychotherapy and Triple P. To provide these practices, the NC ITP is monitoring the availability of staff across the program. The baseline information was collected in 2019 and an updated survey of Social Emotional Supports, including internal and contract staff, tools, etc. is planned for 2022. The program is aware of the NC Infant Mental Health Association's purchase of the Early Childhood Mental Health endorsement system and will continue to explore ways to integrate it into the certification system.

The NC ITP received a Preschool Development Grant (PDG) that included training and professional development on early childhood mental health/social emotional development. Embedded in the proposal was training for EI staff on Attachment and Biobehavioral Catchup and professional development in social emotional health, assessment and identification. The ITP has also been engaging in a TA opportunity from the Zero to Three examining infant and early childhood mental health financing and policy efforts in states across the US. Staff members from the ITP serve on the Leadership Team of the NC Initiative for Young Children's Social-Emotional Health being co-led by NC Child and the NC Early Childhood.

Family Engagement and Leadership

Family engagement and leadership is critical throughout the NC ITP. In addition to the early childhood mental health proposal, the EIB also submitted proposals to the PDG related to system priorities related to family engagement and leadership and teletherapy. With PDG funds, the EIB continues their commitment and work around family engagement and leadership by enhancing family engagement in NC ITP for Preschool Transition and developing family engagement activities to support LICCs.

One of the most significant challenges is when a family moves from ITP services to preschool services. The NC ITP partners with the ECAC to engage families early and provides resources, tools, and training to ease the transition from early intervention to preschool services. These activities align with, and support, the guiding principles as outlined in the NC Early Childhood Cross-System Family Engagement and Leadership Framework.

In NC, LICCs are responsible for child find efforts, public awareness/communication, and the facilitation of collaborative community efforts on issues pertinent to the county populations they represent. The LICCs are comprised of community members who have a vested interest in an interagency system of service provision for children birth to five and their families. A July 2019 survey of LICCs revealed two impediments to the successful achievement of these efforts – lack of funding for child find activities and lack of parent representation on the LICC

(approximately 60% lack parent representation). This PDG initiative focuses on identifying and removing barriers to family engagement by providing intentional supports and incentives to develop, sustain, and empower families through self- and community advocacy to inform local and state-level decisions. More than 32,500 children are enrolled in or referred to the NC ITP in counties with active LICCs. Working through the LICCs, the NC ITP is creating an incentive program to recruit parents and develop a regional LICC conference and communications program to help LICCs establish concrete pathways to recruit and retain family members on the LICCs and fund child find activities.

In addition to these family engagement and leadership activities, the NC ITP continued to contract with the ECAC to provide parent leadership training with enrolled families. The PACL trainings provide detailed information regarding leadership opportunities available to families at both a state and local level.

Teletherapy Efforts

As part of the original SSIP work, the NC ITP identified a critical need for teletherapy to help reach families in rurally disparate areas of the state. Recognizing that shortages in clinical personnel serving young children across the state and that this shortage is particularly magnified in rural areas, where sparse populations and driving distances compound the problem, teletherapy was considered to expand access to high-quality services equitably across the state. Utilizing teletherapy as a method for providing critical and time-sensitive services helps ensure that needed services such as Speech-Language Therapy are provided to young children with developmental delays at the needed frequency and intensity. With the COVID-19 pandemic, the need for teletherapy was magnified as a way to effectively support families with needed resources and services. NC ITP services were shifted to be fully by teletherapy during the COVID-19 pandemic with support from NC Medicaid. As CDSAs transition back to in person visits, they are still utilizing lessons learned during the PDG funded teletherapy pilot and over the last two years to offer a teletherapy option when families want or need it. As the PDG pilot was stopped, grant funds were redirected to purchase equipment for families so that they could use a teletherapy option.

Coaching and Natural Learning Environment Practices

The NCITP also continued to support coaching interactions and Natural Learning Environment Practices (NLEP) across the state. Monitoring of both internal staff and contracted providers occurs every three months through a Coaching Proficiency Tracking Tool. The June 2021 data indicated that 31% of the contracted providers statewide had completed the initial training required by the NCITP Coaching Tool Kit. Internal staff trained at each individual CDSA ranged from 75-100%, and those internal staff who had reached proficiency in coaching skills ranged from 13-96%. In addition to tracking training that is occurring, this tool allows the State Implementation Team (SIT) to monitor the number of Master Coaches and Fidelity Coaches across the state. This allows the team to continue collaboration with the Family Infant and Preschool Program (FIPP) for training for these two groups. SIT has also created a definition for an ‘Approved Observer’ who can help support ongoing coaching fidelity for CDSAs having difficulty finding staff to be trained as either Master or Fidelity Coaches.

Pyramid Model

During FY21, NCITP received a Technical Assistance Grant from the National Center for Pyramid Model Innovations. The program has been actively discussing implementation plans, utilizing the principles of implementation science, for initial implementation at the Winston Salem CDSA. The implementation plan will include support to provide staff and provider training and technical assistance opportunities in order to implement the Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children (Pyramid Model). As part of this work, staff from the NC

ITP are also participating in a statewide cross-sector Pyramid Model State Leadership Team that brings together early childhood professionals and stakeholders from DPH, DPI, DCDEE, DMH, ECAC, NCPC, and the UNC system (with facilitated support from NCPMI) to discuss and plan for a coordinated, aligned, and integrated implementation of pyramid model across sectors in the state of NC. Key foundations of this work are equity and family engagement. The technical assistance provided by this grant will allow the SIT to create a statewide rollout plan based on implementation science and be inclusive of the work already done to bring staff to proficiency in utilizing coaching and NLEP.

CDSA Nutritionist Sharing Calls

In FY21 the Pediatric Nutrition Consultant continued to facilitate quarterly networking calls with six nutritionists/RDN's employed by regional CDSAs to connect them and to discuss topics of common interest pertaining to the nutrition care and medical nutrition therapy of infants and toddlers with special health care needs. Call topics included: how nutrition telehealth and phone consult services for families evolved due to COVID and precautions for going back into the homes; the role and value of CDSA Nutritionists; discussion of case studies; and sharing of favorite nutrition resources.

