Maternal and Child Health Services
Title V Block Grant

State Narrative for
NORTH CAROLINA

Application for 2007
Annual Report for 2005

Document Generation Date: Wednesday, September 20, 2006

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and certifications will be maintained on file in the Women's and Children's Health Section Office, located in Room C-7, 5601 Six Forks Road, Raleigh, NC.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Public input on the MCH Block Grant will be obtained by posting it on WCHS website in July and asking partnering agencies (including Healthy Start Foundation, March of Dimes state chapter, Area Health Education Centers, etc.) to review it and provide feedback to the Section Office.

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview

A. Overview

In North Carolina, governmental health and social services are generally administered through autonomous county-level governmental agencies. This decentralized structure poses special challenges for design and implementation of statewide programs and initiatives. Priority-setting, decision-making and problem-solving within the Title V program routinely involves use of the extensive network of state-level interagency working groups, and the input of public health workers (and others) at the local and regional level. The Title V Program is housed in the Women's and Children's Health Section (WCHS) in the Division of Public Health (DPH), which is found in the NC Department of Health and Human Services (DHHS).

Managed care organizations (MCOs) are increasingly important service providers for populations with private health insurance. Although the use of MCOs for delivery of services to Medicaid recipients was implemented in a deliberate fashion, the shift from public to private sector provision of services to the low income population has had a profound impact on local public health agencies who have traditionally served as direct providers of publicly-subsidized primary and preventive health services. The emphasis on public-private partnerships is strong across the state, as "interested parties" determine what services are needed, and who can best provide them. The role of the state agency is to create and maintain state level partnerships, and to provide leadership and consultation to local decision-makers.

According to 2000 census data, the total state population has grown to 8,049,313, a 21.4% increase from 1990 census data. African-Americans remain the largest racial/ethnic minority group in the state, however the Hispanic/Latino population has increased over 300% from a reported 1.04% in 1990 to 4.7% in 2000. Based on 1997 poverty threshold information, 12.6% of North Carolinians live below the poverty level, with 18.6 percent of children living below the poverty level. The median household income for North Carolina in 1997 was $35,320, while the national average was $37,005. The unemployment rate for 2000 was 3.6%. In 2000, seventy-nine percent of the population over 25 years of age had graduated from high school, while 23% were college graduates. Further demographic data are available in the core and developmental Health Status Indicator forms found in Sections 5.4 and 5.6.

The NC DHHS is the largest agency in state government and is responsible for ensuring the health, safety and well being of all North Carolinians, providing human service needs to populations with mentally illness, deafness, blindness and developmental disabilities, and helping poor North Carolinians achieve economic independence. The Department has more than 19,000 employees and is divided into 24 divisions and offices which fall under four broad service areas - administrative, support, health, and human services. Three divisions account for most of the department's budget. These are the Division of Medical Assistance (which houses the Medicaid program), the Division of Social Services, and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Additional divisions are the following: Aging; Budget, Planning, and Analysis; Child Development; Facility Services; Human Resources; Information Resource Management; Public Health; Services for the Blind; Services for the Deaf and Hard of Hearing; and Vocational Rehabilitation. The department is also responsible for managing the town of Butner. DHHS Offices include: Department Controller; Council on Development Disabilities; Economic Opportunity; Education Services; Internal Auditor; Legal Affairs; Property and Construction; Public Affairs; and Research, Demonstrations, and Rural Health Development. DHHS also oversees 19 facilities, including psychiatric hospitals, schools for the Deaf, and alcohol and drug abuse treatment centers. Direct health and social services are generally administered through autonomous county-level governmental agencies. There are 85 county or district Local Health Departments (LHD) providing health services for the one hundred counties that comprise North Carolina, as well as 100 county Departments of Social Services. This decentralized structure poses special challenges for design and implementation of statewide programs and initiatives. Priority-setting, decision-making and problem-solving within the Title V

program routinely involves use of the extensive network of state-level interagency working groups, and the input of public health workers (and others) at the local and regional level.

The current DHHS Secretary, Carmen Hooker Odom, was appointed in January 2001. During her tenure, the Secretary has identified the following four top priorities for the Department: 1) improving and expanding early intervention services to infants and toddlers; 2) improving long-term care for the elderly and for people with disabilities; 3) reforming the state mental health system; and 4) eliminating health disparities. While all of these priorities impact the work performed by the staff of the Women's and Children's Health Section (WCHS), the most direct impact is felt by priorities one and four.

The NC Infant-Toddler Program, through the Early Intervention (EI) Branch, WCHS, DPH is the state lead agency for Part C of the Individuals with Disabilities Education Act (IDEA). The program completed its reorganization as of July 2004 with the eighteen Children's Developmental Services Agencies (CDSAs) serving as local lead agencies. Over two hundred new employees have been hired by the CDSAs to carry out their new service coordination role and to meet other oversight responsibilities. Early intervention services are being provided through contracts (approximately 400) with public and private agencies, organizations, or individuals. Regional Interagency Coordinating Councils and Local Interagency Coordinating Councils are carrying out their roles as advisory partners to the CDSAs as outlined in the Early Intervention Design Plan.

One of the specific values of the EI Reorganization is that of "easy access to services for families". Beginning July 1, 2004, all referrals are made directly to the CDSAs. The new, streamlined system for referral has worked well. The greatest challenge to timely evaluation of infants and toddlers at the present time is the increase in demand for EI services (reflected in a marked upsurge in referrals) combined with the lack of additional resources to meet the needs of these families. During FY04, there were 4719 infants and toddlers referred to the early intervention program. In the first six months of FY05 (July-December), there were 8144 infants and toddlers referred, which demonstrates a marked increase from previous years. In FY04, the total number of infants/toddlers enrolled in EI (10,978) plus the total number of preschoolers evaluated (6308) was 17,286. While this represents a slightly smaller total number of children served than in some previous years, this is a result of the program's increased emphasis on services for infants and toddlers, for whom the program is required to provide a wide range of services. Services for preschoolers, on the other hand, have been predominantly one-time evaluations, so service provision to infant/toddlers is more resource-intensive.

Several federal mandates have had a significant impact on the early intervention system and have broadened the opportunity for service provision to more children with comprehensive health care needs. The Child Abuse and Prevention Treatment Act (CAPTA), originally enacted in 1974, was most recently amended in the Keeping Children and Families Safe Act of 2003. CAPTA now stipulates that children under three years of age with substantiated abuse and neglect be referred to early intervention. North Carolina began this referral process in July 2004. The Infant-Toddler Program in partnership with the Division of Social Services provided statewide training in order to effectively implement this mandate. The Homeless Assistance Act Amendments of 1990 added "preventative services regarding children of homeless families or families at risk of homelessness" to the CAPTA language. The Individuals with Disabilities Education Improvement Act was reauthorized and signed into law December 3, 2004. This reauthorization echoes CAPTA legislation and also requires a referral to early intervention of young children affected by substance abuse and illegal drug exposure. Estimates from the Division of Social Services are that this will result in 5000 referrals annually; the early intervention program had been serving approximately 29% of these children, so more than 3000 of these children will reflect new referrals to the program. The law specifies that state provide outreach/child find to parents of premature infants; to parents of children with other physical risk factors associated with learning or developmental problems and to homeless shelters and similar settings. In order to meet the CAPTA and IDEA requirements, the Infant-Toddler Program's many partners in the Division of Public Health are more important than ever before.

While these changes are positive in terms of the goals of the state's early intervention program, this substantial increase and the potential for additional numbers of children to be served by the program poses very significant challenges. Because of the entitlement nature of early intervention, all eligible children must be served. The level of state funding has not increased in four years. The Infant-Toddler Program will continue to address its capacity needs over the next year by exploring additional resources, reviewing the program's current eligibility definitions, and reviewing the provision of evaluations to the preschool population.

In regards to the Secretary's fourth priority, eliminating health disparities, the WCHS collaborated with the other divisions and offices in DHHS to develop the DHHS Call to Action to Eliminate Health Disparities report. Three WCHS staff members served on the Steering Committee of Eliminating Health Disparities which developed the report. The purpose of the report is to provide a framework for understanding the magnitude of racial and ethnic disparities in NC and some of the social determinants of these disparities. The Call to Action focuses on the role of the Department in addressing these issues and provides specific action steps proposed by each division and office in the Department to address these issues. As part of the development of the report, the Disparity Program Assessment was conducted throughout the Department to examine divisions' and offices' key health disparities priority conditions or issues, service delivery and socio-cultural challenges, and health disparities focus areas. Results from the assessment in the DPH indicated a need to examine and address several socio-cultural challenges faced by numerous programs in the division, including language and communication difficulties, attitudes and values of providers and clients, and the need to improve health education/knowledge and awareness. The WCHS has developed a series of action steps incorporated into the implementation plan which fall under the nine key recommendations identified in the report. Examples of these action steps include: preparation of maternal health/family planning fact sheets on the health status inequities in NC to assist community-based organizations and other contractors to identify priority areas for health interventions; increasing the number of minorities served in the NC Early Intervention program; and documentation of best practices in serving the Hispanic/Latino community in WIC local agencies.

Children in NC whose family income is under certain federal poverty levels may be eligible for either Medicaid or NC Health Choice, the State's Child Health Insurance Program (CHIP). To qualify for Health Choice, children must be uninsured, be ineligible for Medicaid, and have a family income that is equal or less than 200% of the federal poverty guidelines. This program is administered jointly by DMA and DPH, with DMA providing oversight for the program and establishing eligibility policy and DPH being responsible for outreach efforts and for services to children with special health care needs. The program first started enrolling children in October 1998. Unlike Medicaid, however, Health Choice is not an entitlement program, thus it must operate within specific budget parameters.

Despite NC's decision to implement a separate CHIP rather than a Medicaid expansion, the decision was made to do outreach and enrollment of families for both Medicaid and Health Choice in a seamless process. A range of activities to enhance the enrollment has been implemented, including a simplified 2-page application form, multiple community application sites, mail-in option, training of community professional and agency staff to assist with the application process, twelve months continuous eligibility for both programs, and availability of applications in English and Spanish. In 2001, through funding from a Robert Woods Johnson Covering Kids Project, focus groups have been conducted to propose an even more family-friendly re-enrollment process. Specific messages, graphics, and re-enrollment strategies were tested. In addition, NC continues to focus on a grassroots approach to outreach for Health Choice. Each of the 100 counties, working through the co-sponsorship of local health and social services departments, was asked to form an outreach coalition. These coalitions have been very effective in crafting outreach strategies specific to the circumstances of their individual communities and target groups. In a parallel fashion, SCHS convened a state level coalition called the Health Check-Health Choice Outreach Committee, comprised of state, regional, and local

representatives from public/private agencies, health care provider organizations, and child advocates. The role of the WCHS has been to support efforts of local coalitions by providing print materials, electronic media pieces, monthly updates, consultation/technical assistance, workshops, and targeted outreach to various groups/organizations from the state level.

Due to strong interest from members of the General Assembly and among public health leadership, a Public Health Task Force was established in mid-2003 to study public health in NC and to devise an action plan to strengthen public health infrastructure, improve health outcomes, and eliminate health disparities. Membership on the Task Force is broad and includes legislators, community leaders, public health professionals from state agencies and universities, local health directors, other healthcare providers, and representatives from minority communities. The six committees of the Task Force reflect the Task Force's six focus areas: accreditation of state and local health departments; public health structure and organization; public health funding (finance); workforce development and training; improving public health planning, resources and health outcomes; and quality improvement and accountability. The Title V director was assigned to co-chair the accountability committee and many staff members from the WCHS served on the committees. The Task Force convened four public meetings, held three regional public forums, heard testimony, and reviewed research and lessons from the field during the course of their work. An interim report was released in May 2004 and the final NC Public Health Improvement Plan to guide public health efforts in the next two to three years was released on January 15, 2005. There were two sets of recommendations in the report -- Core Infrastructure, which addresses public health system needs required to deliver the ten essential public health services and Core Service Gaps, which addresses critical needs in core public health service program areas. A copy of the Final Report can be found at the following URL: http://www.ncpublichealth.com/taskforce/docs/FinalReport1.15.05.pdf.

In addition to the work of the Public Health Task Force, staff members from WCHS continue to collaborate with staff across the Department on one of the NC DHHS Secretary's priority areas, that of eliminating health disparities. Efforts to implement the action steps developed in the Call to Action January 2003 report continue. In May 2004, the Office of Minority Health released a publication entitled "Racial and Ethnic Differences in Health in North Carolina: 2004 Update" which clearly illustrates the areas of health disparities and need for improvement in health outcomes. These areas include health insurance coverage rates, sexually transmitted disease rates, and infant mortality rates. A copy of the report is available at the following URL: http://www.schs.state.nc.us/SCHS/pdf/RaceEthnicRpt.pdf. One way in which WCHS staff have collaborated is that C&Y Branch staff were able to work with department leadership to expand the goal for health parity for people with disabilities as well as for ethnic and racial minorities. This has resulted in integration of strategies for eliminating service delivery and health disparities among children, youth and adults with disabilities in the action plans submitted by DPH programs and other DHHS divisions.

During FY04, the WCHS implemented a logic model/outcomes-oriented planning process. Earlier in FY03, the Section Management Team held a retreat and defined a consensus set of core WCH Indicators to be used to communicate the value of the work done by the WCHS with policymakers, stakeholders, and the general public. At the same time, the NC DHHS decided to implement performance-based contracting using logic models as a component of performance-based management. Thus, during FY04, the SMT members were responsible for leading work groups to create logic models for each of the eleven core indicators. Both regional and central office staff contributed to the models which are in the final draft stage. Logic models are by design a work in progress that can be revised as necessary to more clearly and correctly depict causal relationships and integrate program activities. The Section plans to work within the framework of the current logic models over the next fiscal year and review and revise them as necessary in the spring of 2005. Certainly the results of the needs assessment might dictate changes to the inputs and outputs of the logic models. The WCHS Core Indicators are as follows:

1. Reduction of Infant Mortality
2. Improved Health of Women of Childbearing Age

3. Prevention of Child Deaths
4. Elimination of Vaccine-Preventable Diseases
5. Increased Access to Care for Women, Children, and Families
6. Prevention of Birth Defects
7. Improved Health of Children with Special Needs
8. Improved Healthy Behaviors in Women and Children and Among Families
9. Healthy Schools and Students who are Ready to Learn
10. All Newborns Screened for Genetic and Hearing Disorders
11. Provision of timely and comprehensive early intervention services for children with special developmental needs and their families.

/2007/ Session Law 2005-276 by the NC General Assembly (NCGA) mandated the North Carolina Health Choice (NCHC) program to limit participation to eligible children ages 6 through 18 beginning January 1, 2006. This session law also mandated the Medicaid program to provide coverage for children birth through the age of five with family incomes equal to or less than 200 percent of the federal poverty level beginning January 1, 2006. As a result of this legislation, current NCHC children ages birth through five will be moved to the Medicaid Health Check (HC) program on January 1, 2006. Any Medicaid enrolled provider currently providing services to NCHC children ages birth through 5 must bill North Carolina Medicaid for dates of service beginning January 1, 2006. In addition, the NCGA capped NCHC enrollment growth to 3% every 6 months and reduced NCHC reimbursement rates to 115% of the HC fee schedule on 1/1/2006 and 100% on 7/1/2006. The NCGA also directed DHHS to move NCHC children (ages 6 through 18) into the Community Care of NC networks for case management services. WCHS worked closely with DMA to assure a smooth transition for NCHC children to Health Check. This involved drafting notices/letters to families and preparing a bulletin/list serve notices for providers to prepare for transition issues related to prior approval, hospital coverage, etc.

North Carolina received an Early Childhood Comprehensive System planning grant in 2003 which was followed by an implemenation grant in 2005. During the planning grant period, a plan for a comprehensive, integrated early childhood system in North Carolina supporting school readiness and building on existing efforts and initiatives was created. Seven goals were developed by a multi-agency "think tank." These goals were:
Goal #1 -- Share Accountability for an effective, comprehensive and integrated early childhood system.
Goal #2 -- Use a set of shared indicators for school readiness to evaluate success at all levels of the early childhood system.
Goal #3 -- Support efforts in NC to develop data sharing strategies among providers who serve young children and their families.
Goal #4 -- Ensure that providers in the early childhood system have the practical strategies and community relationships necessary to provide effect services to children and families.
Goal #5 -- Build a philanthropic/government partnership for early childhood health and development
Goal #6 -- Contribute to stakeholders' efforts to build broad-based support for investing in efforts to produce positive developmental outcomes.
Goal #7 -- Promote evidence-based or promising practices for all critical components of the early childhood system.

The purpose of the proposed project is to continue to work with a wide group of stakeholders to assure that all children in North Carolina are healthy and ready for school. The status of children on a set of shared indicators of school readiness provides a way to measure the magnitude of the problem in NC. The indicators also provide a mechanism to measure success over time.

The factors that create challenges to the goal of assuring that all children are healthy and

ready for school are complex. Less than optimal connections among systems designed to support school readiness are one challenge. During the planning phase of the grant program, stakeholders agreed that while North Carolina had developed many of the critical components of a comprehensive early childhood system and had well-developed systems in place to support those components, the systems were not necessarily connected in a way that would facilitate positive developmental outcomes, including school readiness, for young children.

During the first year of the implementation period, the goals included in the ECCS plan were prioritized based on the following factors:
1) the potential to enhance integration across systems;
2) stakeholder interest and commitment to working on the goal; and
3) opportunities or barriers created by related activities in North Carolina, including, the development of an Office of School Readiness in the Governor's Office; ongoing work in Support Partnerships to Assure Ready Kids (SPARK) projects in NC; the creation of a Ready Schools Task Force funded by the Kellog Foundation; the development of a Child Maltreatment Leadership Team with leadership in the Division of Public Health; the development of an Infant Toddler Early Leaning Guideline Committee; and a legislatively created Children's Services Work Group charged with addressing coordination issues among agencies serving children and families.

The Child Health Assessment and Monitoring Program (CHAMP) survey was developed in the fall of 2004 and implemented in January 2005. CHAMP is the first survey of its kind in North Carolina to measure the health characteristics of children, ages 0 to 17. Eligible children for the CHAMP survey are drawn each month from the BRFSS (Behavioral Risk Factor Surveillance System) telephone survey of adults, ages 18 and older. All adult respondents with children living in their households are invited to participate in the CHAMP survey. One child is randomly selected from the household and the adult most knowledgeable about the health of the selected child is interviewed in a follow-up survey. All questions about the selected child are answered only by the most knowledgeable adult. CHAMP surveys will be revised each year to meet the child health surveillance needs of North Carolina.

CHAMP, by collecting data for young children, will contribute to a seamless health data system for all North Carolina citizens from birth to old age. Questions on the CHAMP survey pertain to a wide variety of health-related topics, including breast feeding, early childhood development, access to health care, oral health, mental health, physical health, nutrition, physical activity, family involvement, and parent opinion on topics such as tobacco and childhood obesity. Collected annually, the CHAMP survey data will help monitor child health status and identify child health problems; will help evaluate child health programs and services; will help health professionals make evidence-based decisions, policies and plans; and will help monitor progress towards selected health targets, such as Healthy Carolinians 2010.//2007//

B. Agency Capacity

The Women's and Children's Health Section (WCHS) is comprised of five Branches, Children and Youth (C&Y Branch), Early Intervention (EI), Immunization, Women's Health (WHB), and Nutrition Services. The Section Management Team, which is comprised of the Chief, Business Operations Manager, and five Branch Heads, meets weekly to facilitate joint planning, to keep key staff informed of current activities and issues, and to plan short and long term strategies for addressing current issues. A similar process occurs within the Branches which are responsible for assessing and responding to the needs of its target population(s). In addition, once a month additional senior and middle managers meet as part of the Expanded Management Team to discuss issue such as management and leadership skill enhancement and cross-cutting Section issues such as

local agency monitoring and data utilization.

Statutes
State statutes relevant to Title V program authority are established for several programs administered by WCHS. These statutes include:

GS130A-4.1. This statute requires the NC Department of Health and Human Services (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-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. The statute also establishes how refunds received by the Children's Special Health Services Program will be administered.

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, and 5) for each newborn, provision of screening in each ear for the presence of permanent hearing loss.

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 consultation, referral and transportation among hospitals, health departments, schools and other relevant community resources for mothers and infants at high risk for mortality and morbidity.

GS130A-129-130. 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 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-131.10. This statute establishes the manner of disposition of remains of pregnancies.

GS130A-131.15. This statute requires NCDHHS to establish and administer an Adolescent Pregnancy Prevention Program. The statute describes the management and funding of the program including the application process, proposal requirements, operating standards, criteria

for project selection, schedule of funding, and funding limitations and levels.

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-131.25. This statute establishes the OWH in an effort to expand the State's public health concerns and focus to include a comprehensive outlook on the overall health status of women. The primary goals of the Office shall be the prevention of disease and improvement in the quality of life for women over their entire lifespan.

GS130A-134. This statute establishes the list of communicable diseases and communicable conditions to be reported.

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 NC DHHS 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 entering kindergarten in the public schools and establish guidelines for how the assessment is to be conducted and reported. Guidelines for religious exemptions are also included.

Services For Pregnant Women

WCHS supports a statewide network of 85 LHD clinics which provide prenatal services to women in all 100 counties. These clinics have a long-standing commitment to the provision of multidisciplinary perinatal services including medical prenatal care, case management, health education, nutrition counseling, psychosocial assessment and counseling, and postpartum services. A wide range of preventive health services are offered in virtually all of the LHDs, allowing most clients to receive a continuum of reproductive health services at a single site. Standards for provision of WCHS supported prenatal and postpartum services are based on the American College of Obstetrics and Gynecology (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 provided in the Maternal Health Resource Manual. They are also generally quite consistent with the new fourth edition of the American Academy of Pediatrics/American College of Obstetricians and Gynecologists' Guidelines for Perinatal Care. Because of this 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. The accountability tool developed from these standards could form the kernel of an accountability system for Medicaid and commercial managed care services. Consultation and technical assistance for all contractors is available from WCHS staff members with expertise in nursing, social work, nutrition, health education and medical services. Staff includes regional nursing and social work consultants who routinely work with agencies within assigned regions. In order to achieve the WCHS goal of risk-appropriate prenatal care, the Section also supports 18 high risk

maternity clinics (HRMCs) across the state. The "traditional" HRMCs, located at tertiary care centers, are supervised by Maternal-Fetal Medicine specialists with immediate access to state-of-the-art technical support services and subspecialty consultation. These clinics have true regional catchment areas and function as "end providers." They are equipped to handle the highest risk prenatal clients without need for referral to higher levels of care. The remaining HRMCs are housed in larger health departments, and are generally staffed by local obstetricians. They do not draw from a regional catchment area and refer the highest risk clients to the tertiary centers for care. At the time of the inception of the HRMC program, the LHD HRMCs were pioneers in the provision of multidisciplinary care and also filled in some gaps where intermediate level care was somewhat inaccessible. As time has passed, the multidisciplinary care model they pioneered has been widely adopted, at least in the public sector, and the tertiary center network in the State has matured. The future role of these "intermediate level" HRMCs is unclear. As part of its charge to provide technical assistance and oversight to this network of clinics, WCHS continues to assess what changes are needed in the program to achieve the goal of risk-appropriate services for all pregnant women.

Maternity Care Coordination-Maternity Care Coordination (MCC) is the cornerstone of the state's attempts to eliminate barriers to prenatal care service provision. MCC services are provided by a nurse or a social worker whose primary role is to help clients access and effectively utilize services that address medical, nutritional, psychosocial and resource needs, while providing emotional support. The majority of MCCs are based in LHDs, but an increasing number are being based in private prenatal provider offices. WCHS provides start-up funding to local providers of support services to encourage them to hire additional care coordinators in order to increase the percentage of Medicaid clients who receive care coordination. WCHS also administers a limited amount of state appropriations which categorically support the provision of care coordination services to clients ineligible for Medicaid. LHDs are free to allocate portions of the block granted federal and state funds they receive to provide MCC or other support services to clients ineligible for Medicaid.

Maternal Outreach Worker Program-The Maternal Outreach Worker (MOW) program grew out of the state's experience with the MCC program. MCCs, who are trained professionals working primarily in clinic settings, had only limited time to address the social and emotional support needs of many of their clients. It was felt there was a need for community-based services provided by women with strong community roots. MOWs are paid, trained paraprofessionals who work under the supervision of an MCC and function in some respects as an MCC-extender. The MOW functions as a problem solver, assessing each client's needs and working with the client to address those needs, adopt healthy behaviors, and avoid unintended pregnancies postpartum.

Infant Mortality Reduction Programs - In 1994, the NC General Assembly appropriated $750,000 annually to fund projects that demonstrate ways to lower infant mortality and low birthweight rates among minority populations. The Minority Infant Mortality Reduction Project (MIMRP) currently supports l5 projects for an average of $50,000 per year for up to three years. These projects address the two-fold disparity in infant mortality rates between whites and non-whites through many initiatives, including education, community development and awareness, lay health advisors, and other outreach efforts. MIMRP was conceived as primarily a demonstration project, so the numbers of persons served by the program may not be great enough to impact statewide performance measures. The MIMRP is a joint initiative of WCHS, the Office of Minority Health and the Healthy Start Foundation.

The Targeted Infant Mortality Reduction (TIMR) program was established by the General Assembly in 1989 to provide funding that would improve the perinatal care systems in high "attributable risk" counties in the state (i.e., counties with high numbers and rates of infant mortality). Although recipient counties have substantial flexibility in the use of these funds, most of the $306,000 annual appropriation is used to support enabling services. Counties have expanded outreach efforts in maternity and family planning clinics, provided transportation and child care services for clients, and provided enhanced follow-up of persons with positive

pregnancy tests and missed prenatal care appointments.

During FY98, the WCHS received the first year of funding for the federal Healthy Start grant, Eastern Healthy Start Baby Love Plus (HSBLP). The goals of this project are to reduce infant morbidity and mortality in the seven county project area in eastern NC by incorporating three models to: support and empower a community-based consortium; provide outreach and case finding services; and to provide facilitating services which will reduce barriers to accessing services. community-based organizations to also develop local programming to address infant mortality and morbidity in their community. Funding for the Eastern HSBLP project continued in FY00 and funding for an additional Healthy Start initiative, the Triad HSBLP project, began. The Triad HSBLP project focuses on the racial/ethnic disparities in perinatal health in two of the state's more urban counties, Forsyth and Guilford. The four funded models being implemented are community-based consortium, case management, enhanced clinical, and outreach/client recruitment. Also funded in FY00 was a planning grant for the Northeastern HSBLP program. This grant resulted in FY01 funding for a Healthy Start initiative in five rural, underserved counties in northeastern NC. Its focus is to improve African-American perinatal health primarily and Native American/American Indian perinatal health secondly. As of May 2005, the WHB is waiting to hear whether the Triad site has be re-funded for another grant cycle. The NE site will begin year 2 of 4 in round two on June 1, 2005. The Eastern site is in its 4th year of a 4 year cycle - round two. It is slated to end on January 31, 2006, with a new competitive grant application due sometime in August 2005.

/2007/Pending availability of federal funding, the three Health Start Baby Love Plus projects continue. The Eastern Baby Love Plus project was awarded a new four year grant that began February 1, 2006 and will run until January 31, 2010. The Northeastern site is funded until May 2008 and the Triad site until May 2009.//2007//

Child Health Services

WCHS provides preventive health services to children from birth to 18 years of age primarily through LHD clinics. The schedule of recommended visits is based on American Academy of Pediatrics guidelines. Normally, clinic services are not provided for acutely ill children, although some health departments do provide pediatric primary care. Nurse screening clinics are conducted by public health nurses in LHDs. Physicians do not staff these clinics; however, services are provided under the guidance of the physician who attends the pediatric supervisory clinic. Medical management includes written policies and procedures that are updated regularly. Public Health Nurse Screeners receive specialized training for this role through a training program sponsored by the C&Y Branch. Nurse screening clinic services include: parental counseling regarding good health, nutrition practices and developmental milestones; immunizations; assessment of proper growth, development, hearing, vision, and speech; screening for anemia and lead; and referrals as needed. Pediatric clinics are conducted by physicians (family practitioners and/or pediatricians), nurse practitioners, and/or physician assistants. They serve as referral clinics for children with problems identified in nurse screening clinics. Pediatric clinic staff make referral for specialty consultations as needed.

The purpose of the Health Check program is to facilitate regular preventive medical care and the diagnosis and treatment of any health problem found during a screening for children eligible for Medicaid and under the age of 21. Health Check Coordinators (HCC) play a vital role in outreach efforts and assuring that Medicaid recipients access preventive health screenings. The HCC use an Automated Information and Notification System (AINS) to track and follow Medicaid eligible children. This system has the ability to generate personalized reminder and missed appointment letters based on paid claims data. The HCC make direct contact with clients via telephone calls, additional personalized letters, and occasional home visits. The type and results of their contacts are recorded in the comment section of the database. They work closely with the managed care representatives at local departments of social services to ensure children are connected with their primary care provider for continuity of care. In addition, they work closely with the provider

community to ensure children receive regular preventive health care and follow-up for conditions that have been referred to a specialist.

NC Health Choice for Children, the child health insurance program in NC, is a federal and state partnership to provide comprehensive health insurance to uninsured children. It provides free or low cost health insurance to children whose families cannot pay for private insurance and who do not qualify for Health Check. Children with special health care needs are eligible to receive additional benefits under NC Health Choice. This program is administered jointly by DMA and DPH, with DMA providing oversight for the program and establishing eligibility policy and DPH being responsible for outreach efforts and for services to children with special health care needs. Outreach to potentially eligible families is coordinated by Outreach Coalitions in each county. WCHS supports the efforts of the local coalitions by providing tools such as print materials, electronic media pieces, monthly coalition updates, consultation and technical assistance, workshops, and outreach to state and regional organizations.

School Health Matrix Team (SHMT) - The SHMT was created in FY04 in order to formalize a system by which all DPH staff working to improve the health status of students will be able to work together to develop unified plans and activities to work with students and schools. It is hoped that this streamlined effort will maximize the Division's school health resources and more efficiently meet the students' health needs. Membership of the SHMT is made up of DPH staff whose key work responsibilities involve working with schools. This structure brings together four DPH Sections and nine Branches and Units. One direct impact of this new structure is the change in the role of the state public health dental hygienists, who will be cross-trained on a broad range of school health topics and will be collaborating with local school nurses and other school health professionals. The SHMT works in a framework based upon the Centers for Disease Control and Prevention (CDC) eight component model of school health, also referred to as a Coordinated School Health Program. The SHMT will collaborate closely with the Department of Public Instruction (DPI), with the Senior Advisor for Healthy Schools serving as a member of the SHMT.

During FY04, the C&Y Branch worked with the NC Pediatric Society, the state Medicaid agency, LHDs and other partners to institute changes in procedures for developmental screening for all children. The following procedures were implemented for LHDs in July 2004:
- WCHS adopted the July 2001 statement of the American Academy of Pediatrics on Developmental Screening which includes specific instruments and periodic schedules that are recommended for evidence-based, formal developmental screening of children. Where there is concern about developmental status due to screening results or parental/provider concern, the child would be followed through second level screening or, if indicated, referred as soon as possible for in-depth testing/evaluation.
- Children should be screened with a formal, standardized developmental screening instrument at a minimum of 6, 12, and 18 to 24 months and 3, 4, and 5 years of age at well child visits.

The Specialized Services Unit worked with a logic model planning process to develop the following intermediate outcomes related to developmental screening:
Children will be screened early and continuously for special health care needs as measured by:
- % of infants whose mothers began prenatal screening in the first trimester
- % of infants and families monitored for special health care needs and developmental delays
- % of children receiving age appropriate well-child checks
- % of children receiving follow-up due to failed screening (vision, hearing, developmental, behavioral, mental health, oral health, metabolic)

Effective July 2004, DMA will implement policy requiring physicians who perform EPSDT well-child check-ups to use standardized assessment tools to perform developmental screening. These changes will also require the entry of a separate CPT code to indicate that the screen was conducted.

Another major focus area for the C&Y Branch has been to build the capacity of primary care

providers to provide quality preventive mental health services to children and families. Plans include offering training to practices on ways to incorporate behavioral health screening and appropriate interventions as part of their core service provision. Specific steps include:
-Work with existing communities that have developed successful models for information dissemination;
-Provide intensive work with individual practices to successfully integrate behavioral health services into their workflow;
-Coordinate collaborative calls among providers for information exchange on successful intervention strategies;
-Identify quality improvement teams from model practices to meet regularly to discuss issues identified within practices, develop possible solutions, and disseminate that information to practices involved in performance improvement;
-Develop and disseminate referral network information to providers specific to their community; and
-Educate referral resources on the need to provide feedback information to the referring physician.

Services for CSHCN

Children's Special Health Services (CSHS) is a state-administered program, financed by both federal and state funds. Care is provided through a network of professionals in the private section, clinics, hospitals, schools, and community agencies. All aspects of patient care are addressed, including assessment, treatment, and follow-up. CSHS provides cardiology, neurology, neuromuscular, oral-facial, orthopedic, myelodysplasia, speech/language and hearing services. In addition to providing diagnostic and treatment services through CSHS-sponsored clinics, the program also reimburses limited services for eligible children on a fee-for-service basis. Covered services include hospitalization, surgery, physicians' care, laboratory tests, physical, occupational and speech therapy, medication, durable medical equipment, orthotics and prosthetics, medical supplies and other interventions. "Wrap-around" Services. In addition to specialty clinic services, selected "wrap-around" services are funded for Medicaid-eligible children on a fee-for-service basis. CSHS is reimbursed by Medicaid for provision of most of these services, which include hospitalization; physicians' care; laboratory tests; physical, occupational and speech therapy; medication; durable medical equipment; orthotics and prosthetics; medical supplies; and other interventions.

FY03 was a year of deep reflection and change for the CSHCN program. The WCHS continues to be committed and guided by the key principles of comprehensive, community based, coordinated and family-centered care. There have been dramatic changes at the state and community level among key collaborators such as Early Intervention, Mental Health/Substance Abuse/Developmental Disability, School Health, and the private and public health care financing and delivery system, as well as significant shifts in priorities and resource allocation in DPH. In response, the CSHCN program has continued to review and critically evaluate all aspects of the program. The process has been directed by key personnel within CSHCN, in conjunction with a strengthened Family Advisory Council, the Commission for Children with Special Health Care Needs, and other representatives from key constituency groups. Driven by considerations to improve the efficiency and effectiveness of services, while concurrently developing strategies reflective of a family-centered approach, the CSHCN program is being reorganized both centrally and regionally in WCHS, as well as in relation to community partners. The early evidence is that this will result in improved collaboration and coordination. Of equal importance, the objective to better integrate services and supports for children with special health care needs into all aspects of C&Y Branch initiatives is being strongly pursued.

Child Service Coordination-The purpose of the Child Service Coordination (CSC) program is to identify and provide access to preventive and specialized support services for children and their families through collaboration. Children are eligible for the CSC program if they are at risk for, or

have a diagnosis of developmental delay or disability, chronic illness, or social/emotional disorder. In the CSC program, a service plan for the child/family is developed based on an assessment of the families identified strengths, needs and concerns. Coordinators work with other health and social services providers to monitor the child's development, strengthen parent-child interactions, foster family self-sufficiency, provide information about available programs and services, assist with application forms, and/or help to locate desired and appropriate resources. Follow-up contacts are required at least monthly; however, the frequency is actually based on family ability and need. Children from birth to age three who meet one of the definitions of the program Risk Indicators and children from birth to five who meet one of the definitions of the program Diagnosed Conditions are eligible. There are no income eligibility requirements for the CSC Program.

Newborn Screening Services - Universal newborn screening 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 Within the Department of Environment, Health and Natural Resources." The State Public Health Laboratory screens all newborns born in NC for phenylketonuria (PKU), congenital hypothyroidism (CH), galactosemia, congenital adrenal hyperplasia (CAH), and hemoglobinopathy disease (e.g., sickle cell). Beginning in July 1997, screening for an array of metabolic disorders using tandem mass spectrometry technology was instituted. Timely follow-up is provided by the Genetic Health Care Newborn Screening Program on all infants with suspicious laboratory results.

Neonatal Hearing Screening - Hearing screening has been mandatory for all infants born in NC as of October 1, 1999. Screening equipment was provided to 60 birthing hospitals through a special project of WCHS. The tests are performed quickly while babies are asleep. Audiologists affiliated with C&Y Branch Speech and Hearing Teams provide technical assistance to the hospitals and also perform infant hearing screenings and diagnostic assessments for older children.

/2007/The School Based Child and Family Support Team Initiative was begun during FY06. Its mission is to provide appropriate family-centered, strengths-based community services and supports to those children at risk of school failure or out-of-home placements as a result of the physical, social, legal, emotional, and developmental factors that affect their academic performance. While the staff person for the Initiative reports directly to the Secretary of DHHS, he is housed in the C&Y Branch and collaborates with branch members on this project. Through the Initiative, all State and local child serving agencies will collaborate and communicate to share responsibility and accountability to improve outcomes for at-risk children and their families. In 100 schools located in 21 Local Education Agencies across the State, Child and Family Support Team Leaders (a school nurse and social worker team in each school) will identify and coordinate appropriate community services and supports for children at risk of school failure or out-of-home placement in order to address the physical, social, legal, emotional, and developmental factors that affect their academic performance. These services are necessary so that those at-risk children may succeed academically, live in safe, nurturing and permanent families, and have opportunities for healthier and more stable lives.//2007//

C. Organizational Structure

The NC Title V program is housed within the NC Department of Health and Human Services (DHHS) in the Division of Public Health (DPH). DHHS is a cabinet-level agency created in October 1997 when the health divisions of the Department of Environment, Health and Natural Resources (DEHNR) were combined with the existing Department of Human Resources (DHR). Carmen Hooker Odom was appointed as Secretary of the Department of Health and Human Services (DHHS) by the Governor, Mike Easley, in February 2001. Serving as State Health Director and Division Director for DPH is Dr. Leah Devlin.

The Department is divided into 24 divisions and offices which fall under four broad service areas - administrative, support, health, and human services. Divisions include: Aging; Budget, Planning, and Analysis; Child Development; Facility Services; Human Resources; Information Resource Management; Medical Assistance; Mental Health, Developmental Disabilities, and Substance Abuse Services; Public Health, Services for the Blind; Services for the Deaf and Hard of Hearing; Social Services; and Vocational Rehabilitation. The Department is also responsible for managing the town of Butner.

Offices include: Department Controller; Council on Development Disabilities; Economic Opportunity; Education Services; Internal Auditor; Legal Affairs; Property and Construction; Public Affairs; and Research, Demonstrations, and Rural Health Development. DHHS also oversees 18 facilities: Western N.C. School for the Deaf, Morganton; Eastern N.C. School for the Deaf, Wilson; Governor Morehead School for the Blind, Raleigh; Whitaker School, Butner; Wright School, Durham; Broughton Hospital, Morganton; Cherry Hospital, Goldsboro; Dorothea Dix Hospital, Raleigh; John Umstead Hospital, Butner; N.C. Special Care Center, Wilson; Alcohol and Drug Abuse Treatment Center (ADATC)-Black Mountain; ADATC-Butner; Walter B. Jones ADATC-Greenville; Black Mountain Center, Black Mountain; Caswell Center, Kinston; Murdoch Center, Butner; O'Berry Center, Goldsboro; and Western Carolina Center, Morganton.

The mission of the Department of Health and Human Services is to provide efficient services that enhance the quality of life of NC individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

DPH is comprised of the Director's Office and six Sections. The Director's Office houses units with Division-wide impact, including:
- DPH Personnel Office (staffed by DHHS Division of Human Resources)
- Office of Chief Medical Examiner
- State Center for Health Statistics
- State Laboratory
- Vital Records

Other programs and services are operated out of the five Sections: Administrative, Local and Community Support; Chronic Disease and Injury; Epidemiology; Oral Health; and Women's and Children's Health.

The WCHS is responsible for overseeing the administration of the programs carried out with allotments under Title V. Kevin Ryan, Section Chief, is the Title V Program Director and Carol Tant, Children and Youth Branch Head, is the CSHCN Program Director. The mission of WCHS is to assure, promote and protect the health and development of families with emphasis on women, infants, children and youth. WCHS programs place a major emphasis on the provision of preventive health services beginning in the pre-pregnancy period and extending throughout childhood. The Section also administers several programs serving individuals who are developmentally disabled or chronically ill. As mentioned previously, WCHS is comprised of five Branches: Children & Youth, Early Intervention, Immunization, Nutrition Services, and Women's Health.

The public health system in NC is not state administered, but 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. Using federal Title V funds and other funding sources, WCHS must contract with local health departments (LHDs) and other community agencies to assure that these services are available. There are 85 local health department clinics which provide clinic and preventive services in all 100 counties. In addition, there are many community health centers and other agencies providing services. Each contract contains a scope of work or agreement addenda that specifies the standards of the services to be provided. The public health departments, which have local autonomy, have a long-standing commitment to the provision of

multidisciplinary perinatal, child health, and family planning services, including medical prenatal care, case management, health education, nutrition counseling, psychosocial assessment and counseling, postpartum services, child service coordination, well-child care, and primary care services for children.

A wide range of preventive health services are offered in virtually all of these health departments, allowing most clients to receive a continuum of reproductive health services at a single site. Standards for provision of WCHS supported prenatal and postpartum services are based on the American College of Obstetrics and Gynecology (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 provided in soon to be published Maternal Health Resource Manual. They are also generally quite consistent with the new fourth edition of the American Academy of Pediatrics/American College of Obstetricians and Gynecologists' Guidelines for Perinatal Care. Because of this 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. Local health agencies receiving Title X funding to provide family planning services must abide by the January 2001 Program Guidelines for Project Grants for Family Planning Services developed by the Office of Population Affairs (OPA), US Department of Health and Human Services.

Consultation and technical assistance for all contractors are available from WCHS staff members with expertise in nursing, social work, nutrition, health education and medical services. Staff includes regional child health and women's health nursing and social work consultants who routinely work with agencies within assigned regions.

In 2004, the state piloted a new program, the NC Local Public Health Accreditation Program (NCLPHAP). This program seeks to assure and enhance the quality of local public health in NC by identifying and promoting the implementation of public health standards for local public health departments, and evaluating and accrediting local health departments on their ability to meet these standards. In the first year, 6 local health departments volunteered to undergo the accreditation process as a pilot, and in 2005, four more will be evaluated. The goal of the NCLPHAP is to assure the capacity of every local public health agency in NC to perform a standard, basic level of service. The NCLPHAP does not create an entirely new accountability system; rather it links basic standards to current state statutes and administrative code and the many DPH and Division of Environmental Health (DEH) contractual and program monitoring requirements that already exist. The Division's goal is to see that instead of a voluntary process of accreditation, the NCLPHAP becomes a mandated procedure.

Organizational charts for DHHS and DPH are attached.
An attachment is included in this section.

D. Other MCH Capacity

The Section employs over 600 staff members responsible for management and administration of programs and services for the MCH population.

Key staff members

Section Chief - Dr. Kevin Ryan replaced Dr. Ann Wolfe as Title V Director in March, 1999. He had served as Chief of the Women's Health Section (now Women's Health Branch) since 1991. Dr. Ryan graduated from the University of California at Davis Medical School and completed a residency in Obstetrics and Gynecology at the University of Arizona Health Sciences Center in Tucson, Arizona. After completing his residency in 1986, he became an Assistant Professor in the Department of Obstetrics and Gynecology and then began a private practice in obstetrics and gynecology. He completed an M.P.H. from the UNC School of Public Health, Department of

Maternal and Child Health in 1991. Since his graduation he has maintained an active relationship with the Department, and has served as Adjunct Assistant and then Associate Professor.

Section Business Operations Manager - Peter Andersen assumed this position in March 2001. Mr. Andersen has a master's degree in Health Education from the University of Virginia (1976) and a Master of Business Administration from Delaware State University (1989). He has been in the public health field for 19 years. The first eleven were with the Delaware Division of Public Health in a variety of chronic disease program management positions. His eight years with the North Carolina state health agency have been in positions in health promotion and chronic disease prevention.

Women's Health Branch Head - Dr. Joe Holliday replaced Dr. Kevin Ryan as Women's Health Branch Head in February 2000. Dr. Holliday has over 25 years of public health leadership experience, including local health director positions in Virginia, South Carolina and North Carolina. Previous Division of Public Health duties included: program manager for the Comprehensive Breast and Cervical Cancer Control and Wise Woman Programs; and Chief of the Chronic Disease Prevention and Control Branch. He is a graduate of University of North Carolina at Chapel Hill, Vanderbilt School of Medicine, and the UNC School of Public Health (Department of Maternal and Child Health). He also completed a pediatric internship from Pittsburgh Children's Hospital and a preventive medicine residency from the School of Medicine, University of North Carolina.

Children and Youth Branch Head - Carol Tant replaced Tom Vitaglione as Branch Head in February 2000. She has an undergraduate degree in psychology, and earned her M.P.H. in health administration from the UNC School of Public Health in 1980. She worked in increasingly responsible positions in mental health, women's health and children's health services. Carol's work experience in children's health for over 19 years has included positions in genetics, specialized services and preventive health at both the regional and state levels.

Nutrition Services Branch Head - Alice Lenihan earned a B.S. in food and nutrition from the College of St. Elizabeth (New Jersey, 1970), and a M.P.H. in health administration from the UNC School of Public Health in 1983. After gaining local and regional experience in WIC programs, she was appointed state WIC Director in 1984. She continues to serve in that capacity as Nutrition Services Branch Head. In addition to the WIC program, she has oversight of the state's Child and Adult Care Feeding Program, Summer Food Service Program, and Nutrition Education and Training Program.

Immunization Branch Head - Beth Rowe-West assumed the position of Branch Head in December 1999 after serving in an acting capacity since October, 1998. She earned her B.S. in Nursing from the University of North Carolina at Greensboro and has worked most of her career in public health, serving 11 years in a local health department prior to coming to the Immunization Branch as the Hepatitis B Coordinator in 1994.

Early Intervention Branch Head - Deborah Carroll assumed the position of Branch Head in March 2005. She received a BS in Speech Pathology from Appalachian State University, a MA in Speech Pathology-Audiology from UNC Greensboro and a PhD in Human Development and Family Studies from UNC Greensboro. She is licensed and board certified in Audiology. She worked from 1999 to 2003 in the EI Branch as Director of EI's Comprehensive System of Personnel Development. Most recently she was the Unit Manager of the Genetics and Newborn Screening Unit of the C&Y Branch of the WCHS.

Data Specialist/Needs Assessment Coordinator (State Systems Development Initiative Project Coordinator) - Sarah McCracken Cobb began working in this position on July 1, 2000. She completed her undergraduate degree in chemistry at the University of North Carolina at Chapel Hill in 1987 and earned an MPH from Boston University in 1989. After serving in the US Peace Corps, she has held assessment positions with the state health agency in HIV/AIDS,

immunization, and maternal health programs.

During FY04, the C&Y Branch filled the Family Liaison Specialist position by a family member of an adolescent with special needs, Marlyn Wells. She serves as staff to the Family Advisory Council, which works extensively with the staff of the C&Y Branch. She trains, assists and advises staff on the development and promotion of family related issues and activities such as family perspectives, family centered care, care coordination, transition planning, medical home and educational/community resources. She also advises WCHS families on an as-needed basis on issues related to children with special needs.

/2007/Gerri Mattson, MD,MSPH joined the Women's and Children's Health Section in August 2005. She received her MD from the Medical College of Virginia in 1993, completed her internship and residency at Emory University in 1996, and received her MSPH from the School of Public Health at UNC in 2004. She currently serves as the Pediatric Medical Consultant for the Children and Youth Branch, but is available to the other Branches in the WCH Section. Her expertise is available to a wide range of public and private providers on best and promising practices in policy, program development, and evaluation related to child and adolescent health. She has almost thirteen years of experience in a variety of pediatric health care and public health settings.//2007//

E. State Agency Coordination

With creation of the Department of Health and Human Services in October 1997, state-level public health, mental health, social services, Medicaid, child welfare, vocational rehabilitation, substance abuse, and child development programs are now administered from a single agency. The DHHS Secretary has weekly meetings of the directors of these programs. These serve as a forum for discussing common issues and for facilitating coordination of efforts. The DHHS Assistant Secretary for Health conducts regular meetings with the directors of the three divisions that he manages (Public Health; Facility Services; and Mental Health, Developmental Disabilities, and Substance Abuse Prevention) Thus, intra-agency coordination is expected and facilitated at all levels of the organization. In addition, the Division is signatory to formal written agreements with several agencies, including:

-DHHS Division of Medical Assistance for provision of Medicaid reimbursed services for the MCH population. The current agreement includes a wide array of services and defines joint responsibility for informing parents and providers of the availability of MCH and Medicaid services. This agreement is revised in its entirety every five years, with interim changes as needed.

-Department of Public Instruction (state education agency) for assuring the provision of multidisciplinary evaluation, special therapies, health and medical services, and service coordination. This agreement is updated every three years and meets the requirements of the Individuals with Disabilities Act (PL 102-119).

-DHHS Office of Research, Demonstrations and Rural Health Development (formerly Office of Rural Health and Resource Development). The state primary care agreement outlines the Division's relationships with community health centers and other primary care providers.

-DHHS Division of Vocational Rehabilitation Under this agreement, the Division assumes responsibility for informing families of the availability of SSI, eligibility determination (when appropriate) and assurance that children remain under care.

-DHHS Division of Child Development This agreement specifies collaboration in three areas: child care health and safety training calendar; a monthly family child care health bulletin; and support for the child care health specialist position that responds to health and safety issues through the 1-800-CHOOSE1 hotline. The hotline gives access to the resource center which provides training, technical assistance and information to child care health consultants, child care providers, and consumers. WCHS also is an active member of the Advisory Committee on Public Health Issues and Child Care.

WCHS staff assure that information about health and social services is available to the target

population by supporting the following toll-free information and referral hotlines:
-Family Support Network (1-800-TLC-0042) provides information about special health problems and the availability of services for children with special health care needs. (Meets IDEA requirements.)
-CARELINE (1-800-662-7030) provides general information about available social services.
-NC Family Health Resource Line (1-800-367-2229) provides information, advocacy and referrals for primary and preventive health services for children and youth and provides general perinatal information with special emphasis on reaching pre-conceptional and pregnant women. (Database linked to CARELINE.)
-CSHCN Help Line (1-800-737-3028) provides information about genetic services and services for children with special health care needs.

Division of Public Health and WCHS staff work with the state education agency (Department of Public Instruction) on a number of projects including a CDC-funded grant to improve interagency coordination of health services offered by health and education agencies (CDC "infrastructure" grant), and nutrition programs. In addition, WCHS provides leadership, consultation and technical assistance to the state education agency and local school districts for:
-Development and maintenance of school-based and/or school-linked health centers,
-Expansion and enhancement of school nurse services,
-Nutrition and related training for food service workers, and
-Implementation of USDA-funded summer food and nutrition programs.

Close working relationships are maintained with the UNC School of Public Health, particularly with its Department of Maternal and Child Health. Division staff members serve as adjunct faculty members and are frequent lecturers in the Department, in addition to serving on Departmental advisory committees. Faculty members are asked to participate in Division planning activities to provide review and critique from an academic and practice perspective.

Although local health departments operate as autonomous entities, the state health agency funds a substantial amount of their services and the Division of Public Health works closely with them in all phases of program development, implementation and evaluation.

Strong relationships between state and local agencies are maintained by the continuous efforts of WCHS staff members to involve these agencies in the development, implementation and evaluation of WCHS initiatives. WCHS staff lead or participate in state-local collaborations that include, but are not limited to the following task force, on-going, or ad hoc working groups:
-Medicaid Outreach and Education
-Health Check Initiative
-Child Fatality Task Force
-Council on Developmental Disabilities
-IDEA Interagency Coordinating Council
-Smart Start Partnership for Children (Governor's early childhood initiative)
-Coalition for Healthy Youth
-Family Preservation / Family Support Initiative
-Healthy Child Care North Carolina
-Baby Love Program (enhanced services for pregnant women and infants)
-First Step Campaign (infant mortality reduction)
-Early Intervention Intra-agency Work Group
-WCHS/Medicaid Intra-agency Work Group

Adding to the success of these efforts is the strong involvement and participation of professional agencies in Division activities. The Division works closely with the medical societies (pediatric, obstetric/gynecologic, and family practice). The Division also maintains close working relationships with other advocacy and non-profit agencies that include the NC Partnership for Children, Prevent Child Abuse NC, and the NC March of Dimes.