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 FY23, technical assistance 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 RCHNC, SCHNC, and PMC 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; obesity 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 social determinants of health (i.e., food security, transportation, literacy) for all children and especially CYSHCN. The CHNCs will continue to work with DPH LTAT/PHNPDU to encourage child health providers in LHDs to bill for screening for SDOH. CHNCs will also promote linking to NC CARE 360 for resources across the state to address SDOH with the child's medical home. Additional TA will be provided by CMARC program staff to LHDs participating in the Healthy Opportunities pilots 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(See the Child Health Domain for more details about Healthy Opportunities and below for more information about CMARC efforts.). 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 and especially CYSHCN or work with the child's medical home, and audits of services in LHDs will continue. 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 PMC will collaborate with the FLS and FPs to develop a webinar for health care providers about a quality medical home approach. The PMC 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 deliver the presentation and promote family centered and culturally sensitive delivery of care in a medical home for CYSHCN. The PMC, CMARC program manager and child health nurse consultants and other Title V staff will continue to serve on advisory committees and partner with NC Integrated Care for Kids staff and integration specialists to discuss how to identify and support children eligible for care with family navigators. These family navigators will help families partner with the care team (which includes medical home providers) to create a shared action plan across multiple sectors (early learning, education, in the five pilot counties.

In FY23, the Title V CYSHCN director will also work with other DCFW/WCHS staff to review the themes, challenges and recommendations from Path4CNC convenings to determine a timeline and processes to update the CYSHCN Strategic Plan by 2025. This process will help to determine the education, support and trainings to be planned for FY23 for providers 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 FY23 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, 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 support the work of NCDHHS' Plan of Safe Care Interagency Collaborative and support staff in the transition to Virtual Health/Care Impact documentation platform system. 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 also collaborate in FY23 to promote the Healthy Opportunities Pilot and will continue to participate in the NC InCK pilot program.

With the launch of NC Medicaid Managed Care, CMARC state staff members 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 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 the Division of Health Benefits, DMH/DD/SAS, DSS, and other agencies. This includes having the Commission continue its bi-directional communication with the five Prepaid Health Plans that serve Medicaid beneficiaries through managed care. In addition, the Commission will continue to provide feedback and recommendations on the Tailored Plan, which was originally scheduled to launch in 2022, but has since been delayed until 2023.

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 CYSHCN Help Line Coordinator and PMC plan to reach out to two additional pediatric medical homes, including those in rural areas, 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 addition, several staff members from the DCFW/WCHS will continue to serve on the state stakeholder 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 FY23, a small work group comprised of the FLS, CYSHCN Outreach Staff, and Family Partners will continue work to develop and pilot a training focused on the importance of the medical home training specifically for families which will be added to the Parent Leadership Training Cadre. An accompanying flyer highlighting the benefits of a medical home will be developed and posted on the CYSHCN webpage.

The Title V CYSHCN director will work with the FLS, CYSHCN Outreach Staff, Family Partners 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 medical home efforts. The Path4CNC work will also be used to help to determine additional education, support and trainings planned for FY23 for families and youth related to medical home. The DCFW/WCHS also will continue to explore with members of the Children's Complex Care Coalition of NC (4CNC) about 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 4CNC 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 CYSCHN webpage will be updated in FY23 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, Family Partners, 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 the regular communication to families applying for Social Security Disability Insurance which includes linking families to resources to help find a medical home.

The PMC will continue 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 parents (https://www.ncnewbornhearing.org/Parents.asp). Additionally, the website includes a resource section for the purpose of educating families of children who are D/HH on the following topics: 1) Learning about Hearing Loss; 2) Supporting Families; 3) Finding and Obtaining Services; and 4) Helping to Pay for Services. These resources will be maintained and updated regularly.

Increasing Family Engagement

The DCFW/WCHS will continue to develop its multi-faceted family engagement activities in FY23. The FP Steering Committee, including nine diverse Family Partners and the DCFW/WCHS Management Team, will meet quarterly. The focus on less talking, more action and decision making will remain. Family Partners 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 FY23 include offering a three module series called *Teaching Children with Disabilities about Sexual Health* and a Medical Home training. Family Partners 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 Family Partners from the training participant pool will be explored.

In FY23, 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 the FRC of the South Atlantic, holding quarterly meetings where efforts to determine opportunities for collaboration, share training opportunities, and reduce duplicative efforts are discussed.

The DCFW/WCHS will continue to offer Triple P Stepping Stones seminar training events 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 FPs 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, the DCFW/WCHS will continue to pair staff members with a parent or youth to develop and co-present at conferences, workshops, and webinars. These training teams reflect the natural complement of experience 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 Parents as Collaborative Leader 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 DHH 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.

Outreach Efforts

Outreach efforts described in the CYSCHN Domain annual report will continue in FY23. In addition, outreach strategies to promote children's health insurance and programs and supports for CYSHCN in populations not generally served by the Outreach team including refugees, Asian Americans, and American Indians will be developed as contacts will be made with agencies and organizations supporting these underserved groups. Adjusting outreach strategies to the fluctuating COVID climate will continue to be a priority. 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 as training is developed and conducted by the state's community college system.

Innovative Approaches Initiative

FY23 marks the first year of the three-year (2023-2025) funding cycle for IA. The DCFW/WCHS will continue to support two LHDs (serving seven counties) 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:

- Support integration of LTSAE;
- Continue the development of Care Notebooks as a tool that can be used by families of CYSHCN to simplify record-keeping and store information about their child;
- Explore ways to engage community partners, such as the Children and Family Resource Center, to allow for more continuity and sustainability for the PACs moving forward;
- Work with outdoor recreation partners to increase accessibility and physical activity for CYSHCN;
- Support transition services;
- Work with local school systems and school nurses on implementing/enhancing mental health screenings or social emotional screens to address impact of COVID-19;
- Identify a lead nurse Early Childhood case manager to coordinate and educate staff and families to promote health equity and increase access to care, and act as a liaison with providers; and
- Integrate the Special Connections CHW Curriculum into training for CDC-funded Community Health Workers at LHD, DSS, Cooperative Christian Ministries, El Puente Hispano, Community Free Clinic, and other community partner organizations.