/2007/ The name of the "Special Needs Helpline" was changed to the "Children with Special Health Care Needs Helpline (CSHCN Helpline)." This toll-free helpline continued to be the focal point for information on state and local programs and resources for CSHCN. Approximately 3,000 callers/year access the help line, which serves as the division's primary resource for families of CSHCN wanting information on multiple public programs with one call. For the majority of callers, health insurance issues were central to the conversation. Information shared by callers is compiled and reported to the Commission on CSHCN six times per year. The data are useful for program development purposes in terms of capturing trends of unmet needs reported by parents and providers of CSHCN. Through collaboration with the Title V Help Line (NC Family Resource Line) for translation services agreed upon in FY06, capacity for the CSHCN Help Line to adequately assist callers who speak Spanish only has been increased.//2007//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	60.6	70.7	75.4	76.2	61.5
Numerator	3470	3950	4295	4385	3554
Denominator	572868	558585	569623	575492	577894
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
Data are for the prior CY, e.g., FY04 is really CY03 data.

Notes - 2004
Data are for the prior CY, e.g., FY04 is really CY03 data.

Narrative:
/2007/Trend data for this indicator is very erratic, as it has fluctuated between 81 and 61 per 10,000 children since FY95, with provisional CY04 data at a rate of 61.5 per 10,000 children under five years of age. Before FY95, the number of possible diagnoses on the hospital discharge record was five, but this increased to nine in 1995, thus giving a potential for an increased rate, which was realized.

Data from the initial Child Health Assessment Monitoring Program (CHAMP) survey conducted in 2005 give a prevalence of current asthma in children less than 5 years of age as 10.5%, based on a sample size of 625. The prevalence for all children included in the survey (survey was conducted about children ages 0 to 17), the prevalence was 11.5% (N=3,536). As this was the initial year of the survey, it is difficult to make comparisons with previous prevalence data available through a special survey done as part of the BRFSS in 2002. At that time, the prevalence of current asthma in children less than 18 years of age was 13.9%. NC Medicaid claims from 1997-98 provide comparable estimates with an overall prevalence for children 0-14 of 13 percent (Jones-Vessey, 2001). In 2000, the Asthma Alliance of NC, in collaboration with its partners, one of which was the C&Y Branch, conducted an asthma prevalence survey of 192,000 seventh and eighth graders from public schools. The NC School Asthma Survey (NC SAS) showed that 17 percent of 7th and 8th graders reported current asthma-like symptoms (wheezing) with no physician diagnosis. Results from point in time studies and ongoing asthma data collection systems guide the work of the Asthma Branch, formerly a program located in the C&Y Branch, but now found in the Chronic Disease and Injury Section of DPH. The state was awarded a CDC grant which helps fund some of the staff in this branch. Grant funding is

also helping to enhance asthma surveillance using existing Medicaid, hospital discharge, and death certificate data. Work towards incorporation of childhood and work-site asthma modules into the state BRFSS in alternating years continues.//2007//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	87.7	89.2	89.8	90.2	90.8
Numerator	84600	87126	87821	90905	95718
Denominator	96520	97667	97798	100806	105384
Is the Data Provisional or Final?				Final	Final

Notes - 2005
Prior to FY99, calendar year data are reported, but beginning with FY00, state fiscal year data (July-June) are reported. These data are taken from the HMLR5501 SFY report.

Notes - 2004
Prior to FY99, calendar year data are reported, but beginning with FY00, state fiscal year data (July-June) are reported.

Notes - 2003
In May 2003, data for FY99-01 were revised to state fiscal year data (July 1 - June 30) and these data were provided for FY02 & FY03. Prior to FY99, calendar year data is reported.

Narrative:
/2007/Participation rates increased to 90% for FY04, surpassing the highest rate (89% in FY02 and FY03) since data was first reported for FY94 (69%). In addition to the total percentage increase, the denominator of Medicaid enrollees has also shown a steady increase since FY94, going from 84,093 in FY94 to 100,806 in FY04. With the initiation of the SCHIP program in 1998, there were increased outreach efforts to enroll children in the state Medicaid Program (Health Check) as well as the SCHIP (Health Choice) program. It appears that an additional benefit to this outreach is an increase in the percentage of children enrolling in Medicaid and obtaining services.//2007//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	71.7	37.2	75.5	79.0	74.3
Numerator	43	16	77	83	104
Denominator	60	43	102	105	140
Is the Data Provisional or Final?				Final	Final

Notes - 2005
Data are for prior Calendar Year, e.g., FY02 is really CY01 data. Data prior to CY00 are not available. There was a freeze on Health Choice (name of NC's SCHIP) enrollment January 2001 through October 2001, thus the total number of enrollees dropped from previous years. Also, the total number of enrollees is small to begin with because Health Choice only covers the infants between 185% of poverty up to 200% of poverty. Below 185%, infants are eligible for Medicaid.

Notes - 2004
Data are for prior Calendar Year, e.g., FY02 is really CY01 data. Data prior to CY00 are not available. There was a freeze on Health Choice (name of NC's SCHIP) enrollment January 2001 through October 2001, thus the total number of enrollees dropped from previous years. Also, the total number of enrollees is small to begin with because Health Choice only covers the infants between 185% of poverty up to 200% of poverty. Below 185%, infants are eligible for Medicaid.

Narrative:
/2007/There was an anticipated enrollment freeze for the Health Choice program in FY03 that was called off 48 hours prior to its implementation. In FY04, for the first year since the program was implemented, there was no threat of a freeze. This added stability probably contributes to the rise in the percentage of enrolled infants receiving services. However, the numbers for this indicator are still very small and fluctuations in rates should be interpreted with caution.

The NC General Assembly in Senate Bill 622 under Section 10.22(a) changed the NC Health Choice for Children program to cover only children between the ages of 6 through 18 effective January 1, 2006. Children from birth through age 5 on NC Health Choice with income equal to or less than 200% Federal Poverty level are no longer eligible for NC Health Choice after January 1, 2006. These children have been moved to Expanded Medicaid with a new Classification Code of MIC-1.//2007//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	88.5	88.3	87.8	87.5	87.8
Numerator	106019	103969	102683	103236	104833
Denominator	119826	117727	116907	117935	119378
Is the Data Provisional or Final?				Final	Final

Notes - 2005
Data are for previous CY (i.e., FY05 is really CY04).

Notes - 2004
Data are for previous CY (i.e., FY04 is really CY03).

Notes - 2003
Data for this indicator differ from HSCI#5d because this indicator includes women ages 15 through 44 only and HSCI#5d includes women ages 18 through 50.

Narrative:
/2007/The percent of women in NC receiving adequate prenatal care according to the Kotelchuck Index remained high in CY04 as the percentage was 87.8. Over the past ten years, this percentage has steadily remained in the 87% to 88% range.

The WCHS continues to focus on enhancing the service provision of the state's Baby Love Program, specifically the Maternal Outreach Worker (MOW) and Maternity Care Coordinator (MCC) components. During FY04 and FY05, the Baby Love Best Practice Pilot explored and evaluated a standardized service provision process for Maternity Care

Coordination and Maternal Outreach Worker services in eleven local provider agencies. The pilot implemented a new triaging system (risk factor screening process) and a new assessment and care planning process based on best-practice case management methods ("Pathways of Care for Maternity Care Coordination"). The intent of this new process was to focus resources and efforts on those individuals with the greatest need, and subsequently to accurately identify and effectively address those needs to improve the quality of MCC and MOW services. Making sure women are able to access prenatal care early and continually during their pregnancy remains a priority in the Baby Love program. The process implemented in the pilot is now being integrated into the statewide model for MCCP services. Both the Healthy Start Baby Love Plus and the Healthy Beginnings programs continue to provide support services to pregnant women and encourage them to seek early and continuous prenatal care services. In addition, the First Step Campaign continues to promote the NC Family Health Resource Line (the MCH Hotline) and to increase public awareness about the importance of preconceptional health and prenatal care.//2007//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	96.1	86.1	86.8	87.4	87.8
Numerator	726979	688080	727653	766054	796361
Denominator	756858	799360	837949	876866	906853
Is the Data Provisional or Final?				Final	Final

Notes - 2005
The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

Notes - 2004
The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

Notes - 2003
The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

Narrative:
/2007/The methodology for determining data for this measure changed beginning with FY02 data. In years past, any claim was counted, but now claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years. Detailed explanation of new methodology follows:

For Federal Fiscal 2005 (10/1/2004-09/30/2005) the number of under 21 XIX enrolled at some point with the year was 906,853.

Under 21 receiving an XIX service, excluding those for which the ONLY claims were the system generated claims to pay the Carolina Access Fees or the Health Check Coordinator Prorated Salaries was 796,361. Under 21 HMO fees were INCLUDED.

Under 21s for whom a claim was paid whether an actual service or a system generated premium or fee was 888,524.//2007//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	24.4	32.2	34.6	35.7	37.9
Numerator	36763	55972	60682	64550	71513
Denominator	150420	173895	175393	180858	188464
Is the Data Provisional or Final?				Final	Final

Notes - 2005
Data from CY00 on have been revised to include just those children receiving Medicaid and not those under the state SCHIP (Health Choice) plan. Thus, the data for FY99 and FY00 should not be compared to the rest of the data. The FY data are actually for the prior CY.

Notes - 2004
Data from CY00 on have been revised to include just those children receiving Medicaid and not those under the state SCHIP (Health Choice) plan. Thus, the data for FY99 and FY00 should not be compared to the rest of the data. The FY data are actually for the prior CY.

Notes - 2003
Data from CY00 on have been revised to include just those children receiving Medicaid and not those under the state SCHIP (Health Choice) plan. Thus, the data for FY99 and FY00 should not be compared to the rest of the data. The FY data are actually for the prior CY.

Narrative:
/2007/The Division of Medical Assistance provides these data. In FY04, data from CY00 to CY02 were revised to include just those children receiving Medicaid and not those under the state SCHIP (Health Choice) plan. Thus, the data for FY99 and FY00 should not be compared to the rest of the data. The FY data are actually for the prior CY. There has been an increase from 24.4% in FY01 to 37.9% in FY05, with a jump between FY01 to FY02 of 8 percentage points, and then a steady but slow increase of 6 percentage points in the following four years.

In 1999, the NC Institute of Medicine was asked by DHHS to convene a task force to evaluate and recommend strategies to increase dentist participation in the Medicaid program and improve the preventive services provided by Medicaid. The NC IOM convened a one-day meeting in 2003 to review progress on these recommendations. At that time, twelve of the 23 original recommendations (52%) had been fully implemented and some action had been taken on 69% (116) of the recommendations. In April 2005, the Oral Health Section of DPH, conducted the North Carolina Oral Health Summit: Building a Collaborative for Action. Participants at this one-day summit reviewed the findings and recommendations from the 1999 Task Force report to determine if the issues it addressed were still relevant, what actions had occurred to implement the Task Force's recommendations, and the barriers to implementation. The goal of the Summit was to identify potential strategies to improve dental care access - whether by further implementation of the original 1999 NC IOM Task Force recommendations - or through new strategies.//2007//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	100	100	100	100	100
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final

Notes - 2005
New methodology initiated in FY02 application and all indicators have been revised. Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina.

Notes - 2004
New methodology initiated in FY02 application and all indicators have been revised. Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina.

Notes - 2003
New methodology initiated in FY02 application and all indicators have been revised. Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina.

Narrative:
/2007/Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina. In fact, North Carolina provides Medicaid coverage to all elderly, blind and disabled individuals receiving assistance under SSI. The NC child health insurance program (Health Choice) serves as an additional payment source for these children. The Title V program continues to assure that all SSI beneficiaries receive appropriate services. Each month, WCHS receives approximately 300 referrals of newly eligible SSI children. These children are referred to Child Service Coordinators who provide the family with information about available resources, including early intervention and Title V services, and offer additional assistance as needed.//2007//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2004	matching data files	10.7	7.5	9.1

Narrative:
/2007/Since 1985, North Carolina has linked Medicaid newborn hospitalization records to live birth certificates to identify which births were to families enrolled in Medicaid. After

1985, various other linkages have been added to promote data analyses related to maternal and child health. This birth file with added health services data is referred to as the North Carolina Composite Linked Birth File. It is also sometimes referred to as the "Baby Love" file, since much of it was developed initially for evaluations of the Medicaid expansions after 1987, collectively referred to as the Baby Love Program in North Carolina. Data that are now linked annually to the live birth file include: Medicaid newborn hospitalization records, Medicaid maternal delivery records, Medicaid maternity case management records, child service coordination records, prenatal WIC records, records of prenatal visits at public health clinics, infant death records, a summary of Medicaid newborn costs in the first 60 days of life, and a summary of Medicaid infant costs in the first year of life.

Data from calendar year 2004 are the most recent data for this indicator. Since 2001, data for this indicator have remained constant, with almost 11% of births to women receiving Medicaid being low birth weight, but only about 8% of births to women not receiving Medicaid.//2007//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2003	matching data files	10	6.4	8.2

Narrative:
/2007/Since 1985, North Carolina has linked Medicaid newborn hospitalization records to live birth certificates to identify which births were to families enrolled in Medicaid. After 1985, various other linkages have been added to promote data analyses related to maternal and child health. This birth file with added health services data is referred to as the North Carolina Composite Linked Birth File. It is also sometimes referred to as the "Baby Love" file, since much of it was developed initially for evaluations of the Medicaid expansions after 1987, collectively referred to as the Baby Love Program in North Carolina. Data that are now linked annually to the live birth file include: Medicaid newborn hospitalization records, Medicaid maternal delivery records, Medicaid maternity case management records, child service coordination records, prenatal WIC records, records of prenatal visits at public health clinics, infant death records, a summary of Medicaid newborn costs in the first 60 days of life, and a summary of Medicaid infant costs in the first year of life.

Data from calendar year 2003 are the most recent data for this indicator. Since 2000, data for this indicator have remained constant, with a rate of about 10 infant deaths per 1000 occurring in the Medicaid population and about 6 per 1000 in the non-Medicaid population.//2007//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2004	matching data files	75.4	93.4	84.7

Notes - 2007
Data for this indicator differ from NPM#18 because this indicator is based on CY2004 data and NPM#18 2003 is really CY2003 data. This indicator matches the data listed under FY2005 in NPM#18.

Narrative:
/2007/Since 1985, North Carolina has linked Medicaid newborn hospitalization records to live birth certificates to identify which births were to families enrolled in Medicaid. After 1985, various other linkages have been added to promote data analyses related to maternal and child health. This birth file with added health services data is referred to as the North Carolina Composite Linked Birth File. It is also sometimes referred to as the "Baby Love" file, since much of it was developed initially for evaluations of the Medicaid expansions after 1987, collectively referred to as the Baby Love Program in North Carolina. Data that are now linked annually to the live birth file include: Medicaid newborn hospitalization records, Medicaid maternal delivery records, Medicaid maternity case management records, child service coordination records, prenatal WIC records, records of prenatal visits at public health clinics, infant death records, a summary of Medicaid newborn costs in the first 60 days of life, and a summary of Medicaid infant costs in the first year of life.

Data from calendar year 2004 are the most recent data for this indicator. Since 2001, data for this indicator have remained constant, with almost 75% of infants born to women receiving early prenatal care in the Medicaid population and about 93% in the non-Medicaid population.//2007//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is	2004	matching data files	84.9	90.6	87.8

greater than or equal to 80% [Kotelchuck Index])					

Notes - 2007
The data reported in HSCI#4 for a fiscal year is really the data for the prior calendar year. Thus, the data reported in Form 18 for CY04 matches FY05 data, not FY04 data

Narrative:
/2007/Since 1985, North Carolina has linked Medicaid newborn hospitalization records to live birth certificates to identify which births were to families enrolled in Medicaid. After 1985, various other linkages have been added to promote data analyses related to maternal and child health. This birth file with added health services data is referred to as the North Carolina Composite Linked Birth File. It is also sometimes referred to as the "Baby Love" file, since much of it was developed initially for evaluations of the Medicaid expansions after 1987, collectively referred to as the Baby Love Program in North Carolina. Data that are now linked annually to the live birth file include: Medicaid newborn hospitalization records, Medicaid maternal delivery records, Medicaid maternity case management records, child service coordination records, prenatal WIC records, records of prenatal visits at public health clinics, infant death records, a summary of Medicaid newborn costs in the first 60 days of life, and a summary of Medicaid infant costs in the first year of life.

Data from calendar year 2004 are the most recent data for this indicator. Since 2001, data for this indicator have remained constant, with almost 84% of pregnant women with adequate prenatal care in the Medicaid population and about 90% in the non-Medicaid population.//2007//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2005	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2005	200

Narrative:
/2007/These levels had stayed consistent since the state SCHIP program, Health Choice, began in 1998 and continued through 2005. However, the NC General Assembly in Senate Bill 622 under Section 10.22(a) changed the NC Health Choice for Children program to cover only children between the ages of 6 through 18 effective January 1, 2006. Children from birth through age 5 on NC Health Choice with income equal to or less than 200% Federal Poverty level are no longer eligible for NC Health Choice after January 1, 2006. These children have been moved to Expanded Medicaid with a new Classification Code of MIC-1. This change will be reflected in Form 18 in the grant application for FY08.//2007//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2005	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2005	 200

Narrative:

/2007/These levels had stayed consistent since the state SCHIP program, Health Choice, began in 1998 and continued through 2005. However, the NC General Assembly in Senate Bill 622 under Section 10.22(a) changed the NC Health Choice for Children program to cover only children between the ages of 6 through 18 effective January 1, 2006. Children from birth through age 5 on NC Health Choice with income equal to or less than 200% Federal Poverty level are no longer eligible for NC Health Choice after January 1, 2006. These children have been moved to Expanded Medicaid with a new Classification Code of MIC-1. This change will be reflected in Form 18 in the grant application for FY08.//2007//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2005	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2007

The state SCHIP program, Health Choice, does not cover maternity care.

Narrative:

/2007/In cooperation with staff from the NC DMA, the FPRHU is currently in the first year of the implementation of the recently approved 1115(a) Medicaid Demonstration Waiver. The Medicaid waiver, which officially began in October, 2005, will extend eligibility for family planning services to all women and men over age 19 with incomes at or below 185% of the federal poverty level regardless of receipt of previous Medicaid reimbursed service (pregnancy-related or otherwise). The major goal of the waiver is to reduce unintended pregnancies and improve the well being of children and families in NC. Among several

objectives, two specifically target reductions in the number of inadequately spaced pregnancies and in the number of unintended and unwanted pregnancies among women eligible for Medicaid. As of March 2006, there are 1,121 clients enrolled in the Family Planning Medicaid Waiver.//2007//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2007

Narrative:

/2007/It is fortunate for the WCHS that the SCHS has a long history of linking data with infant birth certificates. Since 1985, NC has linked Medicaid newborn hospitalization records to live birth certificates to identify which births were to families enrolled in Medicaid. Since then, other linkages have been added to promote data analyses related to maternal and child health. This birth file with added health services data is referred to as the NC Composite Linked Birth File or the "Baby Love" file, since much of it was developed initially for evaluations of the Medicaid expansions after 1987, collectively referred to as the Baby Love Program in NC. Data that are now linked annually to the live birth file include: Medicaid newborn hospitalization records, Medicaid maternal delivery records, Medicaid maternity case management records, child service coordination

records, prenatal WIC records, records of prenatal visits at public health clinics, infant death records, a summary of Medicaid newborn costs in the first 60 days of life, and a summary of Medicaid infant costs in the first year of life.

Therefore, for the first three data linkages found in HSCI #09(A), the scored response for the first question is three, the state has the ability to obtain data for program planning or policy purposes in a timely manner. However, the WCHS has answered the question for the fourth linkage with one, meaning that the state does not have the ability to link birth certificates and newborn screening files. The Vital Records System Automation Project (VRSAP) was started in 2000 but had its share of setbacks. In 2005, however, the state entered into a contract to purchase an upgrade to the existing Electronic Birth Certificate (EBC) system that moves the system to a web based application and implements the 2003 National Center for Health Statistics revised birth certificate. Roll out of this new system will begin in 2007. Plans are to pilot the new system in three counties in early 2007 and then slowly change all 100 counties to the new system by July 2007. The State Laboratory of Public Health houses the newborn screening data in their Laboratory Information Management System (LIMS), and this system is being replaced by a commercial off-the-shelf product, estimated to be completed by late 2007. There are no current plans to link the EBC system and LIMS or for one database to populate the other database. However, after both systems have been in place for a year or two, the SCHS has agreed to work with the SSDI Project Coordinator to attempt to match data files from each system. If successful, and given that it would not place an undue burden on vital records or public health laboratory staff, this match would then become an annual activity.

The second part of HSCI #09(A) asks whether the state's MCH program has direct access to the electronic database for analysis. Again, thanks to a long history of working with the staff of the SCHS, the answer to this question for the first three data linkages is yes. For the most part, requests for data are made by WCHS staff to statisticians at the SCHS who work with the databases, but should the need arise for a WCHS staff member to have direct access to the database, that could be arranged. Of course, since there is yet to be a data linkage between birth records and newborn screening files, the response to this question for the last data linkage is no.

As for the questions regarding registries and surveys included in HSCI #09(A), again the WCHS is fortunate to collaborate closely with the SCHS on registries and surveys, therefore the score attributed to these questions is also three. Hospital discharge data are available as needed. The Birth Defects Monitoring Program (BDMP), which is located in the SCHS, provides annual birth defects surveillance data. The SCHS first began collecting data through PRAMS on July 1997 births. In 2006 a proposal for continuation of funding was submitted to the CDC, and while no word has been received as of yet, continued funding of the NC PRAMS survey is extremely likely. Findings from the BDMP and PRAMS survey are distributed to LHDs, state agencies, state legislators, professional societies, and others, primarily via the SCHS website. Again, while staff members in the WCHS generally make requests for data directly to the SCHS staff who work with these surveys, should staff need direct access to these data, they could gain access.//2007//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	3	Yes

Youth Tobacco Survey - every other year	3	Yes

Notes - 2007

Narrative:
/2007/North Carolina participates in the Youth Risk Behavior Survey (YRBS) which provides information about tobacco use in teens every two years. 2005 survey results show that 24.9% of high school students smoked cigarettes on one or more of the past 30 days.

The Tobacco Prevention and Control Branch (TPCB) of DPH conducted the first NC Youth Tobacco Survey in the fall of 1999. Since then TPCB has conducted four NC Youth Tobacco Surveys--every fall in odd numbered years (1999, 2001, 2003 and 2005). Nationally more than 45 states and DC have conducted at least one YTS or the equivalent for their state using CDC standard protocols and procedures. Since 1999, NC has seen positive changes in the expected direction related to prevalence. From 2003-2005 significant changes in current cigarette use by both middle and high students were observed. The statistically significant decreases mean that there was less than a 5% probability that these observed changes were the result of random chance.

The final data from the 2005 survey show the lowest cigarette use rates for middle and high school students ever recorded in NC. Not only are they the lowest since the NC Youth Tobacco Survey (NC YTS) was first conducted in 1999, they are also lower than findings of YRBS that has been collecting high school data since 1991. The all-time recorded high for current high school cigarette use was 35.8% in 1997 (YRBS). Rates of reported current cigarette smoking (past 30 days) among both middle and high school students dropped significantly from 2003 to 2005. High school dropped from 27.3% in 2003 to 20.3% in 2005 and middle school from 9.3% in 2003 to 5.8 in 2005. Smoking rates for middle school students in NC are lower than the national average of 8.4%, measured in 2004, and the state's high school rates are on par with the national average of 21.7%.

Eighty school districts were selected as part of the sampling frame by the CDC working with TPCB and DPI. Seventy-nine school districts agreed to participate (98.8%). One hundred seventy-seven schools participated and completed surveys from more than 300 classrooms. This represents more than 6,000 middle and high school students who completed surveys. The overall response rate was 80% for both middle and high school, most of the students not participating were absent during the survey. NC was among the top five in the nation in terms of participation and response rate.//2007//

IV. Priorities, Performance and Program Activities

A. Background and Overview

Data collection and analysis for the majority of the National and State Performance measures are done collaboratively by staff within the WCHS and the State Center for Health Statistics. Specific information regarding most of these measures, including data sources and trends, can be found in the narrative portions for each measure and the detail sheet. The CSHCN Survey data, used in Performance Measures #2-#6, are made available through MCHB. As there is only one year of data for these measures, no statements regarding trends can be made. For the majority of the CSHCN measures, state rates were better than the national result. Due to a small sample size, a state rate is not available for Performance Measure #6 regarding youth with special health care needs and their transition to adulthood. Only for Performance Measure #4 regarding CSHCN whose families had adequate private/public insurance does NC fall just a bit below the national rate.

B. State Priorities

Based on further review of the NC Comprehensive Child Health Plan (our five-year needs assessment), the list of priority needs was slightly modified during FY2001. The following list is the revised list of priority needs which was used from FY01 to FY05.

1. Strengthening public health infrastructure at state and local level
2. Reducing disparities in health outcomes (racial/ethnic, geographical, socioeconomic, and for persons with disabilities)
3. Assuring access to high quality care for all segments of the MCH population
4. Increasing access to high quality health and related services in school settings by increasing the nurse-to-student ratio in NC public schools to an average of 1:750 or less
5. Assuring that the school health curriculum used in NC public schools comprehensively addresses a range of health and related issues relevant to school age children
6. Improving nutrition and fitness among children and adolescents
7. Improving pregnancy outcomes for all women
8. Reducing unintended pregnancies
9. Improving childhood immunization coverage through full implementation of a statewide computerized tracking system
10. Effective organization and delivery of family support (psycho-social, care coordination, home visiting) services for children and families

The changes to the list include dropping two previous priority needs -- 1)reducing occurrence and severity of injuries (particularly unintentional injuries) among children and adolescents and 2)enhancing monitoring, consultation and technical assistance to regulated child care centers to assure conditions that protect and promote health status of children -- and adding two new priority needs -- 1)Reducing disparities in health outcomes (racial/ethnic, geographical, socioeconomic, and for persons with disabilities) and 2)assuring that the school health curriculum used in NC public schools comprehensively addresses a range of health and related issues relevant to school age children. In addition, wording of some of the other priority needs has been amended to make them clearer.

During FY03, the SMT defined a consensus set of core WCH Indicators to be used to communicate the value of the work done by the WCHS with policymakers, stakeholders, and the general public. The purpose of defining the set of indicators was to be able to help the WCHS better define its mission and promote a common vision among staff. In addition, as these indicators are shared with stakeholders and policymakers, they provide information about how the work of the WCHS contributes to the welfare of the state. The process of defining the indicators also helped the SMT gain clarity about where evidence-based interventions exist and identify

areas offering opportunities for improvement. Also, the choice of indicators helps Section staff understand core job responsibilities and evaluate performance as the indicators can be used in individual work plans. Another important outcome of the selection of indicators is that they allow for a more data-driven environment throughout the WCHS.

The first step at establishing core WCH indicators occurred during a SMT retreat of just branch heads and section level managers. After further refinement by SMT as successive meetings, these initial measures were then shared with the expanded SMT, which includes unit supervisors and other staff, for further feedback. The final set of WCHS Core Indicators are as follows:
1. Reduction of Infant Mortality
2. Improved Health of Women of Childbearing Age
3. Prevention of Child Deaths
4. Elimination of Vaccine-Preventable Diseases
5. Increased Access to Care for Women, Children, and Families
6. Prevention of Birth Defects
7. Improved Health of Children with Special Needs
8. Improved Healthy Behaviors in Women and Children and Among Families
9. Healthy Schools and Students who are Ready to Learn
10. All Newborns Screened for Genetic and Hearing Disorders
11. Provision of timely and comprehensive early intervention services for children with special developmental needs and their families.

At the same time that the Section was developing these indicators, the NC DHHS decided to implement performance based contracting using logic models as a component of performance based management. Thus, during FY04, the SMT members were responsible for leading work groups to create logic models for each of the eleven core indicators. Both regional and central office staff contributed to the models which are almost in the final draft stage. Logic models are by design a work in progress that can be revised as necessary to more clearly and correctly depict causal relationships and integrate program activities.

Thus, when it came time to determine the state MCH priority needs as part of the needs assessment process, the SMT quickly realized that while the results of the needs assessment information could help fine-tune the logic models, particularly the intermediate and end outcomes, these results only strengthened the argument that the WCHS Core Indicators reflected the priority needs of the Section. As each state is permitted to report only 7 to 10 priority needs, the NAT was tasked with consolidating the original 11 indicators into 10 priority needs. The NAT brought back several suggestions to the SMT who decided upon the following 10 priority needs to be used in the MCH Block Grant for the next five years:

1. Reduce infant mortality.
2. Improve the health of women of childbearing age.
3. Prevent child deaths.
4. Eliminate vaccine-preventable diseases.
5. Increase access to care for women, children, and families.
6. Increase the number of newborns screened for genetic and hearing disorders and prevent birth defects.
7. Improve the health of children with special needs.
8. Improve healthy behaviors in women and children and among families.
9. Promote healthy schools and students who are ready to learn.
10. Provide timely and comprehensive early intervention services for children with special developmental needs and their families.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			100	100	100
Annual Indicator	100	100	100	100.0	100.0
Numerator				234	228
Denominator				234	228
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

Notes - 2005
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY04 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, MMA, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, VLCAD, and other tests which account for 2 cases.

Notes - 2004
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY03 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, MMA, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, LCHADD, and other tests which accout for 6 cases.

Notes - 2003
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program.

a. Last Year's Accomplishments
Information about newborn screening is available on the State Laboratory for Public Health website (http://slph.state.nc.us/)

A new congenital hypothyroidism (CH) cut-off level was established in November 2004 and the effect of the new cut-off was evaluated during 2005. In 2004 there were 903 abnormal screens and 79 confirmed cases of hypothyroidism. In 2005 the number of abnormal screens decreased to 242, but the detection rate was maintained with 70 confirmed cases, thus dramatically decreasing the CH false-positive rate in NC. Also, in December 2005, the newborn metabolic screening follow-up coordinator contacted pediatric endocrinology practices across the state in order to confirm that no cases of CH were undetected due to the change in cut-off. There were no reports of new cases of CH that were not first identified by an abnormal or borderline newborn screen.

In August 2005, the antibody in the Perkin-Elmer kit used for congenital adrenal hyperplasia (CAH) screening was changed which resulted in an increase in false positive CAH screens. This led to a significant increase in confirmatory testing expense incurred by the intensive care nurseries as well as a heightened emotional burden to the parents. Pediatric endocrinologists and neonatologists voiced concern. In response, the follow-up coordinator and two pediatric endocrinologists evaluated data and then amended follow-up recommendations for confirmational testing. The amended follow-up procedure was approved by a sub-committee of newborn screening advisory board and implemented by the follow-up coordinator in December 2005.

The North Carolina Sickle Cell Syndrome Program (NCSCSP) hosted its Patient and Provider Conference in September 2005. This two day conference marked 32 years of education, support and improved services for persons with sickle cell disease in the state. The conference renewed the NCSCSP's vision to provide better services to sickle cell clients, network with local and state healthcare providers, and promote personal and professional development. The next conference is scheduled for 2007.

The NCSCSP also developed and completed a program video in 2005. The video, "Hope for a Brighter Future," educates viewers about sickle cell disease and sickle cell trait as well as the different services provided by the NCSCSP. Most importantly, the video provides hope for people who are directly affected by sickle cell disease.

In 2005, the NCSCSP continued work on its SCELL database, a system used to track both the number and types of services provided to sickle cell clients across the state of North Carolina. By the end of the year, system development, training and testing had been completed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Initial newborn screening test performed on all blood spot samples received.			X	
2. Follow-up of borderline results with a letter to physician.			X	
3. Follow-up of abnormal results with a phone call to physician.			X	
4. Testing of repeat blood spots received following a borderline or abnormal screen.			X	
5. Continued interaction of state lab and medical center staff as relates to questionable results.				X
6. Contracts providing statewide coverage for consultation related to metabolic conditions.				X
7. Work towards development of data linkage of birth certificates and newborn screening records.				X
8. Purchase of special formula for individuals with certain metabolic disorders through Nutrition Services.		X		
9. Monitoring of phenylalanine, tyrosine, and phe/tyr ratios in blood spots received from individuals with PKU in routine medical management.			X	
10. Newborn screening advisory committee quarterly meetings.				X

b. Current Activities

The change in CAH follow-up recommendation is being monitored through the current year to confirm that there is no adverse effect. The laboratory has changed testing methodology in order to stabilize the CAH screen and is evaluating the data from the new methodology in order to determine a new 17-hydroxyprogesterone cut-off value. In 2004 there were 40 abnormal CAH screens that yielded 8 confirmed cases, while in 2005 these numbers jumped to 6 cases from 128 screens, with 115 occurring after the antibody change.

The follow-up coordinator completed a PowerPoint presentation about Newborn Metabolic Screening which was recently awarded NC Infant-Toddler and Public Health Nursing and Professional Development credits and has been delivered to a variety of health care professionals representing four different regions of NC. A presentation about Biotinidase Deficiency was also completed and will be considered for continuing education credits.

Updates to the newborn screening parent brochure "A Test to Save Your Baby's Life" were

completed. The coordinator also completed the protocol manual for follow-up coordination for abnormal CAH, CH, Galactosemia, and Biotinidase Deficiency screens. A third regional genetic counselor has been trained to provide coverage for the activities of the follow-up coordinator in her absence. A manual dedicated to the issues related to temporary coverage has been created and distributed and the genetic counselors attended a one-day training session.

The lab has completed a newborn screening form on-line training module, "Newborn Screening - Instructions for Completing form #3105." The newborn screening fee has increased from $10 to $14, effective August 15, 2005. Lab staff and the follow-up coordinator participated in the SouthEastern Regional Genetics Group Lab Work Group Meeting to discuss the newborn screening laboratory issues. The lab director is planning a meeting to discuss anticipated follow-up issues related to screening for cystic fibrosis.

Following the completion of the SCELL database, work has been initiatied to transfer its old data into the new web based application. A full-time data entry person was hired in March to lead this effort.

This year, the NCSCSP has placed an increased emphasis on community awareness of sickle cell disease and sickle cell trait. Program staff members have appeared on local television stations to discuss the work that they do and to offer insight into the importance of sickle cell screening for everyone, regardless of background. The program is also working with the NC Healthy Start Foundation to develop public service announcements in English and Spanish. These PSAs are will be released to the public by the end of 2006. Copies of the latest sickle cell poster have also been printed and are being distributed throughout the state. In addition, the NCSCSP will host an annual luncheon and/or banquet to commemorate sickle cell awareness month.

c. Plan for the Coming Year

The follow-up coordinator is in the early stages of conducting a study to better determine and characterize the incidence of congenital hypothryoidism in NC because the reported incidence is much higher than the national average. This study will be completed in phases over the next few years. The study is being conducted in collaboration with pediatric endocrinologists at two major medical centers.

The newborn screening laboratory will finalize plans and move toward the addition of cystic fibrosis to the newborn screen. In addition, discussion of possible follow-up procedures for CF screening will continue. Also, design of a new laboratory information management system (LIMS) for newborn screening is under development and its implementation is anticipated to occur.

As the laboratory determines a new cut-off value for CAH screening, its effect will be monitored though the upcoming year. At that time a determination will be made to continue use of the modified recommendations or return to the previous, more stringent follow-up protocol.

Collaboration between the follow-up coordinator and the regional genetic counselors will continue to be emphasized as educational presentations are provided in all regions of the state. Coverage for follow-up coordination activities when the coordinator is away will also continue through periodic re-training of regional genetic counselors. The Unit Manager will continue to help focus efforts on outcomes for the program, including evaluation of data, protocol, and coverage implementation.

The recently completed newborn screening parent brochure will be translated into Spanish and possibly Hmong. A similar brochure for physicians and other professionals may be written during the upcoming year.

In the coming year, the NCSCSP plans to hire a new Health Education Consultant to lead its

community awareness campaign. Also, it will continue to work with the North Carolina Healthy Start Foundation to fine tune the public service announcements and translate the "Hope for a Brighter Future" video into Spanish.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			75	75	75
Annual Indicator		65.3	65.3	65.3	65.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	75	75	75	75	75

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
During FY05, Family Advisory Council (FAC) members participated in C&Y Branch, EI Branch, and interagency committees. They reviewed EI and WCHS policies, contributed to the redesign plan for EI, and were representatives on local and state councils. They served on the Governor's Commission for CSHCN, the Medicaid Review Board, and as members of oral health and behavioral health work groups. They were members of community advisory councils for the tertiary medical centers, served as support parents for families in NICUs, worked with local and regional training initiatives, and advocated for pertinent legislative issues. Members participated in the AMCHP conference. One member was involved in the implementation of a medical childcare demonstration project. Members received stipends for FAC activities. FAC diversity continued; different races, cultures, geographic areas and child health needs were represented.

FAC members worked with the Exceptional Children's Assistance Center (ECAC) and WCHS staff to strengthen Family Voices NC and the Centers for Medicare and Medicaid Services (CMS) Family to Family Health Information Center Grant (F2F HIC). Family Voices was co-administered by a staff member of ECAC and a FAC leader. There was strong collaboration among the state Title V program, the FAC, and ECAC with FAC members and the Family Liaison Specialist (FLS) involved in the first year's implementation of the F2F HIC Grant.

The FAC members organized 6 of the 7 focus groups that were instrumental in collecting data on National Performance Measures #2, #4, and #5 for the MCHBG Needs Assessment.

The FLS staffed the activities of the FAC and worked with members to become more informed

and committed by increasing understanding of their role in improving system outcomes. She assisted families on individual issues and advised staff on the development and promotion of family perspectives, family centered care, care coordination, transition planning, medical home and community resources.

Other mechanisms within WCHS provided opportunities for family involvement. Parents of CYSHCN represented the family perspective on the NC Commission on CSHCN and on the Early Detection and Hearing Screening Advisory Board. Fathers of CYSHCN were involved with the statewide Fatherhood Initiatives.

The toll-free Help Line for CYSHCN continued receiving input from family members and was a source of information on an array of topics. Data summarizing calls was compiled and presented regularly to the Commission on CSHCN. Persons with disabilities and family members continued to be an integral part of the ongoing work of the NC Office of Disability and Health (NCODH), housed within the C&Y Branch. Adults with disabilities were in key NCODH staff positions and engaged as consultants, trainers and advisors. The Office's initiatives to improve access to health promotion and disease prevention services positively influenced systems of care for CYSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Involvement of families of CSHCN in WCHS through FAC, the Family Liaison Specialist, and planning committees.				X
2. Toll-free Help Line will continue to provide information and support for families of CSHCN.		X		
3. Parent members will continue to work with the NC Commission on Children with Special Needs, the newborn hearing and metabolic programs, and receive standing invitations to Branch meetings.				X
4. At least two representatives from the Family Advisory Council will attend AMCHP conferences.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY06, family involvement across programs and initiatives in the C&Y Branch increased. One focus of the FLS is staffing the FAC. Another is collaborating with key C&Y Branch, DHHS, and community provider staff on topics as diverse as adolescent immunization, Medical Home outreach, website redesign, and transition to adulthood issues. The FLS is engaged in efforts to eliminate racial, disability, and ethnic disparities, including the development of a collaborative plan for infusing cultural competence across branch activities. Also, there are ongoing efforts to address the elimination of health disparities throughout WCHS. The FLS continues with community outreach site visits statewide. She works nationally with the Healthy and Ready to Work project, the National Center for Cultural Diversity, Family Voices, and the Champions for Progress project.

The FAC continues to develop its roles of advising, planning, and advocacy. One activity was the initiation of the Two-Year Leadership, Education, Action Strategic Plan to guide the FAC's work. They also work with stakeholders to support the refined EI eligibility definitions, assist the C&Y Branch staff with disseminating the MCHB Needs Assessment findings, and offer insights into the

development of the F2F HIC. An objective is the development of strategies for expanding family participation at the local and regional levels. FAC members are developing a brochure and helped design a community education curriculum for Title V. They developed governance structures for the operations of the FAC, including term limits. Increasing diversity of the members remains a strong focus. New members represent fathers, Spanish speaking families, and young adults with disabilities.

The NCODH provides technical assistance toward ensuring a life span oriented approach to both WCHS and DPH initiatives. Adults with disabilities provide guidance as to how services can be improved for CYSHCN. The NCODH launched several community-based demonstration efforts, implemented by teams of individuals with disabilities, to improve access to fitness environments, medical care clinics, cancer screening, and worksite health promotion. NCODH also reactivated its advisory council, which is comprised of adults and youth with disabilities, family members, service providers, advocates, Leadership Education in Neurodevelopmental Disabilities (LEND) personnel, and state level policy professionals. The NCODH was awarded a grant from HRSA to address the needs of the state's youth with significant health care needs to receive coordinated, comprehensive care within a medical home and ensure successful transition from pediatric to adult systems of health care. The Carolina Health and Transition (CHAT) project will target barriers in the availability of quality health care services by broadening awareness, teaching specific skills, and changing systems of practice for CYSHCN, their families, and medical providers.

c. Plan for the Coming Year

During FY07, leadership for proceeding with NPM#2 and components of Outcome Measure #1 in the Specialized Services Unit (SSU) logic model regarding family involvement will be provided by the FLS. In addition to the FAC, she will assemble teams of internal and external advisors to assess what has been accomplished to date in NC and the extent to which additional assessments should be undertaken. Specific outputs for the coming year include:
-Utilize input from the FAC on an ongoing basis in developing policy within the C&Y Branch;
-FAC members and other family members of CYSHCN routinely participate in planning, implementation and evaluation of Branch and WCHS programs;
-Evaluate the MCHB Needs Assessment as it relates to CYSHCN programs engaging parents as partners and report findings to the FAC by the end of FY07. Develop linkages to the EI Branch efforts on family involvement data as part of this assessment;
-Develop, expand, and review strategies and mechanisms that assure that FAC members function as liaisons between parents in local communities and the C&Y Branch;
-Develop and distribute a newsletter for families of CYSHCN twice a year;
-Ensure attendance of parent representatives at the AMCHP Annual Meeting;
-Strengthen linkages to the Family Support Network, Family Voices, and ECAC as well as other family support and advocacy groups on an ongoing basis;
-Identify the information given and strategies used in each of the MCH sponsored Information and Referral lines to provide support to families of CYSHCN in order to strengthen linkages and to promote consistently available information across the Birth-21 age range; and
-Convene a C&Y Branch cultural competence work group

Finally, the SSU will develop an integrated work plan for family involvement with other key SSU initiatives including, but not limited to, Medical Home and Transition by the end of FY07. A primary effort for FY07 will focus on the implementation of the CHAT project. The FLS will serve as a member of the CHAT management team and the Transition Work Group which will provide guidance to the project. Members of the FAC will also be represented on this work group. Four contracts will be awarded to implement the youth, family, medical provider and evaluation initiatives of the project. FAC members will be represented on the review committees for these awards. A contract for the medical provider initiative will be executed with Mountain Area Health Education Center to add a transition component to its mini-fellowship and family practice residency focus on individuals with developmental disabilities. All contracts will be required to

represent the state's ethnic diversity and involve individuals with disabilities and their families. First year implementation will include: project planning; recruiting and establishing work teams; developing, piloting and evaluating educational materials.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			75	75	75
Annual Indicator		55.6	55.6	55.6	55.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	75	75	75	75	75

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
The NC Medical Home Initiative (MHI) for CYSHCN was a priority area of focus during FY05. The initiative was designed to integrate with the existing Title V and primary care infrastructure and use processes and approaches with demonstrated efficacy in building systems of care for children and their families in this state. Major accomplishments included:
- Continued support for integrating medical home concepts at Chapel Hill Pediatrics (CHP). The practice team established a registry of over 600 CSHCN. CHP hired two care coordinators to update the registry, make pre-visit contacts with patients with special health care needs, and link the children to appropriate community-based services. A satisfaction survey on pre-visit contacts was conducted and showed that parents do value them. CHP held a family forum entitled, 'Developing a Strong Partnership among Family, School, and Pediatricians for Educational Support of CSHCN" in response to parents' questions about developing partnerships and a Parent Listening Session was held for families who use CHP. This allows families to share their opinions about what makes a successful medical home. ED and after hours usage data were provided by NC Blue Cross Blue Shield and showed significant reductions in CHP compared to other practices.
- Continued collaboration with the Office of Research, Demonstrations, and Rural Health Development (ORDRHD) to increase capacity of Community Care of North Carolina (CCNC) networks to serve as Medical Homes for C/YSHCN. Guilford Child Health agreed to be the first CCNC network to accept this challenge. Engaging one network as an initial partner with future expansion to other sites is the process historically used by the ORDRHD to introduce innovation in the CCNC networks.
- The MHI work group met during the year and includes physicians from CHP, Guilford Child Health, and East Carolina University, Smart Start Partnership in Region A and members of the Children and Youth Branch, Community Care of NC, University of NC, Center for Child Health Improvement, and the Healthy Start Foundation (HSF).

- FSN provided education and outreach to families across the state through eight community-level workshops and one train the trainer session.
- A public education campaign as part of a contract with HSF, "The Right Call Every Time," focused on the importance of a medical home for all children. Five bookmarks were developed in English and Spanish to target specific issues including medical home versus emergency room; fever; colds, the flu and other infections; ear infections; and making each doctor's visit work for you. The contract was expanded to include an initiative to integrate CYSCHN into the existing campaign. Other educational resources for parents were planned that would focus on choosing a quality medical home for all children, especially CYSHCN.
- A part-time position to coordinate the MHI was filled in May 2005.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Educate the families of children enrolled in HCheck and NCHC on the importance of the medical home.				X
2. Support systems of care that assure children are screened early and often for special health care needs.				X
3. Maintain toll free Help Line for referral of CSHNC to appropriate programs, services and providers.		X		
4. Conduct presentations on the Medical Home Initiative at statewide professional meetings.				X
5. Widely disseminate educational information and materials developed specifically for increasing medical home awareness with parents of CSHCN.			X	
6. Support systems of care that assure CSHCN are linked with a medical home for follow-up.				X
7.				
8.				
9.				
10.				

b. Current Activities

Planning for implementation of an 18-month NC Center for Children's Health Care Improvement Learning Collaborative on Medical Home to start in November 2005 was unsuccessful due to funding reductions. Meanwhile, a project through AccessCare, a CCNC network, received federal funding to support medical homes within tertiary care centers. Title V staff and the NC MHI group participated in a roundtable discussion hosted by AccessCare to discuss possible future collaborations with the project. The project director for the medical home/tertiary care project serves on the NC MHI group.

As a result of these changes and a need for internal reassessment, the C&Y Branch formed an internal medical home strategic planning group to review and analyze accomplishments and determine future direction of Title V involvement with medical home efforts and activities in NC. The group has researched mentoring medical home states, developed a logic model to guide future work, and is currently recruiting key partners to implement identified activities. A segment of this work focuses on ongoing development and integration of services for children with hearing disorders.

The State recently received a $900,000 Integrated Community Systems grant to address delivery of coordinated, comprehensive care within a medical home and support successful transition from pediatric to adult systems of health care for CYSHCN.

Other activities include:

- Dr. Jennifer Lail, CHP, has presented the results of the successful integration of medical home concepts within her practice to the AAP.
- The development and dissemination of a medical home bookmark, "Choosing a Quality Medical Home," that includes a focus on CSHCN.
- A new RFA was developed and disseminated to train parents on the different aspects of promoting the concept of a medical home for CYSHCN.
- Access for families to a toll-free help line when needing assistance in choosing a primary care provider with expertise in working with CSHCN.
- Work continues on Medical Home improvement and integration as part of the Early Childhood Comprehensive Systems (ECCS) implementation grant. There are thoughts of using a facilitated discussion among external partners to develop further strategies this year. The shared indicators developed by the ECCS grant program include one that addresses the percent of children ages 0 to 5 years who have access to a medical home according to the AAP definition.
- In addition, through the ECCS grant, a multi-agency group revised the Kindergarten Health Assessment form which is being piloted in two counties to determine if the data can be collected and analyzed electronically, and if a mechanism can successfully be introduced to encourage sharing of information between a child's medical home and school personnel providing follow-up and medications. The information collected will be used as a baseline for indicators of child well-being and to target resources and interventions.

c. Plan for the Coming Year

During FY07, the medical home strategic planning group will implement the logic model and recruit external partners to work collaboratively on activities. The MHI work group will be expanded to include new key partners and a coalition will be formed at the state level to address medical home. The strategic planning group will develop strategies to increase awareness of and provide support for the concept of a quality medical home. Providers and families will be actively involved in planning strategies and implementing activities

A cost analysis will be done of the CHP and efforts will be made to collect additional data from Guilford Child Health (GCH). CHP and GCH will help share best practices for implementing the medical home concept with other practices and providers. Medical home information will be available on the C&Y Branch web site.

The Medical Home Initiative work group will continue to discuss the use of a care organizer and how this would relate to a medical care plan for C/YSHCN.

A marketing campaign will be used to improve the current use of the KHA by families, providers, and schools and a revised KHA will be used in the fall of 2006 statewide, with the format determined by the results of the current pilots located in two counties.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			80	80	80
Annual Indicator		57.3	57.3	57.3	57.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	80	80	80	80	80

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
During FY05, the WCHS continued to lead an effort to improve the quality of mental health benefits within NC Health Choice for CSHCN. The goal was to redefine the standards for Level III Group Home care because concerns had been raised about the high cost of this care and about the quality of services these homes delivered. The Behavioral Health Workgroup submitted recommendations to the Secretary of DHHS and the NC Division of Mental Health/Substance Abuse/Developmental Disabilities (DMH). As a result, DMH undertook further evaluation to develop rules for Level III group homes that would raise the standards of training and credentials for staff, as well as improve the staff-patient ratios to reflect the original intent and rate finding. DMH submitted a request for changes in the rules, which was supported by the Rules Commission.

The name of the "Special Needs Helpline" was changed to the "Children with Special Health Care Needs Helpline (CSHCN Helpline)." This toll-free helpline continued to be the focal point for information on state and local programs and resources for CSHCN. Approximately 3,000 callers/year access the help line, which serves as the division's primary resource for families of CSHCN wanting information on multiple public programs with one call. For the majority of callers, health insurance issues were central to the conversation. Information shared by callers is compiled and reported to the Commission on CSHCN six times per year. The data are useful for program development purposes in terms of capturing trends of unmet needs reported by parents and providers of CSHCN.

Other activities included:
- A new edition of the "Information for Children with Special Health Care Needs and their Families" booklet was published and distributed to families of Health Choice enrollees to help them better understand and fully access the wrap-around services available to their children.
- A public awareness campaign was developed to enable families to obtain information on accessing health care coverage as well as guidance on fully accessing the services already available to children enrolled in Medicaid, Health Choice and private insurance plans.
- A new business card for the CSHCN Helpline was developed and was distributed widely.
- The Health Choice Special Needs position was filled in May 2005.
- The C&Y Branch Head, the HC/NCHC Outreach Coordinator, and the SSU Manager collaborated with internal and external partners, including the Commission for CSHCN, to continue to assess what has been accomplished to date in NC and the extent to which additional needs assessments of CYSHCN should be undertaken.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain HC/NCHC Outreach Campaign in coordination with the NC Healthy Start Foundation, DMA, State Employees Health Plan and DMH//DD/SAS.			X	
2. Maintain NC Family Health Resource Line as a bilingual				

informational telephone hotline.				
3. Continue to expand HC/NCHC Outreach web site.			X	
4. Continue to expand HC/NCHC educational campaign regarding medical home/ER use/preventive care.			X	
5. Support grant-funded initiatives: NC Covering Kids and Families and Wake Rex Foundation Project.				X
6. Simplify enrollment/re-enrollment forms and develop/disseminate family-friendly notices.		X		
7. Develop comparable data sets for HC and NCHC.				X
8. Target outreach to special populations (including minority and CSHCN).			X	
9.				
10.				

b. Current Activities

NC continues to make attempts to identify CYSHCN in the Medicaid program. The Living with Illness screening questions continue to be included on the Health Check/NC Health Choice application. A re-enrollment form for both programs is being developed that will also ask these questions.