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. Meaningful options for promoting the message that increasing dental home education decreases (dental) emergency room visits are on the FY23 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 pandemic) will be a priority.

Additional Strategies to Support CYSHCN

The SCCNC will continue to provide training, technical assistance, and support for 68 local CCHCs to develop strategies for the inclusion of CSHCN in the state's licensed child care facilities in FY23. The SCCNC will also continue to participate in the EarlyWell Initiative, monitoring and sharing the recommendations developed by the Early Care and Education work group focusing on supporting and promoting social-emotional health in the child care setting. The SCCNC will 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 FY22. The learning collaboratives and accompanying toolkit resources were created by the SCCNC in collaboration with the NC CCHSRC regional CCHC coaches and staff, as well as subject matter experts from UNC-CH, ECU, Wake Forest University and others. The goal of the learning collaboratives was 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. The series of seven archived webinars and resources will continue to be promoted. These webinars included the following topics: Inclusive and Accessible Environments; Specialized Enteral Feedings;

Diabetes; Seizures; Allergies and Anaphylaxis; Responsive Feeding; and Responsive Caregiving and Trauma Informed Practices. Additional CCHC learning collaboratives will be developed in FY23.

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 FY23. The SPHGC will explore updating a training which offered NCPD credits to provide guidance on how to take a family history/pedigree for nurses, physician and other interested health professionals. The SPHGC will continue to respond to additional requests from providers for other genetic topics and trainings in FY22 as part of Infant Toddler in-service trainings for CDSAs. The state GGAC, made up of professionals, families, and other stakeholders with interest in genetics, will continue to meet quarterly 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 Early Childhood Integrated Data System (ECIDS) during FY23. 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 FY23.

In addition to continuing all previously mentioned activities related to meeting EHDI 1-3-6 goals, the EHDI Program will engage in several new activities related to diversity, equity and inclusion (DEI) during FY23. The recently hired Spanish-speaking parent consultant will work directly with the Hispanic/LatinX community to engage families and professionals from the community to engage with the EHDI Program through learning communities, the EHDI Advisory Committee, and providing input to program planning, implementation and evaluation activities. She will also work with the Duke Hearing Center for Children and Families to enhance their efforts targeting the Hispanic/LatinX population via their Spanish-speaking parent support group.

The EHDI Program will work collaboratively with the NC Division of Services for the Deaf and Hard of Hearing (NCDSDHH) 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, NC DHHS Strategic Goals (1, 5 and 6), NC ECAP (Goals 1, 2, 5, 7, 8, 9 and 10), 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 2023 CARE Project + NC EHDI Parent Professional Collaborative in February 2023, and the theme of this conference will be Diversity, Equity and Inclusion. 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 conference agenda will include DEI issues specific to the D/HH community, such as communication access, as well as more general DEI information.

Another new EHDI initiative for FY23 is “D/HH Heroes.” 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 FY23, 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. Stakeholder 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.

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 FPs and the YHA Team, and will employ the following strategies, among others, to make that happen. In addition, the DCFW/WCHS is in beginning stages of exploratory work on the development of an Extension for Community Healthcare Outcomes (ECHO) project that includes addressing health care transition and medical home.

Transition Work Group and CYSHCN Strategic Plan Health Care Transition Recommendations

During FY23, the Medical Home Workgroup will address medical home more broadly and continue to include transition as a significant component of the medical home approach. The IA Director, in partnership with several DCFW/WCHS staff members on this workgroup (PMC, Adolescent Health Coordinator, Help Line Coordinator, and Family Partners) will continue to coordinate efforts on medical home and HCT at the Section level.

In addition, the PMC will continue to promote communication and collaboration among academic and community providers working on HCT efforts for YSHCN. Health care transition 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 PMC to LHDs will include strategies and resources about how to address HCT as described in the HCPG and Health Choice Program Guide. The PMC and state school health nurse consultant will also 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 the annual school health conference.

The FLS, Access to Care Specialist, PMC and other DCFW/WCHS staff in partnership with staff from the Family Resource Center South Atlantic (who has served as the Family to Family Health Information Center) will continue to explore strategies to address health care transition. This includes how to adapt a tool called goal cards developed by the Wisconsin CYSHCN for use with medical homes and families, and CYSHCN to address health care transition and other priorities for families. The Help Line for CYSHCN will continue to link families to resources related to health care transition. The Help Line will collect data about how often transitions are discussed at all ages which includes HCT for adolescents.

IA Transition Activities

All IA sites will continue to include in one of the six goals to work on the MCHB NPM to increase the percent of

YSHCN who receive the services necessary to make the appropriate transitions to adult health care, work and independence. IA meetings for all sites will continue to highlight transition related educational materials, policy changes and events they are doing in their communities. The Resource Café sponsored by Cabarrus Health Alliance which covers Cabarrus, Rowan, Gaston and Union has multiple HCT resources will continue to be promoted on the CYSHCN web page and shared more broadly with LHDs and other providers serving as medical homes. This includes the Roadmap (available in English and Spanish) which will continue to be disseminated to multiple agencies related to transition in health care, employment, post-secondary education and independent living/health (which remain essential areas on IEP transition plan). The Cabarrus IA Health Care Transition Checklist will also be promoted with medical providers and families/youth. The Cabarrus IA Text4YourHealth (TextoSalud) initiative materials for youth/young adults with ID/DD from racial/ethnic minorities in English and Spanish will also be promoted more broadly to see if the effort can be replicated by LHDs and medical homes serving YSHCN outside of the four Cabarrus IA counties.