FY06 has been a year of transition for the NC Health Choice Program. Effective January 1, 2006, children ages five and under below 200% of the Federal Poverty Level were required by law to move from NC Health Choice to Health Check (Medicaid). The WCHS collaborated with the NC Division of Medical Assistance (DMA) to establish a policy that enabled Medicaid providers to submit prior approval requests in early December to ensure that critical services would not be interrupted as a result of the transition.

In addition, DHHS will move all NC Health Choice children ages 6 to 18 into the Community Care of NC networks for case management services. The Commission on CSHCN established a workgroup to provide recommendations on the development of guidelines for case management services and the development and coordination of an outreach program of case managers to assist CSHCN and their families in accessing available state and federal resources for all health care services.

Other activities include:

- The adoption of the behavioral health special needs package for NC Health Choice, effective March 2006. This package includes enhanced services that have been approved by CMS and DMA such as community support, day treatment, intensive in-home services, multisystemic therapy, mobile crisis, diagnostic assessment, and Level II -- IV residential group homes.
- Continued clinical and programmatic review of requests for CSHS/Purchase of Medical Care (POMC) Program, metabolic requests, the Health Choice Special Needs Program, and the Assistive Technology funds.
- The proposed rules for the Level III residential group homes went into effect by Executive Order in April 2006.
- Improving capacity for CSHCN Help Line to adequately assist callers who speak Spanish only by initiating a relationship with our Title V Help Line (NC Family Resource Line) for translation services.
- Programming changes made to the CSHCN Help Line database allowing for more information shared by callers to be included in statistical reports.
- The Medical Home Campaign has been enhanced by a new print material for families entitled "Choosing a Quality Medical Home." It describes what a medical home is, its importance, and suggests questions families may want to ask, based on the AAP characteristics of a quality medical home.
- The C&Y Branch continues to work with Health Check Coordinators and partnering organizations on Health Check/Health Choice outreach, enrollment and re-enrollment, targeting

families of CSHCN. Brochures (in English, Spanish and Hmong), envelope stuffers, and posters have been developed and are updated annually to support this effort. (See NPM#13.)

c. Plan for the Coming Year
Activities planned for FY07 include:
- The C&Y Branch will continue to strengthen capacity of the NC Family Health Resource Line (Title V Hotline) to help families understand the importance of maintaining health care coverage and their rights when transitioning C/YSHCN from one insurance plan to another. Insurance fact sheets and other information from the NC Department of Insurance will be incorporated into the resource database which is used by resource line staff.
- The Medical Home Initiative will continue to be promoted among Health Choice enrollees to foster an early and ongoing link to a primary care provider that will encourage families to maintain continuous coverage. (See NPM#13 for further information).
- Through the Healthy Transitions to Adulthood Initiative, continue to work on improved communication between and within key agencies that serve C/YSHCN (ages 13-21). (See NPM#6 for further information.)
- The first NC CYSHCN newsletter will be developed. (See NPM 2 for further information.)
- A re-enrollment form for Health Check/Health Choice will be implemented that will also ask screening questions to help to identify CYSHCN.
- The CSHCN Behavioral Health work group will continue to meet and be involved in the improvement of group home services.
- The FAC will continue to develop ways to promote the importance of obtaining and maintaining health insurance and the use of a medical home.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			90	90	90
Annual Indicator		80.6	80.6	80.6	80.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	90	90	90	90	90

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
In FY04, Early Intervention (EI) implemented system changes impacting the Child Service Coordination (CSC) Program. In FY05, training and technical assistance were provided to CSCs to address ongoing needs and system changes. A standardized orientation was offered quarterly

in 4 regions of the state to new and experienced staff. Regional meetings were provided twice a year and information was distributed to LHD staff via the CSC Program Update, a bi-monthly newsletter.

The CSC technical assistance database was fully implemented to promote consistent and accurate responses to technical assistance questions.

CSC program policies and documents were reviewed with DMA. The Program continued to negotiate for revisions to Risk Indicators and Diagnosed Conditions definitions and to the Identification and Referral Form.

Community Transition Coordinators screened over 58,000 records of hospitalized children statewide and referred over 14,000 children for services - 7,000 to the CSC Program, over 3,200 to the Infant Toddler Program, and the remaining children to other community resources.

The CSC Program Coordinator served as a member of the Hospital Early Intervention Advisory Board to offer guidance to pilot programs providing EI services in hospitals.

The Branch contracted for the operation of a medical childcare center for CSHCN to provide childcare services for 9 children who would otherwise not have the opportunity to participate due to the complex nature of their medical needs. The medical childcare center applied for a Medicaid waiver to expand the number of participants, but DMA does not anticipate a timely review of this request.

Several Branch staff participate in mental health's State Collaborative for Children/Families meetings and subcommittees and have assisted in the development of the state strategic plan for school based mental health services.

Evaluation of Children's Special Health Service (CSHS) Clinics, the Assistive Technology Resource Centers (ATRC), and the CSHCN Helpline continued in the context of C&Y Branch re-organization and Logic Model development.

CSHS Specialty Clinics have decreased in number to 10, as access to private clinics with either Medicaid or Health Choice insurance increased. A high percentage of the Orthopedic Clinics in the LHDs continued to serve those without means of payment.

The 7 ATRCs loaned more than 8,000 Assistive Technology (AT) devices to CYSHCN and one time funds were provided to update equipment inventory at the centers. The CSHS Program fund provided assistive technology and durable medical equipment through 80% of its budget. CSHS provided medications, oral formulas, oral nutritional supplements, and home health equipment to CYSHCN that were not covered by Medicaid. The AT Fund provided devices to over 300 CSHCN ages 0 to 3 years. The Branch also addressed again the issue of recycling AT equipment with the FAC, who recommended marketing the idea for children ages 0 to 3 years.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue Community Transition Program.			X	
2. Continue Child Service Coordination Program.		X		
3. Continue provision of Early Intervention services and implementation of system design changes.	X			
4. Continue CSHS Clinics.	X			
5. Continue Special Needs Helpline.		X		
6. Continue Child Care for children who are medically fragile.	X			

7. Continue to advocate for additional school nurses and provide education and training to enhance their intervention skills in work with CSHCN.				X
8. Develop infrastructure to support transition services.				X
9.				
10.				

b. Current Activities

CSC services are available in each county through LHDs or other providers to offer case management/care coordination for families of children at risk for or diagnosed with developmental delays, chronic illness, or social/emotional disorders. The CSC Program works with DMA to develop new policy, revise risk indicators, and address other programmatic components based on CMS restrictions on targeted case management.

The C&Y Branch provides clinics and services for CYSHCN through local and non-local contracts. The Community Transition Coordinator Program provides screening of records at major birthing hospital and links families to services within the community. The CSHS and AT funds provide services that are not covered by Medicaid or private insurance.

Branch staff provide technical assistance and training through regional physical therapy, speech and language, audiology, genetic, child health nurse, child care health, and school health nurse consultants to increase awareness among families, private therapists, and provider agencies about access to resources at state and community levels. Staff participate in activities of the Commission on CSHCN, NC Pediatric Society, NC Partnership for Children, Family Resource Health Line, Family Support Network, ECAC, NC DD Council, MH State Collaborative for Children/Families, Early Childhood Comprehensive Systems (ECCS) Grant, Behavioral Health Committee, and the NC Interagency Coordinating Council (NC-ICC). Work with NC-ICC focuses on serving young children transitioning between CSC, EI and the public school system. Staff also participate on work groups for CYSHCN in the areas of oral health/access to dental care, physical activity/nutrition, foster care, and special needs car seat loan availability.

An implementation grant was obtained to continue the ECCS program. The group of investors and strategists who worked on the Shared Indicators for School Readiness was broadened. The indicators were finalized and the group was asked to endorse and take an active role in applying the indicators in agency planning, service delivery, and accountability systems to affect child well-being and school readiness.

The Branch partners with private and public agencies to support cultural diversity training and other means of assuring that families receive family centered, accessible, inclusive, and culturally and linguistically competent services. A group of students from the UNC School of Public Health reviewed and analyzed a survey of limited English proficiency needs for the Branch to establish a basis for future activities.

The pediatric medical consultant initiated contact with CSHS Program rostered physicians to update the information database. These contacts have offered an opportunity to provide updated outreach materials for a variety of state and private resources. An email distribution list was created to ensure ongoing communication with these physicians.

c. Plan for the Coming Year

The CSC Program plans to develop an outreach campaign to link more families with CSC services, improve data reporting accuracy, and enhance program evaluation. Negotiations with DMA on redefinitions of program policy are ongoing, and there is a collaborative effort to develop a web-based orientation training for new CSC employees. Training is provided through newsletters, regional meetings and quarterly updates.

Contracts for community transition services will target only hospitals with Level IV neonatal intensive care units and hospitals with the highest numbers of births in the regions.

DPH will work with hospitals around the state to support the development of a state-level perinatal collaborative. The collaborative will examine infant mortality data, assess medical systems of care, and develop recommendations to reduce infant mortality and morbidity.

The Branch will continue its contract for the medically fragile childcare center, but due to funding constraints and political changes ongoing fiscal support is threatened.

The Office of Disability and Health and the Carolina Health and Transition (CHAT) Program will work to assure that CSHCN receive services and supports necessary to make a successful transition to adult life. This builds upon and enhances the need for all children and youth with special health care needs to receive coordinated, comprehensive, family-centered care within a quality medical home. (See NPM #6)

The Branch is developing comprehensive materials to illustrate the broad range of existing children's services, although program specific brochures will continue to be available.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					5.8
Annual Indicator		5.8	5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	5.8	5.8	5.8	5.8	5.8

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
During FY05, there was a strong, sustained commitment within the CYSHCN Program and the C&Y Branch to provide a greater focal point for transition services and diffuse transition responsibilities.

Participating in the Champions for Progress multi-state meeting presented an opportunity for skill building. Information gained at the meeting on the use of national data sources was a basis for state presentations to agencies on the status of CYSHCN. The Transition Program Consultant presented national data to the NC Commission on CSHCN and to the School Health Matrix Team (SHMT) and promoted inclusion of YSHCN needs in relevant school health programs. The

School Health Unit also requested that information and materials be developed for a planned school health conference. As a result of these activities, the Transition Program Consultant was incorporated into the SHMT.

A major accomplishment of the Transition Program Consultant was the development of the Interagency Collaborative on Youth in Transition which addresses the needs of youth ages 13-21 who face chronic challenges in achieving self-sufficiency. The Collaborative's action plan identified the following goals: to share information throughout the system from state, local, and individual levels; to conduct a needs assessment to identify duplication and gaps in services; to assess agencies' capacity to address identified gaps; to obtain commitment from agencies to fill gaps in services; and to promote inter- and intra-agency collaboration to improve transition related service provision. Key partners include: NC Links Program (youth leadership for foster youth), Department of Juvenile Justice and Delinquency Prevention, a local homeless shelter, Division of Vocational Rehabilitation Services, Communities in Schools (non-profit), a youth leader from Strong Stable Youth Speaking Out (SAYSO), DMH/DD/SAS, an Independent Living Program, and the Teen Pregnancy Prevention Initiative.

Another focus of the Transition Program Consultant was to assist the contractor staff at UNC Center for Development and Learning LEND Program to obtain data for the MCHB Needs Assessment. The Transition Program Consultant co-facilitated the focus groups and worked with the contractors to identify available data sources. Feedback from the focus groups and the needs assessment revealed a strong need to focus on services available to youth transitioning to adulthood.

The Transition Program Consultant resigned her position in June 2005. However, the positions of NCODH Program Director and Program Manager were filled in April 2005 and leadership of the SSU's transition activities was incorporated into the responsibilities of these positions. Other positions in the C&Y Branch, such as the Family Liaison Specialist and the Health Choice Program Manager for CYSHCN continue to have transition as a component of their job responsibilities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide a greater focal point for transition, by diffusing transition responsibilities across the C&Y Branch and by inserting transition linkage responsibilities into job descriptions for new staff.				X
2. Continue to provide leadership to the NC Collaborative on Youth in Transition.				X
3. Continue NCODH training and TA to WCHS re: ADA, universal design, fitness, health promotion, and emergency preparedness.				X
4. Provide TA on youth leadership development and access to health care to the NC Developmental Disabilities Council.				X
5. Collaborate with the School Health Program and other WCHS planning bodies, to include youth with disabilities in an advisory capacity for Title V programs.				X
6. Promote transition as a focus in planning for medical homes for CSHCN.				X
7. Continue to use the National Survey of Children with Special Health Care Needs data in planning transition efforts and galvanizing support.				X
8. Continue participation in the DHHS Eliminating Health				X

Disparities Initiative.				
9. Through the HRSA grant, provide training, identify needed policy changes, identify and develop community resources, and provide information.				X
10.				

b. Current Activities

Activities in FY06 have focused on information gained from the MCHB Block Grant Needs Assessment. One priority is to continue to provide leadership for the NC Collaborative on Youth in Transition (NCCYT), which has conducted and published findings of a survey of services available for youth across NC. The NCCYT has also continued to support the development of youth leadership opportunities through the Alliance of Disability Advocates, Easter Seals-UCP, the NC Council on Developmental Disabilities (NCCDD), and the Division of Vocational Rehabilitation Services. The Collaborative's goal has been to not recreate another council, but for these youth to act in an advisory capacity for Title V. The NCODH Program Manager has co-chaired NCCYT.

The vacant Transition Program Consultant position was reclassified to provide data support for the C&Y Branch. The lead responsibility for the transition program was permanently transferred to the NCODH Program. In response to the need to improve transition from pediatric to adult health care identified in the MCHB Needs Assessment and a statewide inventory of transition activities, the NCODH Program submitted a proposal for the Carolina Health and Transition (CHAT) project to MCHB in October 2005 and funding was awarded in April 2006. The project aims to improve health care availability and access by broadening awareness, teaching specific skills, and changing systems of practice for YSHCN, their families, and medical providers. A Transition Work Group serves as a steering committee for the project. The Work Group is under the umbrella of the NCODH Advisory Council and includes youth with disabilities, parents, medical providers, service providers, advocates, educators, and individuals with medical home expertise.

The NCODH continues to provide technical assistance to the NCCDD as it further develops demonstration efforts in youth leadership development and access to health care and has added an emphasis on transition in working with the regional physical therapy staff on initiatives of physical activity and nutrition, oral health, improving the health of children/youth in the foster care system, and NC's new Healthy Active Children policy.
They have also partnered with the School Health Unit in their focus on obesity prevention and also recommended the inclusion of a disability section in the School Health Advisory Council manual.

The WCHS, in conjunction with students in the MCH Masters Program at UNC-Chapel Hill School of Public Health, recently completed AMCHP's Adolescent Health Capacity Assessment Tool. Discussions were inclusive of YSHCN. Key recommendations included forming a section-level adolescent health working group, creating a full-time Adolescent Coordinator position, developing an annual Adolescent Health Report Card, conducting an adolescent health needs assessment, and creating an adolescent-specific strategic plan and over-arching evaluation strategy for the Section.

c. Plan for the Coming Year

During FY07 there will continue to be a strong, sustained commitment within the CYSHCN Program and the C&Y Branch to provide a greater focal point for transition services and diffuse transition responsibilities.

A primary effort will focus on the implementation of the CHAT project. A Transition Project Coordinator will be hired to oversee the project. Also, four contracts will be executed to implement the youth, family, medical provider, and evaluation initiatives of the project. A contract

for the medical provider initiative will be executed with Mountain Area Health Education Center (MAHEC) to add a transition component to its mini-fellowship and family practice residency for developmental medicine for individuals with developmental disabilities. Contracts for the youth, family and project evaluation initiatives will be awarded through requests for applications under the NC DHHS Performance Based Contract System. All contracts will be required to represent the state's ethnic diversity and include individuals with disabilities. First year implementation will include project planning, recruiting and establishing work teams, and the development and evaluation of educational materials.

Additionally, the NCODH Program Manager will continue to co-chair the NCCYT and its plans to support the development of an interagency youth leadership forum that can serve as an advisory group for C&Y Title V efforts. This group will also continue to infuse a health care transition focus to efforts of other agencies and organizations that serve YSHCN.

NCODH also plans to work with the State Center for Health Statistics to update its report on the health of North Carolinians with disabilities. This update will include a stronger emphasis on youth health risks using improved longitudinal data from the YRBS.

The recent hiring of a State School Nurse Consultant and Senior School Health Advisor will increase partnership opportunities for both the SSU and NCODH to address the needs of YSHCN within the School Health Team. Continued participation on the School Health Matrix team will help to develop disability and transition awareness across agencies.

SSU and other staff of the C&Y will continue giving presentations to stakeholders on national and state data, and gaining information on the health of youth in transition.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	90	90	90	90	90
Annual Indicator	80.6	80.7	85.6	86.2	81.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	90	90	90	90	90

Notes - 2005
CY2004 data are from the National Immunization Survey. As this is a weighted estimate, data for the numerator and denominator are omitted. FY05 data are not available at this time, so this is a provisional estimate for this indicator.

Notes - 2004
FY2004 (July 1, 2003 to June 30, 2004) data are from the National Immunization Survey. As this is a weighted estimate, data for the numerator and denominator are omitted.

Notes - 2003
FY2003 data are from the National Immunization Survey. As this is a weighted estimate, data for the numerator and denominator are omitted.

a. Last Year's Accomplishments

The latest published National Immunization Survey results showed that in calendar year 2004, NC coverage remained high as 82% of children in the target age group were fully immunized (4:3:1:3:3). The staff of the Immunization Branch (IB) continues to work to raise this rate. Activities undertaken in FY05 included work with local health departments to raise rates by using the Clinical Assessment Software Application files that are sent bi-monthly. Also, local health departments were encouraged to use Baby-Track files, provided by the state office, to start tracking children who are 12-18 months old during the upcoming year. In addition, Assessment, Feedback, Incentives and eXchange (AFIX) visits were done in private provider offices to help increase rates in the private sector, which would translate to higher rates overall in the public sector. Practices with lower rates were given suggestions for achieving higher rates based on best practices from offices that had rates of >=90%. By the end of FY05, AFIX visits had been made in all 100 counties. In addition, full system development of the North Carolina Immunization Registry (NCIR) began and Milestones 1, 2, 3, 4 were completed by the end of FY05. The pilot phase for the NCIR began in February 2005 and was completed in three months. Pilot participants included a total of 38 public and private providers in four counties: Chatham, Pitt, Henderson, and Cabarrus. Following the successful completion of the pilot, statewide deployment to the remaining 96 local health departments began in June 2005.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintenance of the Universal Childhood Vaccine Distribution Program.			X	
2. LHD assessment and tracking activities.				X
3. Complete at least 287 AFIX visits in calendar year 2006.		X		
4. Update the Immunization Branch web site as necessary.			X	
5. Continue deployment of the statewide registry to the remaining private providers.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In October 2005, statewide deployment of the NCIR to all 100 local health departments was completed. Full system development was also completed. Deployment efforts then began to switch to private provider offices. The goal was for the NCIR to be fully deployed to10% of the providers in North Carolina's Universal Childhood Vaccine Distribution Program (UCVDP) by the end of FY06. Currently the system has been fully deployed to over 20% of UCVDP providers. Immunization Branch staff members continue recruitment and registry readiness efforts with private providers throughout the state. In addition, to raise immunization rates among 19-35 month year olds, the Branch is developing a DTaP 4 initiative. Statistical analysis of North Carolina immunization data suggests that the up-to-date rate for DTaP is significantly lower than for other vaccines in the 4:3:1:3:3 series. The drop-off occurs with the fourth dose of DTaP. In collaboration with the Nutrition Services Branch, the Immunization Branch will kick-off its DTaP 4 awareness campaign in August 2006.

c. Plan for the Coming Year

During FY07 the Immunization Branch will continue statewide deployment efforts for the NCIR. The statewide deployment goal is to have 60% of providers on the NCIR by the end of FY07. The DTaP 4 awareness campaign will begin in August 2006. The goal of this campaign is to heighten awareness of the fourth dose of DTaP among both providers and parents. This

heightened awareness should help to decrease the drop-off rate for DTaP and, consequently, increase the overall completion rate of the 4:3:1:3:3 series in North Carolina. Additional ongoing activities meant to help increase immunization awareness and coverage rates will also continue.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	38.5	32	32	30	26.5
Annual Indicator	32.7	30.4	28.6	26.9	26.8
Numerator	5080	4726	4589	4377	4425
Denominator	155309	155551	160414	163003	165361
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	26	26	25.5	25	25

Notes - 2005
FY year data are actually the prior calendar year, e.g. FY05 is really CY04.

Notes - 2004
FY year data are actually the prior calendar year, e.g. FY04 is really CY03.

a. Last Year's Accomplishments
In North Carolina, the pregnancy rate for all girls ages 15 through 17 decreased 0.1 percentage point from 2003 to 2004. The 2004 overall pregnancy rate for teens ages 15 through 17 was 26.8 pregnancies per 1,000 girls, compared to 26.9 per 1,000 in 2003. This slight decrease corresponds with a 13-year decline that resulted in the state's lowest-ever rates in 2003. Since 1990, the state's overall adolescent pregnancy rate (for 10-19 year olds) has declined by nearly 41%.

In FY05, the Teen Pregnancy Prevention Initiatives (TPPI) funded a total of 65 projects through a combination of state appropriations, TANF, and Medicaid funds. These projects included 32 secondary pregnancy prevention programs and 33 primary prevention programs. The secondary prevention model, or Adolescent Parenting Program (APP), targets first-time pregnant and parenting teens using a single model intervention best described as a youth development/mentoring model. While the primary focus of the APP is in reducing unintended pregnancies among pregnant teens, it is also focused on promoting parenting skills, preventing child abuse and neglect, and ensuring high school graduation among its participants. During FY05, there were 165 custodial teen moms and dads to graduate from NC local APPs.

The Adolescent Pregnancy Prevention Program (APPP) continued to emphasize the use of best practice models in primary pregnancy prevention. In this year's application process, TPPI prescribed 17 best practice models. Applicants are strongly encouraged, though not required, to use the prescribed models. Because most programs serve both males and females, identified best practices are mostly those which are effective for either population. North Carolina has three APPP projects specifically established to reach males. There is increased attention to male involvement in both primary and secondary prevention efforts across the state.

Program evaluation activities, a requirement for all TPPI projects, continued throughout FY05 and included process and outcome evaluation. Process evaluation uses a web-based data collection modality for both primary and secondary prevention programs. Outcome evaluation, specific to the primary prevention programs, included the administration of a survey instrument to program participants and comparison group members in an effort to assess the efficacy of local

programming efforts in effecting change in knowledge and behaviors.

Finally, the Family Planning and Reproductive Health Unit (FPRHU) continues to collaborate with the state Department of Public Instruction (DPI) in the implementation of the statewide abstinence education program funded with Section 510 MCHB Abstinence Education Funds. The FPRHU is the official grantee agency for the Section 510 MCHB grant. However, state legislation mandates the transfer of Section 510 funds to DPI to supplement the implementation of an existing statewide abstinence education program in local schools.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ongoing support provided for Teen Pregnancy Prevention Initiative projects.		X		
2. Primary prevention projects participate in annual evaluation process.				X
3. All TPPI projects participate in a web-based process evaluation program.				X
4. Annual Teen Pregnancy Prevention Symposium (with the Adolescent Pregnancy Prevention Coalition of NC).				X
5. Annual Adolescent Parenting Graduation Conference.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Data from the 2005 NC Youth Risk Behavior Survey suggest that high school youth in North Carolina continue to engage in behaviors that put them at risk for unintended pregnancies and sexually transmitted diseases. Survey results show that 51% have ever had sexual intercourse. Seventeen percent (17.2%) of adolescents surveyed have ever had four or more sex partners. Thirty-seven percent (37.1%) of adolescents surveyed have had sexual intercourse during the past three months, and the same number did not use a condom during last sexual intercourse. Eighty-two percent (82.4%) of female adolescents surveyed did not use birth control pills during last sexual intercourse. National studies, however, have suggested that the continuing decline in teen pregnancies can be attributed to increasing numbers of teens delaying first intercourse and increased use of contraception among those who are sexually active.

Efforts to reduce racial disparities in health indicators, including rates of teen pregnancies and sexually transmitted diseases, are ongoing activities within TPPI. In addition to the inclusion of an objective that specifically addresses the reduction and elimination of health disparities for all FPRHU local programs, TPPI has identified and funded several programs throughout the state that target ethnic/racial minorities. Nearly 11% of all TPPI funded projects specifically address the needs of Hispanic/Latino and Hmong populations, including a special initiative in collaboration with the Annie E. Casey Foundation, by the name of "PLAINTALK." Efforts to identify best practices that address reductions in racial disparities in health indicators at the local level will continue. The FPRHU will support continued funding for agencies to provide teen pregnancy prevention programs using best practice models that demonstrate proven means of reducing unintended teen pregnancies. The statewide Family Planning program will also continue to develop its response to a new Title X mandate to incorporate the "ABC" concept in the program's HIV/AIDS education and teen pregnancy prevention initiatives.

TPPI continues to collaborate with the Adolescent Pregnancy Prevention Coalition of North

Carolina (APPCNC), a statewide coalition. APPCNC serves as a resource to funded local projects through the provision of training and its lending library of best practice model curricula. Additionally, APPCNC and TPPI co-sponsor an annual adolescent pregnancy prevention symposium for prevention advocates, allied health workers, and practitioners.

c. Plan for the Coming Year
Throughout FY07, rule changes resulting from legislative action in 2002 will continue to be implemented for the program. The RFA proposal process in the fall of 2005 resulted in 15 proposals suitable for funding in FY07, thereby increasing the number of local initiatives throughout the state. The TPPI program will continue to implement the Annie E. Casey Foundation initiative, "PLAINTALK," targeting Hispanic/Latino populations. Funding this particular project will add to the two existing projects within the state which have a specific focus on Hispanic/Latino populations. Consequently, TPPI has an opportunity to address ethnic and racial disparities among Hispanic/Latino youth by building a bridge of collaboration between state government, local government agencies, private organizations, and local Hispanic-focused efforts. Efforts to identify specific program objectives that address reductions in racial disparities in health indicators at the local level will continue.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	50	50	50	50	50
Annual Indicator	37.0	37.0	37	41.0	43.0
Numerator	30603	32668		31452	33793
Denominator	82710	88293		76711	78588
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	50	50	50	50	50

Notes - 2004
These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

Beginning in FY02, these date will only be available every other year as efforts are being redirected from annual surveillance activities to promote an increase in the number of sealants placed.

Notes - 2003
37% is just an estimate based on the data from 2002. School year data was not collected in FY03 on the proportion of children who have dental sealants because of budget restraints, but should be available for FY04. As part of state supported sealant promotion projects in cooperation with volunteer private practitioners, the Oral Health Section provided 20,272 sealants for 5,364 children

a. Last Year's Accomplishments
Last school year, data was collected on 78,588 (74 percent) of fifth grade schoolchildren. The proportion who had dental sealants was 43 percent. This is an increase from 28 percent in 1996.

As part of state supported sealant promotion projects in cooperation with volunteer private practitioners and using Preventive Health and Health Services Block Grant funding, the Oral Health Section provided 14,682 sealants for 3,910 children during 73 sealant projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide dental assessment of oral health status conducted in alternate school years (even years).				X
2. Staff driven and community-based sealant projects conducted.	X			
3. Educational services provided in various settings.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This year, the Oral Health Section will once again focus on providing dental sealants for schoolchildren at high-risk for dental decay. Staff target children in grades one through three in order to give priority to recently erupted first permanent molars, the teeth with the highest incidence of decay. With funding from the Preventive Health and Health Services Block Grant, we plan to provide approximately 20,000 sealants. The educational exhibits will continue to be used by staff to educate parents and decision-makers about dental sealants.

c. Plan for the Coming Year

Assuring that children at high risk for tooth decay get dental sealants continues to be one of the Oral Health Section's top priorities. Plans for the coming year are uncertain. Funding that allows the sealant projects and use of the educational exhibits currently comes from the Preventive Health and Health Services Block Grant, which the President has repeatedly targeted for elimination. If these funds are lost, the Section does not have replacement funds for these activities. The Section has requested state funds to replace the PHHSBG funds, but we do not know if that funding will be appropriated.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	3	5.5	5	5	4
Annual Indicator	5.9	5.6	5.3	4.5	5.5
Numerator	99	94	90	78	96
Denominator	1671411	1682289	1706584	1717971	1731988
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	4	4	4	4	4

Notes - 2005

In June 2001 all annual indicators for this measure (1991 - 2000) were revised to reflect the new age group (<14 years versus age 1 to 14) as indicated on the detail sheet with the guidance for the FY02 Block Grant. Data are for the calendar year preceding the fiscal year. In August of each year, the NC Office of State Planning releases certified population estimates for North Carolina and its counties as of July 1 of the previous year. These estimates represent annual average resident population rather than the population on that date.

a. Last Year's Accomplishments

The rate of deaths due to motor vehicle crashes for children <=14 years old increased from 4.5 per 100,000 in 2003 to 5.5 in 2004, which is a 22% increase. The local Child Fatality Prevention Teams (CFPT) provided full-team reviews on 96 deaths and submitted reports to the state Team Coordinator. To increase child safety efforts, the North Carolina House enacted a new "Booster Seat" law in 2004. The North Child Fatality Task Force (NCCFTF) was instrumental in conducting the research needed to assess the problem and advocate to the NC General Assembly to get this law passed. Although NC had a previous booster seat law, the task force saw the need to strengthen this law based on recommendations from national experts such as the National SAFE KIDS Campaign.

Several local CFPTs (those located in the counties of Beaufort, New Hanover, and Swain) used their child fatality prevention funds to purchase car and booster seats for distribution to low and no income families. Families also received information on child safety seat laws and proper installation of car and booster seats. The Davidson County team so-sponsored a Kmart Safety Event with the local Sheriff's Department and spent a day checking the installation of local resident's car seats. Also, the Pitt County team provided an educational program on safe driving with the local Driver's Education Program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued review of child deaths due to motor vehicle crashes on the state and local levels.				X
2. Enactment of the Graduated Drivers License Restriction law.				X
3. Community car seat distribution programs.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY06, the local CFPT reviewed deaths of children <= 14 caused by motor vehicle crashes and ATVs. As of 2005, NC has a new All Terrain Vehicle (ATV) Safety law. This law increases the safety of children by: 1) banning riding of ATVs for children under 8 years of age 2) restricting the size of machines used by young riders based on age, 3) restricting the age of children who can ride with or without supervision of an adult, 4) requiring safety training and use of protective equipment such as helmets and eye protection, 5) restricting the carrying of passengers except on vehicles designed by the manufacturer to carry passengers; and 6) providing a financial penalty for those who violate the law.

c. Plan for the Coming Year

In 2004 motor vehicle crashes were the second leading cause of death among children in NC (the first being natural deaths among infants). There were 139 child fatalities due to motor vehicle crashes in 2004. Of those deaths, the largest group (81 deaths) were teenagers aged 15-17 years, 50of these teenagers died while driving the vehicle. For those reasons, the Child Fatality Task Force (CFTF) is working to reduce the number of motor vehicle crashes by introducing bills to restrict teen driver cell phone use during the Graduated Driver's License period (ages 15-17). In addition, the CFTF is working closely with the NC Governor's Highway Safety Program to pass a bill requiring all passengers in a motor vehicle to wear a seat belt (including back seat passengers).

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					15.0
Numerator					11570
Denominator					76949
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	15.5	15.5	16	16	16.5

Notes - 2005
Data are for CY04. CY05 data will be available in March 2007. Calendar year data are delayed almost a year and a half due to waiting for the 6 month duration time and including time to verify the data. Data are on WIC participants only as population data are not available.

a. Last Year's Accomplishments
The rate of breastfeeding mothers participating in WIC and still breastfeeding their infants at 6 months of age in CY03 was 14.8% which represents a small increase from previous years. Specific activities undertaken in FY05 to increase breastfeeding duration rates included:
- co-sponsoring the NC Lactation Educator Training Program (NCLETP) which was offered twice;
- distributing additional hospital strength and manual breast pumps and pump kits based on the indicated needs of local WIC agencies;
- continuing a free-of-charge Vitamin D (Tri-Vi-Sol Vitamins A, C & D) drops distribution program for infants and children who are at least 6 weeks old, breastfeeding, and not receiving more than 12 ounces of infant formula or milk daily;
- providing professional resources and client educational materials to local WIC agencies;
- promoting World Breastfeeding Week and recognizing "Mother-Friendly" Business Leaders;
- supporting accurate breastfeeding data collection and analysis;
- promoting breastfeeding support activities in child care agencies;
- hosting a 3-day statewide WIC Breastfeeding Coordinators Meeting (May 2005);
- developing plans for implementing the USDA Loving Support Breastfeeding Peer Counselor Model in local WIC Programs;
- planning a competitive process for establishing Regional WIC Lactation Resource and Training Centers in each of the six perinatal regions; and
- hosting a public forum on breastfeeding as the first step in developing a state breastfeeding plan titled "North Carolina Blueprint for Action: Promoting and Supporting Breastfeeding through Policy and Environmental Changes". The public forum was convened in September 2004 and attended by 145 North Carolina breastfeeding stakeholders who assisted in the development of recommendations and strategies for the promotion and support of breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the efforts of Breastfeeding Peer Counselor Programs.		X		
2. Promote and recognize World Breastfeeding Week annually.			X	
3. Offer the North Carolina Lactation Educator Training Program two times a year.				X
4. Seek nominations for “Mother-Friendly Business Leaders.”				X
5. Distribute electric & manual breast pumps and accessory kits to local WIC agencies throughout the state		X		
6. Enhance and support accurate breastfeeding data collection and analysis.				X
7. Maintain a free-of-charge Vitamin D program for infants (>= 6 weeks) and mostly breastfeeding.		X		
8. Assure local agency public health staff receive training in breastfeeding support & lactation management				X
9. Offer training and consultation targeted toward childcare industry on breastfeeding and pumped breastmilk.				X
10. Distribute & promote a North Carolina plan for promoting, protecting and supporting breastfeeding.				X

b. Current Activities

The rate of breastfeeding mothers participating in WIC and still breastfeeding their infants at 6 months of age in CY04 remained steady as compared to the previous year's rate (15.04%). Activities undertaken in FY06 to further increase breastfeeding duration rates included:
- co-sponsoring the NC Lactation Educator Training Program (NCLETP) which was offered twice;
- distributing additional hospital strength and manual breast pumps and pump kits based on the indicated needs of local WIC Agencies;
- continuing a free-of-charge Vitamin D (Tri-Vi-Sol Vitamins A, C & D) drops distribution program for infants and children who are at least 6 weeks old, breastfeeding and not receiving more than 12 ounces of infant formula or milk daily;
- providing professional resources and client educational materials to local WIC agencies;
- promoting World Breastfeeding Week and recognizing "Mother-Friendly" Business Leaders;
- implementing the USDA Loving Support Breastfeeding Peer Counselor Model in 23 local WIC Programs with new funding, program policies, and training;
- drafting the breastfeeding state plan "Promoting, Protecting and Supporting Breastfeeding: A North Carolina Blueprint for Action";
- establishing three Regional WIC Lactation Resource and Training Centers;
- supporting accurate breastfeeding data collection and analysis; and
- promoting breastfeeding support activities in child care agencies.

c. Plan for the Coming Year

New activities planned for FY07 include:
- distributing and promoting the implementation of activities included in the breastfeeding state plan "Promoting, Protecting and Supporting Breastfeeding: A North Carolina Blueprint for Action";
- planning and hosting the bi-annual WIC Program Breastfeeding Coordinator's Meeting;
- expanding the number of Regional WIC Lactation Resource and Training Centers;
- establishing additional USDA Loving Support Breastfeeding Peer Counselor Model Programs in Local WIC Programs; and
- developing and distributing a self-study manual on "Breastfeeding Pumps Issuance and Loaning Guidelines" to local WIC agencies.

In FY07, we will continue supporting the ongoing activities of:

- co-sponsoring the NC Lactation Educator Training Program (NCLETP);
- distributing additional hospital strength and manual breast pumps and pump kits based on the indicated needs of local WIC Agencies;
- conducting a free-of-charge Vitamin D (Tri-Vi-Sol Vitamins A, C & D) drops distribution program for infants and children who are at least 6 weeks old, breastfeeding and not receiving more than 12 ounces of infant formula or milk daily;
- providing professional resources and client educational materials to local WIC agencies;
- promoting World Breastfeeding Week and recognizing "Mother-Friendly" Business Leaders;
- promoting and enhancing local WIC Program breastfeeding peer counseling programs;
- supporting accurate breastfeeding data collection and analysis;
- promoting breastfeeding support activities in child care agencies; and
- supporting and enhancing the existing Regional WIC Lactation Resource and Training Centers.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	85	95	95	99	90
Annual Indicator	86.5	85.6	87.6	87.8	87.4
Numerator	101937	102196	102988	103985	106880
Denominator	117885	119372	117501	118493	122274
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	90	95	95	95	95

Notes - 2005
Universal newborn hearing screening program was implemented in calendar year 2000.

FY data are actually from the previous calendar (e.g., FY03 data is really CY02). The denominator is provided by the State Laboratory and the denominator for resident live births differs somewhat from the denominator used in outcome measures and other performance measures where the data are obtained from Vital Records.

Although NC had previously reported that over 99% of infants born in the state receive newborn hearing screenings prior to discharge from the birthing facility (an over reporting), a more sophisticated statistical analysis strategy was implemented in FY05 and used on current and past data and the procedures will be applied to data analysis plans in the future. Data for 2000, 2001, and 2003 have been updated using the new methodology.

Notes - 2004
Universal newborn hearing screening program was implemented in calendar year 2000.

FY data are actually from the previous calendar (e.g., FY03 data is really CY02). The denominator is provided by the State Laboratory and the denominator for resident live births differs somewhat from the denominator used in outcome measures and other performance measures where the data are obtained from Vital Records.

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Notes - 2003
Universal newborn hearing screening program was implemented in calendar year 2000.

FY data are actually from the previous calendar (e.g., FY03 data is really CY02). The denominator is provided by the State Laboratory and the denominator for resident live births differs somewhat from the denominator used in outcome measures and other performance measures where the data are obtained from Vital Records.

Although NC had previously reported that over 99% of infants born in the state receive newborn hearing screenings prior to discharge from the birthing facility (an over reporting), a more sophisticated statistical analysis strategy was implemented in FY05 and used on current and past data and the procedures will be applied to data analysis plans in the future. Data for 2000, 2001, and 2003 have been updated using the new methodology.

a. Last Year's Accomplishments
All 93 hospitals/birthing facilities continued their newborn hearing screening programs and submitted quarterly hearing reports. Hospital self-reported data for 2005 indicated that 99% of all babies born in the hospitals received hearing screens before leaving the birthing facility. Hospital checklists were completed by the speech and hearing team during their annual monitoring visits with all birthing facilities.

The Hearing Link, North Carolina's web-based data entry system, continued to develop. Staff at the six pilot hospitals were trained to do direct data entry for demographic information and hearing screening results.

Membership of the Early Hearing Detection and Intervention (EHDI) Advisory board was reorganized. A mission statement and objectives were adopted.

Otoacoustic emission (OAE) screeners were purchased and distributed to 86 local health departments. Staff received hands on training and support from the Child Health Audiology Consultants. A PowerPoint presentation was developed and used in the training as well as hands on hearing screening training with OAE screeners.

North Carolina held its first state EHDI conference in April 2005 with 114 participants. Grant funds from the CDC were used to support this effort.

Our MCHB grant application, "Monitoring Children with Hearing Loss in a Medical Home," was approved and an interim project coordinator identified from the EHDI team.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhancements to the Newborn Hearing Screening Data Tracking and Surveillance System.			X	
2. Technical support to the local newborn hearing screening programs in birthing/neonatal facilities.				X
3. Identification of needs and training opportunities for pediatric audiologists.				X
4. Regional staff assuring that all infants have access to screen and rescreen.		X		
5. Infants tracked through the screening, evaluation, and amplification process to assure no children missed.			X	
6.				

7.				
8.				
9.				
10.				

b. Current Activities
All 89 hospitals continue to implement their newborn hearing screening program. The WCHS Child Health Consultants (6 audiology and 8 speech-language consultants) provide ongoing technical assistance, consultation, and support as needed. Monitoring of the 93 hospitals continues by the DPH Child Health Consultants. The hospital checklist used by the speech and hearing team is being revised to insure its functional use and to include pertinent Hearing Link items.

One hundred computer printers and 100 barcode scanners have been ordered through grant monies for additional hospitals planning to use the Hearing Link data entry system. Seven hospitals are routinely entering demographics and hearing screening results directly into Hearing Link. In addition, the WCHS speech-language pathology and audiology consultants are accessing Hearing Link to update hearing screening information and track those babies identified with a hearing loss in a timely manner. A system has been developed to keep track of needed enhancements with the Hearing Link database to improve its functional use and insure user friendliness. Passwords for hospital users and label printing issues have been resolved. Specific, easy to read instructions have been written and compiled into user manuals for quick reference.

The EHDI Advisory Board elected a new chairperson and a parent co-chairperson. Monetary reimbursement for parent participation has been identified and a process implemented. A core voting membership has been operationally defined and identified while a list of other interested parties will receive routine updates and information and encouraged to participate especially on subcommittees. Parents of minority and under represented groups will be encouraged to participate as members.

Staff at the local health departments who are using OAE hearing screeners are receiving annual training/updates by the WCHS Child Health Audiology Consultants. A PowerPoint training presentation to update staff who had received initial training has been developed. Nursing CEUs are now awarded to training participants.

The Child Health Audiology consultants have developed a pilot study to look at the efficacy of using OAE screeners in local health departments to identify young children with hearing impairments. Four local health departments have been identified as potential participants and letters of interest distributed. Tympanometers have been distributed to these health departments for use in the study. Protocols, data review, and follow-up procedures have been developed.

A Medical Home survey tool for help in the selection of Community Access Care networks has been developed. A project coordinator position has been approved and posted. Hearing screening equipment has been identified and a purchase order submitted with grant funds.

c. Plan for the Coming Year
In the coming year, hospitals will continue their newborn hearing screening programs and quarterly reports. Many of them will be able to generate their reports via Hearing Link, our web-based data entry system. Regional Child Health consultants will provide ongoing support to the hospitals.

Six new hospitals that have been identified as interested in using the Hearing Link database have completed statements of interests. Letters of agreement will be sent to the hospitals outlining the support and training their staff will receive by the WCHS Child Health Consultants in order to use the Hearing Link for direct data entry of hearing screening results. Each new birthing facility will

receive an instruction manual, a printer, and a barcode scanner. User IDs and passwords will be created for identified staff. Additional hospitals (a goal of at least 24 hospitals) will be systematically trained until all birthing facilities are able to use Hearing Link to report initial hearing screening results. Identified enhancements to the Hearing Link will be developed and implemented including a diagnostic page that private providers can use to enter diagnostic and amplification hearing results directly into the Hearing Link database.

The 4 local health departments participating in the pilot OAE study will begin using hearing screening protocols and equipment and recording data. The study will collect data through January 2007. A proposal has been submitted to the American Academy of Pediatrics (AAP) for participation in their national conference in 2007.

A project coordinator for the medical home grant will be hired and hearing screening equipment will be distributed to three community care networks.

Regional Child Health Audiology consultants will continue hearing screening training of staff in local health departments. Additional OAE equipment will be purchased and distributed to health departments.

The EHDI Advisory Board will continue to provide input and guidance in the implementation of the NC EHDI program.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	10	10	9	9	10
Annual Indicator	11	11.1	12.3	12.8	12.0
Numerator		242660	267020	276660	266980
Denominator		2181520	2177890	2156720	2231120
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10	10	10	9	9

Notes - 2005
FY05 Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2004 and 2005 Current Population Surveys for children <18.

Notes - 2004
FY04 Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2003 and 2004 Current Population Surveys for children <18.

Notes - 2003
FY03 Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2002 and 2003 Current Population Surveys for children <18.

a. Last Year's Accomplishments
By July 1, 2004, 115,571 children were enrolled in the NC Health Choice (NCHC) Program and an additional 181,991 had been enrolled in Health Check/Medicaid (HC) since SCHIP began in FY99. 2002-03 data from the Urban Institute and Kaiser Commission on Medicaid and the Uninsured (based on the CPS from 2003-04) indicated that 12.8% of children <=18 years old in NC remained uninsured. A freeze on new enrollment was threatened in early FY05, but the NC General Assembly (NCGA) appropriated an additional $6.6 million and NC DHHS moved additional monies into NCHC to keep the program open.

The Medical Home Campaign, launched in July 2005, was similar in scope and target audiences to the launch of the NCHC Program back in 1998, with one significant difference being the access to list serves and the ability to hyperlink to the HC/NCHC website. Nearly 1,400,000 Medical Home educational materials were distributed in FY05.

In FY05, a focal point for HC/NCHC and the Medical Home Campaigns was a renewed effort toward targeted outreach to CYSHCN. New materials under development included an NCHC Booklet "Information for CSHCN and their Families" and a business card promoting the services offered through the CSHCN Help Line. The SSU launched pilot projects to develop provider capacity to serve as medical homes for CYSHCN. WCHS, partnering with the NCHSF and the Family Support Network of NC, developed family-focused medical home materials to complement this effort, including a new piece entitled "Choosing a Quality Medical Home." The NCHC CSHCN consultant position was filled after a budgetary delay.

Targeted outreach to minority populations continued to be a major focus of the Campaigns as WCHS worked with sister agencies on Title VI compliance, efforts to eliminate health disparities, and cultural competence. WCHS and the NCHSF partnered with Univision (Latino TV Station) to develop 7 PSAs promoting medical homes and health insurance for children. A Fotonovella (picture story) was created to help Latino families understand the American health care system. This piece was slated for publication in FY06.

Both Campaigns continued to be supported through toll-free lines that serve as the "call to action" in outreach materials. The NCFHRL (NC's Title V line) is administered by UNC Department of Maternal and Child Health and responds to an average of 2500-3000 calls per month with a 95-99% Service Level. Approximately 68% of callers request information about HC/NCHC. The CSHCN Help Line serves as a link to public programs for those living with, caring for, or concerned about a child with special health care needs. Both lines are invaluable programmatically in identifying or quantifying the success or failure of outreach efforts, programmatic communication breakdowns, service gaps and barrier issues.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain HC/NCHC Outreach Campaign in partnership with the NC Healthy Start Foundation.			X	
2. Maintain a bilingual NC Family Health Resource Line that offers information, referrals and advocacy.			X	
3. Maintain HC/NCHC Outreach Web Site as a one-stop-shop for outreach workers.			X	
4. Maintain HC/NCHC education campaign “The Right Call Every Time” to promote use of a medical home for preventive & primary care and to reduce inappropriate ER use.			X	
5. Continue to develop Medical Home education campaign for children with special health care needs.			X	
6. Support grant-funded initiatives: NC Covering Kids and Families and Wake Rex Foundation Project				X
7. Simplification of enrollment/re-enrollment forms and continued development of family-friendly notices.		X		
8. Development of comparable data sets for HC and NCHC				X
9. Targeted outreach to special populations (including minority and CSHCN).			X	
10.				

b. Current Activities

By July 1, 2005, 130,694 children were enrolled in NCHC (a 13% increase from 7/1/2004), and an additional 216,747 had been enrolled in HC since SCHIP began in FY99. 2003-04 data from the Urban Institute and Kaiser Commission on Medicaid and the Uninsured indicated that 12% of children <=18 years old in NC remain uninsured (a 6% drop from last year). In FY06, the NCGA adopted the 2003 NCIOM recommendation to move NCHC children 0-5 with family incomes <=200% of FPL into HC. This assured that these children would have an assigned Primary Care Provider, a higher likelihood of continuous coverage, and preventive benefits would be realized due to the involvement of Health Check Coordinators and receipt of timely notices re: check-ups. WCHS worked closely with DMA to assure a smooth transition for NCHC children to HC. This involved drafting notices/letters to families and preparing a bulletin/list serve notices for providers to prepare for transition issues related to prior approval, hospital coverage, etc. In addition, the NCGA capped NCHC enrollment growth to 3% every 6 months and reduced NCHC reimbursement rates to 115% of the HC fee schedule on 1/1/2006 and 100% on 7/1/2006. The NCGA also directed DHHS to move NCHC children (ages 6 through 18) into the Community Care of NC networks for case management services.

WCHS continues to work toward institutionalization of outreach efforts through state and local partnerships. New statewide partners in FY06 included the Employment Security Commission (ESC) and the Department of Juvenile Justice and Delinquency Prevention (DJJDP). Announcements re: the partnerships will be disseminated, web links created, and direct outreach by ESC intake workers and DJJDP court counselors will be implemented. Anticipating the mass distribution that such an outreach effort will require, a less expensive bilingual HC/NCHC envelope stuffer was developed.

Targeted minority outreach efforts continue. Through a partnership with the United Hmong Association of NC, staff provide information about HC/NCHC to key community leaders and attendance at Hmong Festivals. The UHANC partnered with WCHS to develop a HC/NCHC Brochure (English/Hmong) and presented at state meetings to improve our cultural competence. Through the new HC/NCHC Fotonovela, new Latino immigrant families are learning about the American health care system, HC/NCHC, and the importance of medical homes for children. The NCHSF launched a Spanish language web site in February 2006 and a Spanish HC/NCHC PPT is now posted on the HC/NCHC Outreach Web Site for use by bilingual outreach workers, who are growing in number.

Efforts continue to improve access to quality medical homes in North Carolina. WCHS is working on a Medical Home Logic Model to map out our strategic plan for the next 3-5 years. For families, the Medical Home Campaign is the focal point for outreach/education efforts.

c. Plan for the Coming Year

In FY07, a continued focal point will be institutionalization of outreach for HC/NCHC. This will be enhanced through new collaborative partnerships, such as the efforts initiated with ESC and DJJDP, and maintenance of existing efforts in child care settings, schools, health care settings and through other means-tested government programs. The new bilingual envelope stuffer will serve us well in mass distribution efforts as it is a low cost piece that contains critical information. Minority outreach efforts in the coming year will focus on refugee communities and other populations with limited English proficiency. Translation of materials into other languages is planned. The English/Hmong Fact Sheet printed in late FY06 will be distributed to the Hmong community through the United Hmong Association of NC, local agencies, community-based organizations and outreach staff.

Due to provisions in the Federal Budget Deficit Reduction Act, new requirements to document citizenship and identity become effective July 1, 2006 for all those applying for or renewing their

Medicaid coverage. These are troublesome requirements which impose an additional expense on families who must obtain copies of birth certificates and have photo identity cards made for their citizen children. A tremendous educational effort will be required to prevent a drop-off in enrollment.

The newest addition to the suite of Medical Home Campaign Outreach Materials in late FY06 is our "Choosing a Quality Medical Home" bookmark. This piece describes what a medical home is, why it's important to have one, and suggests questions families may want to ask based on the AAP characteristics of a quality medical home. In FY07, WCHS will launch the "Choosing a Quality Medical Home" Bookmark. Target audiences include new or about to be new parents, families who have children with special health care needs, families who have recently moved, families who have recently enrolled in publicly-funded child health insurance, and any parent considering a new medical home for their child. The outreach to CSHCN provides an opportunity to promote HC/NCHC and our other Medical Home materials anew. Through the Family Advisory Group, plans to institutionalize and sustain outreach to CSHCN families will be discussed. New Child and Family Support Teams, placed in 100 schools, offer an exciting opportunity to work on systems of care for children with a quality medical home and access to health insurance as two key starting points. WCHS will also continue to work on a Medical Home Logic Model Strategic Plan and begin implementation.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					30.1
Numerator					20837
Denominator					69138
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	25	25	25	25

Notes - 2005
Data Source: NC-Nutrition and Physical Activity Surveillance System (NC-NPASS) The subselection of WIC has been done from the composite NC-NPASS file. The annual composite file is created by combining the records from the WIC, Child Health and CSHS. The first records are kept during unduplication. So if a child visits the Child Health clinic first followed by WIC on a different day, the child health record would be kept provided the heights and weights are available. So depending on how a visit occurs, the numbers could vary from year to year and as such the numbers are very much dependent on which records gets selected.

a. Last Year's Accomplishments
Refer to SPM #3 for discussion of children, ages 2 to 18 years who are overweight (overweight being defined as a body mass index (BMI) greater than or equal to the 95th percentile for gender and age.)