Health Care Transition for Youth in Foster Care

The PMC will work with and help to mentor a young adult who was formerly in foster care as a co-chair of the Transition Age Youth (TAY) Work Group with Fostering Health NC in FY23. A goal of the TAY Work Group will be to increase engagement and active participation from additional young adults who have been in foster care in more of the work group efforts. The TAY Work Group will work with its multiple partners to 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 will use information collected from an adolescent survey of former youth in foster care and from youth and provider focus groups to 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 choose and apply for the appropriate Medicaid plan. The TAY Work Group will also work with DSS to explore the need for additional agency protocol and guidance to help social workers to support shared decision making and informed with youth, to help create and teach youth about use of a health care transition passport, and increase awareness and support for youth to have a health care power of attorney.

The Access to Care Specialist, Minority Health Outreach Specialist, CSHCN Help Line staff, and PMC will work with DSS, DHB, and Fostering Health NC to develop materials to assist youth transitioning out of foster care with how to maintain continuous insurance coverage and navigate the changing Medicaid options.

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

Modifications to Agreement Addenda and 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 one AA with LHDs 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 FY23. Sickle Cell Educator Counselors 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, 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 FY23, the Sickle Cell Education Consultant, in collaboration with Sickle Cell Educator Counselors and other staff members, will complete development of a toolkit for parents that will include information about the importance of prophylactic antibiotics for children with sickle cell disease. Sickle Cell Educator Counselors will pilot the toolkit during initial contacts with parents who have a baby with sickle cell disease. Feedback received from pilot testing will be used to modify the toolkit for parent education. The final toolkit will be rolled out by June 30, 2023, and be used during initial encounters and will during annual assessment visits with each family until the child reaches five years of age. Sickle Cell Educator Counselors will be required to document completion of these action steps in writing and in the WCSWeb Database.

The Sickle Cell Education Consultant, along with hematologists from the six sickle cell comprehensive medical centers, will complete work on the development of a 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 will work with the planning team to create an agenda, finalize learning objectives, identify presenters, create a plan to promote the webinar and develop a post-webinar questionnaire to measure increase in knowledge gained. The webinar will be created and conducted by May 31, 2023, and will be archived on the NC Sickle Cell Syndrome Program's website.

Social Emotional Health of Children Served Through the CDSAs

The NC ITP efforts to provide timely and comprehensive early intervention services for children with special developmental needs and their families described in the CYSHCN Domain Annual Report will continue during FY23. The PMC will work with several CDSA providers to increase outreach to medical homes about developmental and social emotional screening, management and appropriate referrals to EI and other agencies. The PMC will provide TA and consultation to the NC ITP and the CDSAs to help with implementation of universal screening using the ASQ-SE and increase use of other evidence-based SE tools. In addition, the NC ITP will make a plan to increase the number of Infant Mental Health Specialists and providers of social emotional services available as staff and contract providers.

Family Engagement and Leadership

Family engagement and leadership will continue to be of high importance throughout the NC ITP, and activities as described in the CYSHCN Domain Annual Report will continue as possible in FY23, although the PDG grant ends in October 2022.

Teletherapy Efforts

As part of the original SSIP work, the NC ITP identified a critical need for teletherapy to help reach families in rurally disparate areas of the state. Recognizing that shortages in clinical personnel serving young children across the state and that this shortage is particularly magnified in rural areas, where sparse populations and driving distances compound the problem, teletherapy was considered to expand access to high-quality services equitably across the state. Utilizing teletherapy as a method for providing critical and time-sensitive services helps ensure that needed services such as Speech-Language Therapy are provided to young children with developmental delays at the needed frequency and intensity. With the COVID-19 pandemic, the need for teletherapy has been magnified as a

way to effectively support families with needed resources and services.

The EIB, through the PDG, will ensure equity and access to technological and linguistic supports to families enrolled in the program. Provision of teletherapy will be implemented using appropriate devices which are encrypted and confidential ensures that families are protected under both the Family Education and Privacy Rights Act (FERPA) and the Health Information Portability and Accountability Act (HIPAA). Further, interpreter services will be afforded to families across the state to receive high-quality teletherapy services. In addition, an online self-paced teletherapy module that emphasizes the importance and practical implementation of a coaching approach will be made available to CDSA staff and contracted providers.

Coaching and Natural Learning Environment Practices

The NC ITP will continue work on its goal to achieve statewide implementation of coaching and NLEP by 2025. During FY23, the ITP will provide training and follow-up support as outlined in the NC ITP Coaching and NLEP Toolkit; maintain a cadre of certified Master Coaches; and establish and maintain a cadre of Fidelity Coaches. In addition, the ITP will continue to partner with the Family Infant and Preschool Program to provide training and certifications opportunities.

Pyramid Model

In FY23, the NC ITP will also continue to work with the National Center for Pyramid Model Innovations (NCPMI) to utilize what is learned from the Pilot CDSA to roll out the Pyramid Model to all CDSAs. This will include integrating the Pyramid Model into what CDSAs are already doing with coaching interactions and NLEPs. The SIT will integrate the Pyramid Model requirements into the current Coaching and NLEP Tool Kit, to ensure sustainability of all three practices.

CDSA Nutritionist Sharing Calls

In FY23, the PNC will continue quarterly 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-3 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
Annual Objective			2.3
Annual Indicator	2.7		2.7
Numerator	12.5		12.8
Denominator	4.7		4.8
Data Source	NC Vital Statistics/SCHS		NC Vital Statistics/SCHS
Data Source Year	2019		2020
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2.5	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 five DPH Health Equity Framework strategies into their work.
CCSB 8A.4. NC Title V Program will identify additional ways they can incorporate the five DPH Health Equity Framework strategies into their work.
CCSB 8A.5.WICWS will continue to require all LHD staff, clinical and non-clinical 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, etc.) 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/food insecurity; create training package; and identify audiences in the NC Title V Program and across NCDHHS that would also benefit from these trainings and materials.

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 over the past two decades. The ratio was 2.3 in 1999, was at its highest at 2.9 in 2009, dropped to its lowest point at 2.2 in 2015, and was 2.7 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. In addition to being a SPM, reducing this disparity ratio is a performance measure in the DPH Strategic Plan, 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 Infant Mortality Reduction 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 was limited in some ways during FY21 due to work assignments brought on by the COVID-19 pandemic, 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.

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 of the Department's first Chief Health Equity Officer, the training has not yet been approved for use by NCDHHS. The initial plan was for the training to be required of every DPH/DCFW 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 FY21. 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*.

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. As DPH has not conducted a follow-up survey as of yet, the NC Title V Program did not conduct a survey in 2021 and is determining how often the survey should be done internally.

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. In concert with two new federal grants, Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) and the state Maternal Health Innovation, implicit bias and other equity trainings were offered to the Maternal Mortality Review Committee along with providers through the Provider Support Network in FY21.

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.

During FY21, the NC ITP prioritized addressing issues of inequity within the Part C system. Program leadership consulted with the DHHS Diversity and Inclusion Office and the DPH Office of Health Equity to explore resource availability and Departmental/Divisional support to embed diversity and inclusion within the program. The NC ITP plans to conduct a diversity audit to examine personnel and child/family data to explore disparities that exist in human resources and service provision within the program, respectively. In addition, the program plans to establish a Diversity and Inclusion entity to provide ongoing support for system equity explorations and also to provide recommendations for professional development strategies/opportunities, policy, practice, and system enhancements to address inequities.

Social Determinants of Health

As shared earlier, addressing SDoH is foundational to the NCDHHS priorities, Perinatal Health Strategic and Early Childhood Action Plans. It also is a priority for NCDHHS as NC moves into Medicaid transformation, particularly with the Healthy Opportunities Pilots. 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 Healthy Opportunity Pilots 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.

Food Insecurity

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) https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions
- Food Insecurity (and other SDOH) referral and follow up through NCCARE360 – a Statewide Coordinated Care Network online platform https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nccare360
- Medicaid Transformation through the Healthy Opportunities Pilots which includes a focus on food insecurity and healthy food access. As reported in the Child Health Domain Annual Plan, the PNC is providing technical assistance on Food and Nutrition services being offered through the Healthy Opportunities Pilot.
- 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.

The two strategies to address this food insecurity objective complement interest and staffing within the NC Title V Program. NCCARE360 was launched in 2019 and became available statewide in June 2020, six months ahead of schedule. LHDs are natural partners to be enrolled in and using NCCARE360, but they may not all have integrated food insecurity screening, referral, and follow up (outside of their Medicaid populations) or may have experienced other challenges due to COVID-19. Therefore, strategy CCSB 8B.1. states that the NC Title V Program will work with NCCARE360 partners to identify how food insecurity screening, referrals and follow up being tracked in NCCARE360 and conducted through LHDs can be enhanced. The PNC did submit and was accepted by ASPHN to record a Poster Session titled *MCH Title V State Actions to Reduce Food Insecurity: North Carolina Experience* which was presented in June 2021. Due to the impact and length of COVID and the prioritization of state and local public health to address COVID, this food insecurity activity (CCSB8.B.1) had very little other activity. The PNC did consult with the NCDHHS staff person who manages NCCARE360 data from the Departmental standpoint, and it was determined that at that point (May 2021), LHD data would be under-represented because LHDs had not been brought into NCCARE 360 as of FY21 and likely wouldn't be brought in until FY23. Other confounding variables may mean that this strategy may need to be revised in future action plans.

For strategy CCSB 8B.2., the PNC in the DCFW/WCHS will increase training to child health staff around nutrition/food insecurity; create a training package; and identify audiences across DCFW/WCHS and DPH that would also benefit from these trainings and materials. This strategy fits well with prioritized food insecurity work that

the PNC has already been doing as part of the MCHBG since FY18 and because of the exponential rise in food insecurity due to COVID-19. Due to the impact and length of COVID and the prioritization of state and local public health programs to address COVID, this food insecurity activity also had to be modified. The PNC continued to provide resources and some select trainings for state and local staff on food insecurity, but a formal training package was not feasible for FY21 or FY22.

These food insecurity strategies can also be aligned with work by the DPH Health Equity Committee and Framework where feasible and reasonable. Initial work in both strategies in FY21 included the PNC working with NC Title V Program leaders to assess needs and opportunities within the Program and throughout DPH as appropriate. This was accomplished through a Food Security team of interested staff members with lived experiences of food insecurity, expertise, and/or passion to plan for, address and evaluate this issue. Sensitivity and awareness around racial equity issues and systems that affect food insecurity will also be incorporated into plans developed by this team.

COVID-19 has 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 will continue to work with multiple partners to ensure innovative ways to feed children and families during this pandemic. The Title V Director co-chaired the Governor's Education and Nutrition workgroup with the Department of Public Instruction, working with so many partners, volunteer organizations and advocates, to develop innovative strategies to ensure children across North Carolina and their families could access food with schools closed to in-person instruction. 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 FY21 and into FY22. One purpose of creating the DCFW was to bring together 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).

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 for FY21 and FY22 have not been accomplished, but will carry over into FY23. The NCODH has expanded collaborations with NCDHHS Office of Health Equity during the COVID-19 pandemic. In FY23, 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.

DPH Health Equity Framework

Promoting health equity remains a key goal for NCDHHS as illustrated by it being one of the four core principles in the *Moving Forward Together: The Next Phase of North Carolina's COVID-19 Pandemic Response* released in April 2022 as well as being Goal 1 of the NCDHHS 2021-23 Strategic Plan. As stated in the annual report, work continues on how to determine how well the NC Title V Program is embedding the DPH Health Equity Framework into its work. As the new 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, the NC Title V Program will determine its next steps as well, not only regarding the 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 Diversity, Equity, and Inclusion Council, which includes members from the NC Title V Program, will be enhanced.