Data from the NC Nutrition and Physical Activity Surveillance System (NC-NPASS) which is comprised of data collected on children seen in NC Public Health sponsored Women, Infants and Children Program (WIC), child health clinics and some school-based health centers, show that the percentage of children ages 2 to 5 years who receive WIC and who have a BMI at or above the 85th percentile has hovered around 30% for several years. While not increasing, this rate of at-risk for becoming overweight/overweight is twice the expected rate.

In FY05, activities were undertaken related to the prevention and reduction of overweight in young children participating in WIC including:
- enhancing the NC-NPASS to monitor trends in key nutrition and physical activity behaviors.
- training public health staff on a new client education initiative, "Families Eating Smart, Moving More".
- reducing the amount of juice prescribed to children through the monthly WIC food package to comply with the AAP recommendations.

The above activities were done in addition to the following ongoing activities:
- integrating obesity prevention into all C & Y and nutrition programs.
- identifying young children at-risk for overweight and providing nutrition education and counseling in addition to monitoring health status.
- educating parents, caregivers, and young children themselves on healthy nutrition and physical activity behaviors.
- promoting implementation of recommendations from the Healthy Weight Initiative, "Moving Our Children Toward a Healthy Weight."

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhancement of Nutrition and Physical Activity Surveillance System (NC-NPASS).				X
2. Education of health care professionals/staff training.				X
3. Education of children and their parents/caretakers.	X			
4. Continuation and expansion of Nutrition and Physical Activity Self Assessment for Child Care.				X
5. Implement WIC program policies supportive of dietary change.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Refer to SPM #3 for discussion of children, ages 2 to 18 years who are overweight (overweight being defined as a body mass index (BMI) greater than or equal to the 95th percentile for gender and age.)

During FY06, the C&Y and Nutrition Services Branches continued:
- enhancing and promoting the NC-NPASS to monitor trends in key nutrition and physical activity behaviors.
- training public health staff on a new client education initiative, "Families Eating Smart, Moving More".
- integrating obesity prevention into all C & Y and nutrition programs.
- identifying young children at-risk for overweight and provide nutrition education and counseling in addition to monitoring health status.
- educating parents, caregivers, and young children themselves on healthy nutrition and physical activity behaviors.
- promoting implementation of recommendations from the Healthy Weight Initiative, "Moving Our Children Toward a Healthy Weight."

The Nutrition Services Branch also implemented new nutrition assessment forms for the WIC

Program and provided staff training on nutrition assessment.

c. Plan for the Coming Year
Refer to SPM #3 for discussion of children, ages 2 to 18 years who are overweight (overweight being defined as a body mass index (BMI) greater than or equal to the 95th percentile for gender and age.)

During FY07, the C&Y and Nutrition Services Branches will continue to work on the activities detailed in the previous section and add the following:
- offer training to public health staff on motivation interviewing.
- implement changes to the WIC food package which could help promote healthy weights (i.e., offer only 1% or less milk as the standard issuance).
- increase utilization of Medicaid funded MNT services for children.
- coordinate with the Expanded Food and Nutrition Education Program (EFNEP) to implement Families Eating Smart, Moving More group education modules in public health departments and WIC agencies.
- coordinate efforts to implement the Nutrition and Physical Activity Self-Assessment for Child Care in child care centers participating in the Child and Adult Care Food Program (CACFP).
- introduce new client nutrition and physical activity education materials.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					12.5
Numerator					14959
Denominator					119773
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	12	12	11	10	10

Notes - 2005
Data for this measure are not available at this time as the 2003 birth certificate has not yet been implemented in NC. The data included here is CY04 data for the percentage of women who smoked during pregnancy, not just in the last three months, according to birth certificate data. The annual performance objectives are also based on women who smoked during pregnancy, not just in the last three months.

a. Last Year's Accomplishments
The Women's Health and Tobacco Use Program Consultant position was filled in May 2005.

The WHB received third-year funding from the Health and Wellness Trust Fund Commission of NC to implement the Smoking Cessation for Pregnant Teens Project (SCPTP). Three Carolina ACCESS (Medicaid) sites in NC (Durham County Health Department, Gaston County Health Department, and Robeson Health Care Corporation) developed policies and procedures to integrate smoking cessation counseling into prenatal care services. These office-based systems continued to be piloted in the three sites in order to develop lessons learned from the process. Under the SCPTP, the WHB continued to provide funding to the NCHSF to develop, print and distribute new age-appropriate smoking cessation and secondhand smoke educational materials.

The development and design for the smoking cessation educational material for pregnant teens was completed.

The WHB collaborated with ACOG in the Provider Partnership Project on women and tobacco. A subcommittee of the Women and Tobacco Coalition for Health (WATCH), the Survey Action Team, developed the NC Collaborative Survey on Smoking Cessation During Pregnancy to assess clinical practice behaviors and resource and training needs among all prenatal care providers in the state. This survey was pilot tested, printed, and distributed through ACOG.

The Perinatal and Neonatal Outreach and Education Trainers (POETs and NOETS) provided training to local health departments and community-based groups using the "Guide for Counseling Women Who Smoke". Over 150 health care and human service providers across NC were trained. The Guide was also distributed to providers in other states in the nation.

The results of the NC Collaborative Survey on Smoking Cessation During Pregnancy were published and 3000 copies of the report were distributed to survey respondents and to agencies and individuals who provide health care services to pregnant women.

The 5As cessation method training was provided to all staff who provided Maternity Care Coordination prenatal case management services and Maternal Outreach Worker services at the 10 agencies participating in the Baby Love Best Practices Pilot. Additionally, the 5As method was a requirement of the prenatal case management provided to all clients of the 10 agencies during this year of the pilot activities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Update and distribute The Guide for Counseling Women Who Smoke and other educational materials.			X	
2. Facilitate and manage the Women and Tobacco Coalition for Health activities.				X
3. Develop/sustain partnerships with women's health and tobacco use prevention/cessation organizations.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The SCPTP ended in December 2006. Under the program, counseling services for smoking cessation and secondhand smoke were provided at all three project sites. Secondhand smoke educational materials for pregnant teens were completed and distributed, with the primary focus being in project area counties.

WATCH formalized its mission statement to guide the program and expanded to include five standing committees and two ad hoc committees to focus on issues around smoking and women's health.

The NC Quit Line became active in December 2005.

The FY06 Maternal Health Agreement Addenda with all local county health departments included

a requirement for 5As cessation method to be used with all pregnant women receive health department services. Statewide training was provided by POETS and NOETS for local health departments. An office-based system for tobacco cessation counseling for local health department use was developed. Information on implementation of 5As method was gathered from Maternity Care Coordination Prenatal Case Management providers at statewide meetings in February and March. Feedback was provided to the Women's Health Branch to assist in guiding future efforts to improve 5As method implementation.

c. Plan for the Coming Year

Plans for the coming year include the following activities:
- Update of the "Guide for Counseling Women Who Smoke" and of the video which accompanies the guide, entitled "Counseling from the Heart: Techniques for Counseling Women Who Smoke"
- Continued pursuit of Medicaid reimbursement for tobacco cessation counseling.
- Advocacy for inclusion of 5As counseling in the Family Planning and Reproductive Health Agreement Addenda
- Development of a plan to address postpartum relapse, develop a hospital packet on postpartum relapse, and build relationships with hospitals who are currently or who are becoming 100% smoke free.
- Explore expansion of "Counseling Women Who Smoke" training to non-local health department sites.
- Work with primary care providers who participated in prior survey around clinical practice on tobacco cessation issues.
- Include 5As method information in the formal policy requirements for provision of Maternity Care Coordination prenatal case management services statewide.
- Implementation of office-based system for tobacco cessation counseling for local health department use.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	5	5	5	5	6
Annual Indicator	7.1	8.7	5.2	7.4	7.3
Numerator	38	49	30	43	43
Denominator	535356	560336	572740	581841	592645
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	6	6	5	5	5

Notes - 2005

FY year data are actually the prior calendar year, e.g. FY05 is really CY04.

Notes - 2004

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

Notes - 2003

a. Last Year's Accomplishments

During FY05, The Youth Suicide Prevention Task Force (YSPTF) published North Carolina's state plan for suicide prevention entitled "Saving Tomorrows Today." The plan issued the following recommendations: 1) promote awareness that suicide is a public problem that is

preventable; 2) develop and implement community-based suicide prevention programs; 3) implement training for recognition of at-risk behavior and delivery of effective treatment; 4) promote efforts to reduce access to lethal means and methods of self harm; 5) improve access to linkages with community mental health and substance abuse services; and 6) improve and expand surveillance systems.

Eight hundred (800) copies were printed and sent to the original 34 professional, non-profit, and community organizations who endorsed the state plan which included the School Nurses Association, the School Counselors Association, the Department of Juvenile Justice and the Mental Health Association of NC. The Department of Juvenile Justice and Delinquency Prevention developed their own on-going training schedule to educate departmental staff in suicide awareness/intervention. The NC Child Fatality Task Force continues to take part in the work of the YSPTF and supports the state suicide prevention plan. Eight LivingWorks trainers were able to receive required training upgrades within the state through the Task Force's collaboration with Fort Bragg who conducted training for the military. YSPTF also applied for federal funding through the Garrett Lee Smith Memorial Fund in the amount of $400,000 for three years. The focus of the grant was on awareness and education, increased gatekeeper training, and piloting community programs to identify at risk youth, make referrals, and provide follow-up on outcomes of service linkage and treatment outcomes.

The complete state youth suicide prevention plan was published in October 2004. This report can be found on-line and can be accessed through the Injury and Violence Prevention Branch web page (http://www.communityhealth.dhhs.state.nc.us/injury.htm).

During this period, the Task Force collaborated with the NC Mental Health Association to sponsor the first statewide conference on youth suicide prevention. Two hundred participants attended this conference.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. LivingWorks Training conducted.				X
2. Development of a surveillance plan.				X
3. Development and implementation of a listserve.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The number of suicides for the age group 15-19 in NC for 2004 was 43, giving a rate of 7.4 per 100,000. North Carolina did not receive the Garret Lee Smith Memorial funding for the previous year; however, new funding was available for this fiscal year and the Task Force has re-applied for $400,000 for three years.

This year federal legislation appropriated a total of $4.8 million for State/Tribal Youth Suicide Prevention Programs. The grant will be administered by SAMHSA and the RFA process will begin in April. Only one entity in a state can receive an award. The YSPTF held three meetings in April in order to garner cooperation and consensus about North Carolina's effort to receive grant funding.

The chairperson of the YSPTF continues to participate in the School Health Matrix Team in order to promote addressing self-injurious behavior issues in the school setting. Three members of the YSPTF currently participate in a newly formed community group called the Triangle Consortium for Suicide Prevention. Applied Suicide Intervention Skills Training has been rendered to over 200 gatekeepers. LivingWorks provided four scholarships to North Carolina in order for the state to increase their trainer pool. These scholarships helped to increase the diversity of the trainers. These new trainers include one Hmong male, two Latino males, and an individual who conducts outreach to African American churches.

The Epidemiology Unit of the Injury and Violence Prevention Branch (lead agency of the YSPTF) implemented the NC Violent Death Reporting System. It has generated data on the characteristics of suicide such as involvement in legal problems and stress from mental health problems and the mode of death such as firearms. The chairperson of the YSPTF is part of their Data User's Advisory Board. An annual report will be released this year. Data will provide more descriptive information about individuals who die by suicide.

c. Plan for the Coming Year

It is hoped that NC will receive either a federal grant and/or a state grant to implement goals of the youth suicide prevention plan. Implementation of these strategies will require even greater cooperation between agencies. If no funding is received, the YSPTF will continue to seek support of agencies to implement goals of the plan which are applicable to a particular agency's area of work.

The NC Violent Death Reporting System will continue to operate. The data generated will be available to organizations who can use the information for strategic planning purposes.

Implementation and management of the statewide list serve in order to create an informative and supportive network for exchange of ideas about youth suicide prevention will be performed by the Injury and Violence Prevention Branch.

The YSPTF will continue to build a network of agencies (professional, non-profit, faith-based) across the state that are interested in youth suicide prevention.

The YSPTF will co-sponsor a suicide prevention awareness walk with the Triangle Consortium for Suicide Prevention in November 2006.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	82	82	83	83	83
Annual Indicator	81.8	79.6	78.1	80.2	79.2
Numerator	1600	1562	1447	1450	1542
Denominator	1956	1963	1852	1808	1946
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	83	83	83	83	83

Notes - 2005

These data include deliveries at 12 facilities originally designated for high-risk deliveries and neonates back in the 1980s. There are other hospitals within the state with NICUs whose

deliveries are not included in this count.

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

Notes - 2004
These data include deliveries at 12 facilities originally designated for high-risk deliveries and neonates back in the 1980s. There are other hospitals within the state with NICUs whose deliveries are not included in this count.

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

a. Last Year's Accomplishments
The Neonatal Outreach and Education Trainers (NOETs) and Perinatal Outreach and Education Trainers (POETs) continue to educate providers on this service and other issues of importance of very low birth weight infants born in tertiary centers. During FY05, nearly 10,000 health care and human service providers from across the state received training through this program.

The Neonatal Bed Locator Service continued to provide 24 hour per day, 7 day per week, 365 day per year service to physicians and hospitals to ensure that the most appropriate level of care bed space was secured for neonates.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementation of contract with Wake Forest University for Neonatal Bed Locator services.				X
2. Continual review of data to access sites more likely to keep low birthweight babies.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The NOETs' primary focus areas continue to include: substance abuse (includes smoking); breastfeeding; resuscitation and stabilization; the care and discharge of convalescing newborns; and the promotion of best practices in neonatal care.

From July 1, 2005 through February 28, 2006, the Neonatal Bed Locator Service had 282 total calls for requests to locate neonatal and maternal bed space.

c. Plan for the Coming Year
Plans for the coming year include:
- Development of the NOET/POET Orientation Manual
- Standardization of the Maternal Newborn Assessment Training
- Inclusion of Maternal Newborn Assessment standardized training process in the Child Health Agreement Addenda

During the upcoming year, the Neonatal Bed Locator Service will continue to provide 24 hour per

day, 7 day per week, 365 day per year service to field calls to locate neonate and maternal bed space in NC hospitals.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	86	86	87	87	87
Annual Indicator	84.0	83.9	83.7	83.7	83.3
Numerator	100988	99092	98226	99039	99822
Denominator	120247	118112	117307	118292	119773
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	87	87	87	87	87

Notes - 2005
FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

Notes - 2004
FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

a. Last Year's Accomplishments
The First Step Campaign continued to promote the MCH Hotline, called the NC Family Health Resource Line (NC FHRL), and encouraged women to seek early and continuous prenatal care services. The Campaign focused on the following topics: prematurity and low birthweight issues, evidence-based practices on disparity in perinatal health, and awareness of safe sleep practices. Educational and promotional materials which address the impact of infant mortality, racial disparity, low birthweight and prematurity on families and the state were developed and narrowed in focus. They were completed by June 2005. A new educational material was developed that addressed the interconceptional time period and related desired behaviors that increase the chance of having a subsequent healthy pregnancy. A Spanish Sickle Cell Program brochure was developed as well as a Spanish language brochure for teens about secondhand smoke ("No Fume Aqui"). The NC Healthy Start Foundation website was updated to include expanded information about the First Step Campaign such as minority infant mortality reduction issues and efforts, smoking cessation, annual infant mortality/morbidity statistics, low birthweight and prematurity, wellness for women of reproductive years (i.e., positive preconceptional and interconceptional health behaviors), and parenting/child development. The website was also revamped for Spanish speakers, which included identifying appropriate links to Spanish websites and featuring relevant information for Latinos. Updates and reprints were completed for: "NC Healthy Start Foundation Catalog" (for ordering materials); "Are You Ready" (pre-and interconceptional brochure for women); "Are You Strong Enough" (preconceptional and interconceptional brochure for men to complement the brochure for women); and "Giving Our Children A Healthy Start" (for the African American community).

The Eastern Baby Love Plus (EBLP) program has enhanced its existing services by developing a Lay Health Advisors (LHA) program. This program provided an avenue to deliver health education and training to a captive audience as participants included local barbers and hair stylist. The LHAs completed a series of educational sessions that focused on women's health issues. The LHAs have provided the opportunity for the EBLP project to reach women of childbearing age who may not have ordinarily been reached and have been beneficial in dispelling myths about local health and human service agencies as well as identifying women who are at high risk (due to lifestyle factors). There are currently 20 active LHAs working in

eastern North Carolina. EBLP anticipates reaching approximately 3,500 community participants during year one.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maternity Care Coordination and Maternal Outreach Worker programs ongoing.		X		
2. Re-application process for Minority Infant Mortality Reduction Projects.				X
3. Continued outreach through Baby Love Plus with a focus on perinatal women's health.		X		
4. Work with Sickle Cell Program to educate families of childbearing age on perinatal health issues				X
5. 10-county pilot project with MCCs and MOWs.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The First Step Campaign continued to promote ways to improve the health of women of childbearing age and infants by the promotion of the NC FHRL's information and referral service and First Step campaign activities focusing on African American and American Indian communities. The Back To Sleep Campaign is promoting Sudden Infant Death Syndrome awareness and risk reduction practices targeting African American and Latino parents and childcare providers. In conjunction with the March of Dimes and N.C. Folic Acid Council, educational information and materials are being distributed that promote good health during women's childbearing years and raise awareness of consuming folic acid as a way to reduce birth defects. A focus to raise awareness of the dangers of smoking and secondhand smoke by promoting individual behavior change for pregnant teens, their families, and friends is included. Web-based information continues to be updated to meet information needs of the public, health and human service providers, and the objectives of the educational campaigns. Assessments such as focus groups and consumer and outreach worker input are being used to develop appropriate materials. Both Spanish and English versions of the following materials are being reprinted: "Thanks For Asking;" "English Back To Sleep Information Sheet;" English Back To Sleep light switch cover; "Humos Letales" (Publication for young adults on secondhand smoke); Do Not Smoke decals featuring the message in multiple languages; "Get Real - Secondhand Smoke Matters;" Reality Check" (encouraging pregnant teens to quit smoking); and "Oh Baby" (secondhand smoke). Also a Spanish language video and discussion guide entitled "How Will I Pay For My Pregnancy?" is being duplicated.

To date in the EBLP, 20 LHAs have been trained and continue to provide positive health messages and refer families to needed services. The LHAs will begin participating in quarterly continuing education sessions during the summer of 2006. The information given by the LHAs is received on three levels: 1) the LHAs themselves are men and women of childbearing age who can personally benefit from the information; 2) as members of the priority population, the LHAs are more in tune with the issues and concerns of that population; and 3) the LHAs are viewed as leaders by other members of the priority population, thus are viewed as having credibility.

The LHA program has also been expanded to include more than just barbers and hairstylists. The expansion of community members will afford the opportunity to reach a broader number of people in the community. The LHAs will complete a five-session training curriculum centered on

women's and children's health issues along with individual, family, and community empowerment. A skill-building component is built into each module as well. The Regional Network Manager, Consumer Advocate, and MCH staff from the local agencies will teach the modules.

c. Plan for the Coming Year

The First Step Campaign will continue to promote ways to improve the health of women of childbearing age and infants by the promotion of the NC Family Health Resource Line's information and referral service and First Step campaign activities focusing on African-American and American Indian communities. The Back to Sleep Campaign will promote Sudden Infant Death Syndrome awareness and risk reduction practices targeting African American and Latino parents and childcare providers. The following materials will be either reprinted or redesigned: reprint "See How We Grow;" print updated "Giving Our Children A Healthy Start;" reprint "Take Them For Life" campaign cards, brochure and posters; design and print new Spanish materials in conjunction with the N.C. Folic Acid Council; duplicate the current folic acid campaign video and discussion guide; and reproduce "Be Smart" English and Spanish brochures, flyers and posters. A video up to 10 minutes in length about living with sickle cell disease will be produced and duplicated, along with a discussion guide to accompany the video. An additional segment, no more than 1.5 minutes, of an adult talking about getting tested for sickle cell disease will be filmed. This segment will be edited into the existing "HOPE for adult talking about getting tested for sickle cell disease" video. Also, a video up to 15 minutes in length to reinforce the 5A's of smoking cessation used to counsel women of childbearing age along with a video use guide will be developed and duplicated.

Plans are to continue to train approximately 45 LHAs per year to maintain an active group of participants. These members will be able to provide feedback and give updated information on the number of people reached throughout the community.

D. State Performance Measures

State Performance Measure 1: *Number of children affected in substantiated reports of abuse and/or neglect as compared with previous years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	30000	30000	30000	30000	27000
Annual Indicator	32581	32883	30016	27310	26670
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	27000	26500	26500	26000	26000

Notes - 2005

Manual indicator (count) is used in this state performance measure.

Notes - 2004

Manual indicator (count) is used in this state performance measure.

Notes - 2003

Manual indicator (count) is used in this state performance measure.

a. Last Year's Accomplishments

The Child Fatality Task Force (CFTF) Executive Director position, housed in the C&Y Branch was filled. The Child Fatality Prevention Team (CFPT) Office received a second year of funding with the Governor's Crime Commission (GCC) grant for a project to inform the public about the Infant Homicide Prevention Act of NC's Safe Surrender Law. Grant goals were to increase safe surrender awareness among parents and agencies and develop a tracking system for reporting instances of child abandonment and deaths due to abandonment. Working with the Office of the Chief Medical Examiner, a computerized tracking system collects data on newborns that die as a result of being killed by a parent and abandoned or die due to abandonment. In collaboration with local and state agencies, more than 20,000 posters, flyers and fact sheets in English and Spanish were distributed.

A Task Force on Child Abuse Prevention (TFCAP) was convened by the NC Institute of Medicine (IOM) and funded through the Duke Endowment. The Task Force was co-chaired by the Secretary of DHHS and the Medical Director of Guilford Child Health, Inc. This was a statewide initiative that involved multiple agencies and 53 members, including WCHS staff.

The funding for 31 Adolescent Parenting Prevention projects continues, with one of the six goals of the case management component being to prevent abuse and neglect of the babies and teen mother.

Parenting education activities included the 4th annual Parenting Education Institute, collaboration with NC Parenting Education Network (NCPEN), and advocacy for the inclusion of fathers and men in the resources and services provided by WCHS. Ongoing activities of the Fatherhood project included Fatherhood Development Curriculum training sessions and regional forums; speaker's bureau; updating a resource directory of male-focused programs across NC; convening a Men's Preventive Health Symposium; and participation in the Fatherhood Development Advisory Council.

Meetings for the implementation of recommendations from the legislative Child Well Being and Domestic Violence Task Force were completed, and work continues through multiple agencies including Prevent Child Abuse NC, the Domestic Violence Commission, and the Public Health Alliance Against Violence Against Women.

Members of the Branch continued to work with the State Collaborative For Children's Mental Health.

The Child Service Coordination (CSC) program received a grant to provide a series of trainings for local CSC's on how to effectively support families by promoting healthy parent-child interactions.

The Branch hired a temporary consultant to survey internal staff and programs in an effort to identify opportunities to increase our efforts in the prevention of child abuse and neglect. Assessment data were collected through key informant interviews, attendance at relevant meetings, and document reviews from November 2004 through August 2005.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued implementation of the Adolescent Parenting Program Projects.		X		
2. Continue training professionals and public awareness activities for the Infant Homicide Prevention Act.			X	
3. Assist with implementation of Task Force on Child Maltreatment Recommendations.				X

4. Expand the role of the Parenting Program Manager to be a focal point for prevention of CAN activities and expand the inclusion of fathers in planning, education and training.				X
5. Continue collaboration with NC Parenting Education Network.				X
6. Continue support of the NC Fatherhood Development Advisory Council.				X
7.				
8.				
9.				
10.				

b. Current Activities

The NC IOM TFCAP released a report "New Directions for NC" with 37 recommendations, one of which was the creation of a Child Maltreatment Prevention Leadership Team, to be co-chaired by the Vice President for program services at Prevent Child Abuse North Carolina (PCANC) and the Chief of the WCHS. The team's emphasis is on the implementation of evidence-based practices for the prevention of child maltreatment. A part-time staff person was hired to work with the team until a permanent position is approved by the state legislature. Work has been initiated with Family Resource Centers supported by DSS. Additional workgroups were created to begin work on community violence prevention, surveillance, public education, and legislative/funding issues. Activities by PCANC include: creating a statewide public education campaign on positive parenting; coordinating the development of a pilot project linking the Nurse Family Partnership to CCNC pediatric practices to assess viability as a quality enhancement and cost-containment strategy for Medicaid; and, collaborating with DCD, the NC Partnership for Children, DPI, and DPH to increase childcare provider skills with high risk parents.

The GCC grant ended, but the CFPT Office continues to inform the public about NC's Safe Surrender Law with the work of the Safe Surrender Advisory Committee. Local CFPT trainings focused on improving team member skills in problem identification and writing useful system-related recommendations.

Instead of a statewide Fatherhood Conference, 5 regional conferences were held. The Parenting Program Manager position is vacant, but the Unit Manager participates in the Fatherhood Advisory Council meetings, and this position's scope was expanded to include a focus on a very broad family concept and to be the coordinator of Branch activities related to prevention of child maltreatment and neglect. The Branch works with NCPEN to develop topics for their quarterly newsletter and web-based announcements.

The parent-child interaction training planned for the CSCs was modified based on the CMS changes for reimbursable case management activities. The state continues to work with DMA on restrictions related to family education through case managers. In the interim, parent-child interaction training was redirected to target local child care health consultants.