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 FY23. In addition, the Reproductive Health Branch will be adding a Reproductive Justice staff position which will help drive both the work of the Branch and the Section. 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 Perinatal Health Strategic and Early Childhood Action Plans and a priority for NCDHHS. The updated Perinatal Health Strategic Plan will also be released to continue prioritizing SDoH including addressing poverty and racism, while strengthening collaboration with communities and other entities leading these efforts. In FY23, 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 Healthy Opportunities Pilots and NCCARE360.

Food Insecurity

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. 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.

Plans for FY23 around our revised strategy CCSB 8B.1 NC Title V Program staff (including the DCFW PNC) 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 include:

- The PNC will co-lead a *Working Group for Healthy Opportunities Pilot (HOP) Food/Nutrition Services***.** The purpose of this group will be to work closely with HOP leadership in DHB/Medicaid to develop operational guidance on HOP food services that are being administered in three pilot regions across NC. This working group will be made up of HOP representatives and content experts (which may include: food access and security, nutrition and dietetics, care management, healthcare, local agriculture and protein aggregation, and federal/state food assistance programs). The seven 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.
- 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. One planned activity is to update and disseminate a NC Federal Nutrition Food Assistance Program resource that the PNC developed in 2019.
- Another activity may be to develop, implement and summarize a survey of NCDHHS state level staff to identify needs, assets and interests in food/nutrition security. One potential outcome of this assessment would be to create a Nutrition Security Team of interested staff members with lived experiences of food insecurity, expertise, and/or passion to plan for, address and evaluate this issue. Sensitivity and awareness around racial equity issues and systems that affect food insecurity will also be incorporated into plans developed by this team. These food insecurity strategies can also be aligned with work by the DPH Diversity, Equity, and Inclusion Council and through work under the Health Equity Framework where feasible and reasonable.

Strategy CCSB 8B.2. (The PNC in the DCFW/WCHS will increase training to child health staff around nutrition/food insecurity and identify audiences in DCFW and across DPH that would also benefit from these trainings and materials) has only become more important because of the rise in food insecurity due to COVID-19 and inflation. As part of this strategy for FY23, the PNC and the PMC in her new role as Senior Medical Director for DCFW will continue to integrate food insecurity trainings into child health and specific nutrition trainings targeted in the CHTP for CHERRNs.

The COVID-19 pandemic has caused (and experts predict will continue to cause) 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 try 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, P-EBT, and WIC during pandemic and beyond. In addition, the PMC will explore how to share resources as they become available through the HOPs and other efforts (i.e., Legal Aid of NC) to address increased needs for housing, transportation, and other SDoH to providers.

The PMC will also continue to work with the AAP Technical Assistance Project Advisory Committee for the Screening and Technical Resource Center to increase resources for health care providers and professionals around SDoH. The PMC 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 PMC 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 PMC 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 (http://ncdhhs.gov/dph/wch/) 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. In the past, the Title V Director has held a public meeting to discuss updates to the MCHBG and receive feedback, but this did not occur this year with the competing priorities related to the COVID-19 pandemic and the DPH/DCFW reorganization. The Title V Program does plan to develop a short summary with highlights for partners. 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 has been engaged in multiple technical assistance and training opportunities related to MCH. Therefore, we have not specifically taken advantage of the opportunities through the MCH Bureau. Various examples include:

- ASTHO Increasing Access to Contraception Learning Collaborative
- 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
- National Center for Pyramid Model Innovations 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.

Potential future areas of needed technical assistance for the NC Title V Program are:

1. Setting up MCH systems for success amidst the creation of the DCFW and reorganization of the DPH.
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.)

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 IAA-MOU 2022.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 FY23 NC MCHBG Application.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FY23 NC MCH Block Grant Application O-Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: North Carolina

	FY 23 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	$ 6,600,923	(34.9%)
B. Children with Special Health Care Needs	$ 7,509,113	(39.7%)
C. Title V Administrative Costs	$ 215,441	(1.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 14,325,477	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 45,189,526	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 65,311,808	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 67,155,895	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 177,657,229	
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)	$ 196,528,961	
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)	$ 413,861,107	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 610,390,068	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 124,785
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 2,000,743
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 237,874,865
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood	$ 446,213
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 247,216
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 12,148,898
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,969,646
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 6,355,692
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) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 3,522,996
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 239,466
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Children's Health Insurance Program Reauthorization Act (CHIPRA)	$ 264,035
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 136,477,230
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 935,407
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,746,589

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 428,779
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,816,048
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sickle Cell Funding	$ 395,668
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > COVID Immunization Funding	$ 882,335

	FY 21 Annual Report Budgeted		FY 21 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 21 Federal Award: $ 17,561,399)		$ 16,804,521	
A. Preventive and Primary Care for Children	$ 6,375,595	(33.9%)	$ 5,852,615	(34.8%)
B. Children with Special Health Care Needs	$ 7,355,860	(39.1%)	$ 6,825,147	(40.6%)
C. Title V Administrative Costs	$ 253,323	(1.3%)	$ 276,547	(1.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 13,984,778		$ 12,954,309	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 34,195,972		$ 35,228,731	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 66,371,749		$ 57,078,391	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 69,967,790		$ 67,155,895	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 170,535,511		$ 159,463,017	
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)	$ 189,341,819		$ 176,267,538	
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)	$ 393,826,669		$ 291,783,688	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 583,168,488		$ 468,051,226	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 118,837	$ 91,997
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,942,807	$ 1,144,720
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 229,561,334	$ 150,047,068
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood	$ 429,093	$ 409,271
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 238,927	$ 81,947
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 14,589,293	$ 6,907,663
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 5,746,650	$ 6,951,709
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 2,839,893	$ 2,294,445
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 3,450,000	$ 3,069,524
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 300,951	$ 184,610
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Children's Health Insurance Program Reauthorization Act (CHIPRA)	$ 251,175	$ 34,929
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 127,575,411	$ 86,640,467
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 1,090,188	$ 221,590

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,724,384	$ 1,259,757
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,967,726	$ 3,812,735
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal Health Innovation		$ 1,297,097
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > COVID Immunization Funding		$ 26,959,359
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting MMRC		$ 374,800

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The difference in the FY21 budget and expended amounts is directly due to the mandates on spending by the impact of COVID-19 pandemic on programs and the April 2020 request by the NC Office of State Budget and Management to reduce unnecessary General Fund expenditures by implementing budget management measures which are described more fully in the Financial Narrative section of the application.	
2.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The variance is primarily due to expenditures in the WIC program being significantly lower than what is budgeted as budgeted amounts were projections based on caseloads from previous years.	

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 1,426,174	$ 1,324,537
2. Infants < 1 year	$ 1,509,616	$ 1,089,082
3. Children 1 through 21 Years	$ 6,600,923	$ 5,852,615
4. CSHCN	$ 7,509,113	$ 6,825,147
5. All Others	$ 1,610,465	$ 1,436,593
Federal Total of Individuals Served	$ 18,656,291	$ 16,527,974

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 45,617,813	$ 38,499,293
2. Infants < 1 year	$ 21,209,899	$ 18,043,074
3. Children 1 through 21 Years	$ 57,615,388	$ 57,049,466
4. CSHCN	$ 27,409,339	$ 27,406,769
5. All Others	$ 25,643,190	$ 23,109,433
Non-Federal Total of Individuals Served	$ 177,495,629	$ 164,108,035
Federal State MCH Block Grant Partnership Total	$ 196,151,920	$ 180,636,009

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 23 Application Budgeted	FY 21 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	$ 15,095,851	$ 13,785,484
3. Public Health Services and Systems	$ 3,775,881	$ 3,019,037
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	$ 16,804,521

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 27,051,055	$ 24,693,318
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 12,758,279	$ 11,344,919
B. Preventive and Primary Care Services for Children	$ 12,956,575	$ 12,956,575
C. Services for CSHCN	$ 1,336,201	$ 391,824
2. Enabling Services	$ 139,568,591	$ 117,132,140
3. Public Health Services and Systems	$ 6,943,578	$ 7,907,871
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		$ 24,693,318
Direct Services Line 4 Expended Total		$ 24,693,318
Non-Federal Total	$ 173,563,224	$ 149,733,329

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIB. - Other - Other**
	Fiscal Year:	**2023**
	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: 118,637 **Data Source Year: 2020**

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	116,584 (98.3%)	1,516	265	265 (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	X-Linked Adrenoleukodystrophy		

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn Hearing	117,658 (99.2%)	5,215	245	245 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

WCHS 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 2021

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	18,718	67.0	0.0	4.0	26.0	3.0
2. Infants < 1 Year of Age	4,816	79.0	0.0	2.0	18.0	1.0
3. Children 1 through 21 Years of Age	69,578	68.0	0.0	5.0	8.0	19.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	39,958	66.8	0.0	0.3	0.1	32.8
4. Others	8,269	37.0	0.0	14.0	48.0	1.0
Total	101,381					

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	116,730	No	118,699	90.0	106,829	18,718
2. Infants < 1 Year of Age	118,616	No	122,733	99.2	121,751	4,816
3. Children 1 through 21 Years of Age	2,768,020	Yes	2,768,020	14.6	404,131	69,578
3a. Children with Special Health Care Needs 0 through 21 years of age^	634,992	Yes	634,992	9.8	62,229	39,958
4. Others	7,714,494	Yes	7,714,494	0.8	61,716	8,269

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2021**
	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:	**2021**
	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:	**2021**
	Field Note: Data source for Children Age 1 through 21 is Special Report of LHD-HSA data run by State Center for Health Statistics. Data source for CSHCN is explained in next note.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: This is based on FY20 CMARC data from the CareImpact database and FY21 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:	**2021**
	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:	**2021**
	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:	**2021**
	Field Note: Data Source is YTD2021 Birth EpiCurve file that Perinatal Epidemiologist prepared for resident births.	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**
	Field Note: 99% of all infants received newborn hearing screening.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2021**
	Field Note: Source is YTD2021 Birth EpiCurve file that Perinatal Epidemiologist prepared for occurrent births.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: Includes: 5 year-olds in 2020 per Census Bureau Population Estimates as all have received kindergarten health assessments and immunizations histories have been reviewed (125,924); Average monthly participation count of children being served by WIC (142,692); and the number of 12 year-olds in 2020 per Census Bureau Population Estimates as all are required by law to have received immunizations for school (135,219).	
6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: Includes: CMARC, CYSHCN Help Line, Early Intervention Infant Toddler Program, and Help Line Outreach.	
7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**
	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, fathers, and community members; 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 2021

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 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	2023 Application Year	2021 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"	Nikki Hinnaut	Nikki Hinnaut
4. Contact Person's Telephone Number	(919) 707-5675	(919) 707-5675
5. Number of Calls Received on the State MCH "Hotline"		403

B. Other Appropriate Methods	2023 Application Year	2021 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://www.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 CYSHCN Director/Assistant Director, Division of Child and Family Well-Being, Whole Child Health S
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 or Youth Leader (Optional)	
Name	Holly Shoun
Title	CYSHCN Access to Care Specialist
Address 1	1928 Mail Service Center
Address 2	
City/State/Zip	Raleigh / NC / 27699
Telephone	(919) 707-5605
Extension	
Email	holly.shoun@dhhs.nc.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: North Carolina

Application Year 2023

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
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
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
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
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
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
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
2020/Q3-2021/Q2	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 %			
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
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
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
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**
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
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
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
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
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**
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
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
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
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
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
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
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
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
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
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
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 <50 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
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
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
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
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
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
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
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
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
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
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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				78	78
Annual Indicator			77.6	76.1	75.8
Numerator			1,412,575	1,386,809	1,385,665
Denominator			1,820,993	1,823,266	1,827,713
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	78.0	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					
	2017	2018	2019	2020	2021
Annual Objective	90	90	90	90	90
Annual Indicator	76.1	77.3	76.7	80.1	75.1
Numerator	1,502	1,560	1,269	1,375	1,253
Denominator	1,974	2,017	1,654	1,717	1,668
Data Source	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics	NC Vital Statistics
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	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:**	**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.	
3.	**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.	
4.	**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.	

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	79	80	84	85	85
Annual Indicator	83.5	84.9	82.5	80.3	85.0
Numerator	90,633	103,683	88,249	90,222	91,471
Denominator	108,563	122,165	106,953	112,365	107,553
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	85.0	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	23	24	25	26	26.5
Annual Indicator	26.1	27.0	23.4	23.3	20.2
Numerator	27,283	31,775	24,051	25,865	21,416
Denominator	104,660	117,705	102,887	111,143	106,047
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	27.0	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		62	50	50	50
Annual Indicator	47.6	44.4	43.0	48.1	55.8
Numerator	132,477	120,289	112,720	119,658	123,695
Denominator	278,073	270,809	261,906	249,001	221,849
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.0	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		83	83	83	87.5
Annual Indicator	85.5	81.0	81.0	87.3	81.6
Numerator	643,711	638,902	638,902	786,182	698,073
Denominator	752,936	788,733	788,733	900,582	855,558
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	83.0	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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		60	50	45	48.5
Annual Indicator	52.6	46.9	41.0	48.4	45.2
Numerator	257,575	225,282	199,181	241,421	227,867
Denominator	489,644	480,138	485,743	498,468	504,402
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	48.5	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
Annual Objective			59.7
Annual Indicator	55.9		58.6
Numerator			
Denominator			
Data Source	NC Pregnancy Risk Assessment Monitoring System		NC Pregnancy Risk Assessment Monitoring System
Data Source Year	2019		2020
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	60.0	60.3	60.6	61.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percent of women who smoke during pregnancy

Measure Status:	Active

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

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	7.0	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
Annual Objective			15
Annual Indicator	15.3		16.6
Numerator			
Denominator			
Data Source	2018-19 NSCH		2019-20 NSCH
Data Source Year	2018-19		2019-20
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	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
Annual Objective			90
Annual Indicator	80.1		75.9
Numerator			
Denominator			
Data Source	2017-19 National Immunization Survey		2018-20 National Immunization Survey
Data Source Year	2019		2020
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	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
Annual Objective			2.3
Annual Indicator	2.7		2.7
Numerator	12.5		12.8
Denominator	4.7		4.8
Data Source	NC Vital Statistics/SCHS		NC Vital Statistics/SCHS
Data Source Year	2019		2020
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2.5	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
Annual Objective			15
Annual Indicator	15		10
Numerator			
Denominator			
Data Source	NC FP Program Service Site Information		NC FP Program Service Site Information
Data Source Year	2020		2021
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.5	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
Annual Objective			0
Annual Indicator			0
Numerator			
Denominator			
Data Source			WICWS Internal Log
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	0.0	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 was delayed and and won't be implemented until FY23.

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
Annual Objective			30
Annual Indicator			32.9
Numerator			28
Denominator			85
Data Source			WICWS Internal Log
Data Source Year			FY20-21
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	40.0	50.0	60.0	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
Annual Objective			74
Annual Indicator			84.5
Numerator			82
Denominator			97
Data Source			NC FP LHD Clinical Practice Survey
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.0	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
Annual Objective			50
Annual Indicator	33.7	37.2	70.9
Numerator	29	32	61
Denominator	86	86	86
Data Source	WICWS Internal Log	WICWS Internal Log	WICWS Internal Log
Data Source Year	FY18-19	FY19-20	FY20-21
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

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
Annual Objective			25
Annual Indicator		1.2	2.4
Numerator		1	2
Denominator		85	85
Data Source		WICWS Internal Log	WICWS Internal Log
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	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
Annual Objective			28,350
Annual Indicator	27,587	25,020	22,263
Numerator			
Denominator			
Data Source	NC Crossroads WIC System	NC Crossroads WIC System	NC Crossroads WIC System
Data Source Year	SFY18-19	SFY19-20	SFY20-21
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	29,120.0	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
Annual Objective			80
Annual Indicator		75	80.9
Numerator		51	55
Denominator		68	68
Data Source		DCFW/WCHS staff internal log	DCFW/WCHS staff internal log
Data Source Year		FY19-20	FY20-21
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.0	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
Annual Objective			24,225
Annual Indicator		16,676	7,656
Numerator			
Denominator			
Data Source		LHD/HSA and NC SHC Annual Report	LHD/HSA and NC SHC Annual Report
Data Source Year		2020	2021
Provisional or Final ?		Provisional	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	8,000.0	8,500.0	9,000.0	9,500.0

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.	

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
Annual Objective			66.3
Annual Indicator			71.6
Numerator			4,334
Denominator			6,054
Data Source			LHD/HSA
Data Source Year			SFY20-21
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	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
Annual Objective			88.7
Annual Indicator	85		80.8
Numerator			
Denominator			
Data Source	2018-19 NSCH		2019-20 NSCH
Data Source Year	2018-19		2019-20
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.0	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
Annual Objective			10
Annual Indicator		8	9
Numerator			
Denominator			
Data Source		DCFW/WCHS Internal Staff Log	DCFW/WCHS Internal Staff Log
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	12.0	12.0	14.0	16.0

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).

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:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number 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</td></tr><tr><td>**Denominator:**</td><td>Number of LHDs providing child health services</td></tr></table>
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 2021

	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 NC Title V Program 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 the State Center for Health Statistics in 2020. 2020 PRAMS data are available, and the State Center has committed to conducting an in-house PRAMS-like survey to obtain similar data, but as of Summer 2022, this survey has not been implemented.