A report was completed by a consultant hired to identify opportunities for increased efforts in the prevention of child abuse and neglect within WCHS. A matrix was used to indicate how programs address ecological risk factors for child maltreatment in the context of expanding levels of a child's social ecology and in different spheres of influence. Based on the report, training and educational materials were provided to LHD nurses and child care health consultants on child abuse prevention and social-emotional developmental screening.

c. Plan for the Coming Year

The DPH and the Safe Surrender Advisory Committee are in discussions with the Junior League of Raleigh and the NC Bar Association to collaborate on a public awareness campaign to be implemented this fiscal year. The Advisory Committee has tentatively scheduled 3 workshops on Safe Surrender to cover the eastern part of NC, the middle part of the state and the western part

of NC for August, November and March of this fiscal year. Presentations will be made by members of the Advisory Committee on "Spreading the Word about Safe Surrender." Posters, flyers, fact sheet, and a revised safe surrender booklet and PowerPoint presentations will be distributed at each workshop site. Information continues to be distributed at conferences such as Baby Love, Fatherhood, and Adolescent Pregnancy. Recently, representatives from DPH and DSS were guest speakers at the Prevent Child Abuse Conference.

The Child Maltreatment Prevention Leadership Team will continue to meet approximately every 8 weeks to guide the implementation of the TFCAP's recommendations. Work that was commenced in FY06 on a number of issues will continue in FY07: 1) an effort to secure funding for a feasibility study to develop a data monitoring system for child maltreatment; 2) a statewide campaign on positive parenting; 3) a pilot project linking the Nurse Family Partnership with CCNC pediatric practices; and 4) an effort to move Family Resource Centers toward evidence-based practice in the prevention of child maltreatment. Upon completion of the Family Resource Center project, the Evidence-Based Workgroup will begin to work DSS, the North Carolina Partnership for Children, and the Children's Trust Fund to support evidence-based parent education programs. The Legislative/Funding Workgroup will prioritize Task Force recommendations that have a legislative component in terms of feasibility, and work with the Child Fatality Task Force and other groups on these items.

The Leadership Team plans to commence work on a number of child abuse prevention recommendations related to early childhood, including: assessing the prevalence of maternal and post-partum depression and examining service accessibility and availability; assessing the potential costs and benefits of providing some level of service to all pregnant adolescents and adolescent parents in the state; and working with ECCS to identify needs and strategies to enhance systems for promoting infant mental health. During FY07, planning will begin to reconvene the original TFCAP to assess progress made toward the recommendations in the Task Force Report.

The C&Y Branch and WCHS will continue to identify ways to enhance programs within the Branch that have the capacity to address risk and protective factors for child maltreatment. The Health and Wellness Unit Parenting/Fatherhood position is being broadened to include a focus on child abuse and neglect and strengthening families.

State Performance Measure 2: *The number of children in the State less than three years old enrolled in early intervention services to reduce the effects of developmental delay, emotional disturbance, or chronic illness.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator			10504	10978	12436
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	13673	15040	15500	15700	16000

Notes - 2005
Manual indicator (count) is used in this state performance measure.

Notes - 2004
Manual indicator (count) is used in this state performance measure.

Notes - 2003
Manual indicator (count) is used in this state performance measure.

a. Last Year's Accomplishments
The early intervention program in the Early Intervention Branch (EIB) of the WCHS went through a statewide reorganization during FY04. This reorganization consisted of local lead agency status being changed from local mental health agencies to local EIB public health agencies. The reorganization was piloted in 16 of the 100 North Carolina counties in FY04. These local public health agencies had been called Developmental Evaluation Centers (DECs), and they had focused only on evaluation of children who had been referred to the early intervention system and on evaluation of children older than 3 years of age. The DECs' name was changed to Children's Developmental Services Agencies (CDSAs). Their new role is to accept all referrals for the early intervention birth to age three program, assure the process of eligibility determination for children, assure enrollment and ongoing services for eligible children, and monitor the program at the local level.

The CDSAs began this local lead agency responsibility statewide July 1, 2004. During FY04, the number of children enrolled in this program increased to 10,978, and during FY05, the number of children enrolled in the program was 12,436.

In addition, a state level monitoring system was developed. Public comment was solicited and received on multiple policy changes. As a statewide program, however, the most challenging issue in FY05 was the number of referrals received by the CDSAs. In past years referrals to the early intervention program typically were 4500-5000, whereas during FY05, the number of referrals was 17,263.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued implementation of state level monitoring system				X
2. Collection of referral data on a monthly basis				X
3. Increase in number of enrolled children to 15, 040 in 2006-2007	X			
4. Development and implementation of State Performance Plan (SPP)				X
5. Site verification visits at state level and at each of local lead agencies				X
6. Eligibility definition for the program proposed, public comment received, and definition approved				X
7. Education regarding new eligibility definition			X	
8. Public reporting on all data from SPP at local and state levels				X
9. Examination of and improvement in efficiency and effectiveness				X
10.				

b. Current Activities
During FY06, the CDSAs continued the second year of the reorganization mentioned above. Their role of evaluation and eligibility determination for children, enrollment and ongoing services for eligible children, and monitoring of the program at the local level was more clearly defined and processes became more efficient for both families and staff. During FY05, increased efficiency was achieved in the form of enrolling 13% more children (12,436 enrolled children) than in the previous fiscal year. The projected number of children to be enrolled in FY06 is 13,673, as additional funding of $5M was appropriated from the state for the early intervention program. Continued work is needed for both efficiency and effectiveness in the program, and projections of

numbers of enrolled children for FY07 include consideration of the use of the additional funds.

A site verification visit by the federal granting agency (U.S. Department of Education Office of Special Education Programs or OSEP) was completed in July 2005. Two major noncompliance issues received focus as did the requirement to re-institute monitoring at the state level. The noncompliance issues focus on the timeline from a child's referral to the development of a service plan for him or her, and children's transition out of the program at age 3.

A federally required six-year State Performance Plan was completed in December 2005. The state level monitoring system was fully implemented, with quarterly record reviews and corrective action plans by each CDSA across the fiscal year. An additional noncompliance issue of beginning services within 30 days of their listing on the service plan was found. Site verification visits to each of the CDSAs by state level staff are being completed in April-June 2006. A pilot of effectiveness measures on children's developmental progress began in April 2006.

Due to the continued very high number of referrals (annualizing to 17,000 for FY06), the program proposed a change in its eligibility definition. Public comment processes for both state (Administrative Rules) and federal (OSEP) approvals were completed. The new eligibility definition includes a more restricted level of developmental delay and lists specific established conditions. Potential high risk and atypical development categories were reduced (or included as appropriate) in the new categories. State and federal approvals of the new eligibility definition were received as of April 2006, and the changes with be implemented for new children referred to the program as of July 1, 2006.

c. Plan for the Coming Year

Although a new eligibility definition will be implemented, the program projects to enroll even more children in FY07. Given the number of referrals, the proportion of the number of children with a more restricted eligibility definition will decrease, but the actual numbers of children enrolled will increase. The projected number of children to be enrolled in the program is 15,040 if no additional funds are appropriated by the state; otherwise, the projected enrollment would be higher as there is an identified need for many more children to be enrolled.

During FY07, the program will continue to explore and initiate further processes to increase efficiency. Effectiveness measures on children's developmental outcomes will be standardized across CDSAs by the end of the fiscal year. Further efficiency measures will be identified by internal staff and presented for input to external stakeholders. Initial work on these further measures will begin in FY07.

The state level monitoring system will continue with quarterly reports and corrective action plans and will include focused technical assistance to CDSAs per needs identified in the site verification visits noted above. An annual performance report on the State Performance Plan activities will be completed in FY07.

The new eligibility definition will be implemented for children referred as of July 1, 2006. This implementation will require publication of revised policy documents (e.g., approved new eligibility categories) and procedural issues (e.g., process of referral to eligibility determination procedures). Central office quality improvement staff will coordinate these efforts as well as the state level monitoring system noted above. Education of staff, families, and inter-agency partners on the approved new eligibility definition will be needed. Central office resource and information staff will provide technical assistance to CDSA directors for these educational efforts as well as on public reporting of data for the State Performance Plan activities.

State Performance Measure 3: *Percent of children 2-18 who are overweight. Overweight is defined as a body mass index (BMI) greater than or equal to the 95th percentile for gender and age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator			15.6	16.5	17.0
Numerator			15820	16155	17394
Denominator			101184	98201	102480
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	15	14	13	12	10

Notes - 2005
FY year data are actually the prior calendar year, e.g. FY03 is really CY02.

a. Last Year's Accomplishments
Refer to NPM#14 for discussion of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Overweight in NC children ages 5 to 18 continues to increase, however the rate of increase appears to be slowing. Data from the NC Nutrition and Physical Activity Surveillance System (NC-NPASS), which is comprised of data collected for children seen in NC Public Health sponsored Women, Infants and Children (WIC) and child health clinics and some school-based/school linked health centers, show that the percentage of children age 5 to 11 who were overweight (BMI >95th percentile) increased 1.04 percentage points from 2003 to 2004 and increased only .67 percentage points between 2004 and 2005. Likewise, the percentage of overweight children 12 to 18 years increased .77 percentage points between 2003 and 2004, but increased .05 percentage points between 2004 and 2005. Moreover, the percentage of overweight children 2 to 4 years of age increased .48 percentage points between 2003 and 2004, but declined .31 percentage points between 2004 and 2005.

Last year's accomplishments are inclusive of the following:
- The State Board of Education (SBOE) changed one of its 5 strategic priorities to include health in response to the C&Y Branch's Healthy Weight Initiative, "Moving Our Children Toward a Healthy Weight," and other school health initiatives. The SBOE Strategic Priority #2 now reads: "Focus on Healthy Students in Safe, Orderly and Caring Schools.
- Revision of the Healthy Active Children Policy to require at least 30 minutes of daily physical activity in grades K-8 by the 2006-07 school year.
- Implementation of pilots for the Eat Smart School Standards in elementary schools in 7 school districts.
- State funding for 145 school nurse positions provided to local schools through DPH.
- Adoption of an anti-harassment, anti-bullying and anti-discrimination policy that includes obesity as one of the target areas.

The C&Y Branch also continued to expand its obesity prevention efforts by the following strategies:
- Develop the capacity of the School Health Unit to integrate obesity prevention in existing programs.
- Advocated for funding for physical activity program consultant position that has been approved, but not funded.
- Build school nurse capacity in LEAs that do not currently meet the 1:750 recommended school nurse to student ratio to allow increased school nurse involvement in obesity prevention.
- Collaborate with PAN Branch, NS Branch, DPI and Cooperative Extension on Eat Smart Move

More CDC grant objectives.
- Collaborate in work on the NC Health and Wellness Trust Fund Commission grant on obesity prevention in minority elementary school students.
- Assist with pilots of a nationally developed staff wellness program in two LEAs. Obesity prevention is one part of that wellness program.
- Integrated obesity prevention into all C&Y programs when appropriate.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuation and expansion of Nutrition and Physical Activity Self Assessment for Child Care.				X
2. Enhancement of Nutrition and Physical Activity Surveillance System.				X
3. Provide local funding for community-based interventions on healthy eating and physical activity.		X		
4. Healthy Weight Initiative (CDC grant funded project) activities continue.				X
5. Education of health care professionals on a variety of strategies .				X
6. Education of children and their parents/caretakers.	X			
7.				
8.				
9.				
10.				

b. Current Activities
Refer to NPM #14 for discussion of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

During FY06, the C&Y Branch is continuing to work on the activities detailed in the previous section in addition to the following:
- Coordination with the NS Branch on surveillance through the NC-NPASS system expanded to include Physical Activity and Nutrition Behaviors.
- Training on obesity prevention developed and presented to school nurses through "To BMI or not to BMI" presentation by the Nutrition Program Consultant at the state school nurse conference.
- Obesity prevention integrated in local action plans for Coordinated School Health Program staff through presentation by the Nutrition Program Consultant on nutrition and physical activity for school aged children at the Coordinated School Health Programs' [CSHP] Institute by the Sea.
- Required nutrition performance measure added to School Health Center contracts and agreement addenda for the tracking of BMI on growth charts and a minimum of two counseling sessions for students with BMI for age > 95th percentile.
- Technical assistance and training on obesity prevention, treatment and continuous quality improvement provided to local School Health Center staff.
- School Nutritionist Network developed to provide a venue for communication, professional development, and exploration of the various areas of practice management for nutritionists working in NC school settings with children, teachers, parents, school health personnel, and food service staff.
- Develop and implement the first phase of an 18-month nutrition and physical activity pilot [Students Eating Smart And Moving More (SESAMM)] in 4 School Based Health Centers, including formative research to evaluate the first phase.
- Sponsor a statewide SESAMM Youth Summit to foster teen and adult partnerships working together as positive leaders and advocates for healthy eating and physical activity in NC schools

and communities. The Summit was co-sponsored by the NS Branch, the PAN Branch, the Department of 4-H Youth Development at NC State University; DPI's Child Nutrition Services Section; NC Healthy Schools; and the Northwest Area Health Education Center (AHEC).

c. Plan for the Coming Year

Refer to NPM 14 for discussion of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

During FY07, the C&Y Branch will continue to work on the activities detailed in the previous section and add the following:

- Use results of formative research on the first phase of the SESAMM pilots to make recommended revisions and continue pilots in the 4 School Based Health Centers.
- Provide mini grants to local teams that attended the SESAMM Summit and submit applications for local projects in their plan of action begun at the Summit.
- Enhance nutrition component of the credentialing process for School Based and School Linked Health Centers.
- Add a new nutrition performance measure to School Health Center contracts and agreement addenda that will require a follow up BMI-for-age assessment within 12 months for all enrolled students of School Health Centers who have medical record documentation that they have been assessed as underweight or at risk for overweight.
- Train school nurses on obesity prevention through a break out session conducted by the nutritionist at the annual school nurse conference.

The NS Branch plans to:

- provide training for K-5 teachers on nutrition education curriculum that integrates health eating with math, English arts, and science.
- collaborate with DPI on implementation of USDA required local wellness policies, Winner's Circle, and nutrition standards.

State Performance Measure 5: *The percent of women responding to the Pregnancy Risk Assessment Monitoring System (PRAMS) survey that they wanted to be pregnant later or not then or at any time in the future.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	40	40	40	40	40
Annual Indicator	45.3	42.6	40.6	42.2	42.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	39	39	38	38	38

Notes - 2005

CY04 data (FY05) have not yet been released from the CDC, thus this data is an estimate and is just a repeat of CY03 data.

Notes - 2004

PRAMS data are weighted to get the final state percentage, so numerator and denominator data are not available.

Notes - 2003

FY01 data (actually CY00 survey data) was replaced with weighted data in spring 2004. FY03 data have not yet been released from the CDC.

a. Last Year's Accomplishments

The unintended pregnancy rate for North Carolina, as measured in PRAMS, has been steadily declining. The combined rates for the 1997-99 cycle was 45.1%. For 1999-2003, the weighted data is 42.5%. However, the most current data from the CY03 PRAMS show that 42.2 % of births were unintended. This is a slight increase from the 40.6% observed in CY02. Nevertheless, the long-term trend seems to indicate a continuing but slow decline in the rates of unintended births. While the current rate is lower than the 2010 objective (43%) in the Logic Model adopted by the Women's Health Branch; it is still much higher than the national HP2010 objective of 30%. The Logic Model intermediate objective will be revised to concur with the HP2010 objective. A related objective, also included in the Logic Model, is to increase the proportion of women (and their partners) enrolled in the statewide Family Planning Program who use an effective, long-term contraceptive method from 84% in CY02 to 100% in 2010. In CY05, 85.8% of the men and women enrolled in the program were using long-term contraceptives. Emergency contraception, foam and condoms, and abstinence were excluded from this total.

A number of factors may have contributed to the declining trend in unintended pregnancies. The FPRHU continues to provide comprehensive family planning services through a network of approximately 140 service sites throughout the state, which served 145,166 unduplicated patients in CY05. The number of patients served in CY05 increased by approximately 5% compared to CY04. The increase in patient numbers in CY05 is significant when compared to the CY04 patient numbers which declined by 3.3% when compared to CY03 data. However, the long-term trend projects positive growth in patients served in spite of severe budget cuts and significant increases in the cost of contraceptives and other supplies (Thin Prep) the past three years. Local outreach initiatives to improve access to services, reduce unintended pregnancies, and increase patient numbers began in FY99 with special initiative bonus funding and has continued through FY05. The growth momentum resulting from these initiatives is expected to sustain the long-term trend. The success of the demonstration projects enabled the FPRHU to formally adopt a performance based funding strategy in distributing additional funds in FY05, which awarded local health departments "bonus" funds commensurate with long term and short term patient increases.

The FPRHU continues to develop and update logic models that address improvements in the health of women of childbearing age and reductions in infant mortality. Towards this end, the FPRHU has adopted intermediate outcomes that specifically address reductions in unintended pregnancies, teen births, and the percent of live births with short birth intervals, and increasing the proportion of females at risk of unintended pregnancies that are using the most effective contraceptive methods.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Full implementation of the 1115(a) demonstration waiver (Medicaid waiver).				X
2. Continuation and expansion of the Hispanic/Latino Outreach Initiatives.		X		
3. Continuation and expansion of special outreach initiatives, particularly to teen patients.		X		
4. Continuation of sterilization funding and services				X
5. Continuation of TPPI, with greater emphasis on programs for Hispanic/Latino youth.				X
6.				

7.				
8.				
9.				
10.				

b. Current Activities

In cooperation with staff from the NC DMA, the FPRHU is currently in the first year of the implementation of the recently approved 1115(a) Medicaid Demonstration Waiver. The Medicaid waiver, which officially began in October, 2005, will extend eligibility for family planning services to all women and men over age 19 with incomes at or below 185% of the federal poverty level regardless of receipt of previous Medicaid reimbursed service (pregnancy-related or otherwise). The major goal of the waiver is to reduce unintended pregnancies and improve the well being of children and families in NC. Among several objectives, two specifically target reductions in the number of inadequately spaced pregnancies and in the number of unintended and unwanted pregnancies among women eligible for Medicaid. As of March 2006, there are 1,121 clients enrolled in the Family Planning Medicaid Waiver.

The significant increase in the Hispanic/Latino population of the state continues to be a challenge for local maternal health and family planning clinics. To help meet this challenge, the FPRHU is continuing to fund and expand the Latino Family Planning Outreach Initiative with $300,000 in special Title X funds and to support special Latino Adolescent Pregnancy Prevention programs. A Request for Application has recently been re-issued to local public and private not-for-profit agencies located in communities with high Hispanic/Latino population growth rates. The FPRHU is also currently implementing the specific action steps prescribed for the unit in DPH's Recommendations for Eliminating Health Disparities.

Funding for sterilization services, temporarily suspended in FY03, has been restored in FY05 at approximately $354,343. One of the anticipated benefits of the Family Planning Medicaid Waiver is an increase in the numbers of vasectomies provided the eligible males age 19-60; a significant target population for this initiative.

A recent reorganization of the Women's Health Regional Nurse Consultants (RNCs) is designed to improve and streamline the provision of technical assistance and consultation to local grantee agencies related to the Medicaid waiver and other family planning issues that impact on efficiency and cost effectiveness of clinical services. RNCs are working closely with the four regional Women's Health Social Work Consultants (RSWCs) to conduct systematic assessment of local agencies success in meeting specific process and outcome objectives related to reductions in unintended pregnancies.

c. Plan for the Coming Year

The FPRHU will continue the initial implementation of the recently approved 1115(a) Medicaid demonstration waiver. Full implementation of the Medicaid waiver may take the remainder of this year and most of next year. An evaluation component is being implemented which will measure outcomes including unintendedness and birth spacing. Data from the social marketing contract will be carefully analyzed by Unit staff and the contract agency, and results will help shape future social marketing activities for the Medicaid waiver. RNC reorganization will continue to be refined, and activities and responsibilities added as the waiver is implemented. Accountability issues will also be a major focus particularly as they relate to local contracts, which now must reflect specific intermediate outcomes in the logic models. The emphasis on increasing patient census, particularly teens, will continue. The Teen Pregnancy Prevention Initiative will continue to expand with the restoration of TANF funds. This is significant in light of the high rates of out-of-wedlock births and unintended pregnancies among teens.

State Performance Measure 6: *Percent of women of childbearing age taking folic acid regularly.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective		50	50	50	50
Annual Indicator	49	42.2	42.2	47.1	47.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	50	50	50	50	50

Notes - 2005
2005 data are not available as the folic acid module was not included in the state's BRFSS for this year. As an estimate has to be entered into the data system, the CY04 data value was entered, but there is no way to know if this is a good estimate or not.

Notes - 2004
Data source is he Behavioral Risk Factor Surveillance System. Unweighted numerator and denominator are not available. Data are based on prior calendar year, e.g., FY02 is really CY01 data.

Notes - 2003
2003 data are not available as the folic acid module was not included in the state's BRFSS for this year. As an estimate has to be entered into the data system, the CY02 data value was entered, but there is no way to know if this is a good estimate or not.

a. Last Year's Accomplishments
In FY05, state funding of $300,000 continued to support and expand activities from previous years. Emphasis was placed on improving the 35-40% level of multivitamin intake by focusing on messages and behavior change for women 18-24 years of age. Other activities included redesigning the web site (www.getfolic.com), developing new campaign materials (e.g. posters, PSAs and brochures were designed and promoted by an advertising agency), building the infrastructure and capacity for the Eastern Region Campaign, continuing support of the Fullerton Genetics Center's Western Region Campaign, expanding and evaluating the Office Champion program, and continuing the distribution of campaign materials through the NCHSF and the NC Family Health Resource Line. Continued planning efforts were directed at using the $3 million settlement from a multi-state vitamin anti-trust lawsuit (funds allocated to the Folic Acid Council's fiscal agent, the NC March of Dimes, and available through 2009).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Education of health care professionals via a variety of strategies				X
2. Education of consumers and reminders to take a multivitamin daily			X	
3. Mass media and public awareness activities			X	
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
Efforts and activities undertaken in FY06 included expanding and supporting the NC Folic Acid Council infrastructure and targeted interventions to affect awareness and behavior change, maintaining committee participation, training new community volunteers, training NC Family Health Resource Line staff, continuing the funding for statewide and regional campaign coordinators, distributing new campaign materials, participating in community health events targeting women, and hiring an additional regional coordinator and a Hispanic Outreach Coordinator to broaden the population reached.

c. Plan for the Coming Year
Planned activities for FY07 will focus on the continuation of previous efforts to support and expand the NC Folic Acid Council including training of health care professionals through workshops, in-services, and professional conferences; training community volunteers to educate their peers; increasing community awareness through health fairs and community events; distributing consumer brochures/flyers; providing continued funding for statewide and regional campaign coordinators; and maintaining and enhancing collaboration with partners (i.e., universities, hospitals, and AHECs).

State Performance Measure 7: *The ratio of school health nurses to the public school student population.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	1:2100	1:2000	1:1900	1:1700	1:1500
Annual Indicator	1:2075	2,047.0	1,918.1	1,897.2	1,593.1
Numerator		1271995	1279768	1311163	1332009
Denominator		621.4	667.2	691.1	836.1
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	1300	1200	1200	1150	1150

Notes - 2005
As colons aren't allowed in the measure, the number listed in the obejectives is the second number of the ratio (1:1918, etc.), i.e., the number of students per school health nurse.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY03 Students: 1,279,468 School Nurse FTEs: 667.24; ratio 1:1918
FY04 Students: 1,311,163 School Nurse FTEs: 691.11; ratio 1:1897
FY05 Students: 1,332,009 School Nurse FTEs: 836.06; ratio 1:1593

Notes - 2004
As ratios are not allowed in state performance measures at this point, the actual indicator is not going to be very meaningful for this measure, but one needs to look at the numerator (number of public school students in NC) and denominator (number of er school health nurse FTEs) to get the 1:XXX ratio. The goal is to have one nurse per 750 students, but NC is still a long way from accomplishing that goal at 1:1897. The indicators for 2006 to 2008 just list the number of

students per school health nurse as a ratio isn't allowed. School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows: FY97 Students: 1,183,335 School Nurse FTEs: 425.50 FY98 Students: 1,206,607 School Nurse FTEs: 465.10 FY99 Students: 1,218,135 School Nurse FTEs: 491.25 FY00 Students: 1,237,794 School Nurse FTEs: 563.15 FY01 Students: 1,243,442 School Nurse FTEs: 599.22

Notes - 2003
As ratios are not allowed in state performance measures at this point, the actual indicator is not going to be very meaningful for this measure, but one needs to look at the numerator (number of public school students in NC) and denominator (number of er school health nurse FTEs) to get the 1:XXX ratio. The goal is to have one nurse per 750 students, but NC is still a long way from accomplishing that goal at 1:1918. The indicators for 2006, 2007, and 2008 just list the number of students per school health nurse as a ratio isn't allowed.

a. Last Year's Accomplishments
Data from the NC Annual School Health Services Report was utilized to identify trends in student health needs and service delivery and support recommendations for policies and staff increases. The NC General Assembly established the School Nurse Funding Initiative (SNFI) that provided 80 permanent and 65 time limited (two-year) school nurse positions. This doubled (from 10 to 21) the number of Local Education Agencies (LEAs) meeting the recommended school nurse to student ratio of 1:750. It also provided school nurses to four LEAs that had previously had none. The statewide school nurse to student ratio improved from 1:1897 in 2003-04 to 1:1593 in 2004-05. As SNFI nurses were hired, the Regional School Nurse Consultants (RSNCs) worked closely with their supervisors and lead school nurses to assist them in developing Action Plans to guide nursing practice in six health service areas. At the end of the school year, SNFI nurses completed Annual Reports that demonstrated the positive outcomes achieved. The RSNCs also increased the number of New School Nurse Orientation workshops from two to four in order to provide access to this training for the increased number of new school nurses. Other educational opportunities, provided in collaboration with Area Health Education Centers (AHECs) and the NC Institute for Public Health, included workshops on Documentation, Physical Assessment, Diabetes Training for Support Staff, School Nurse Certification Review, and the 21st Annual School Nurse Conference. The conference had more than 500 participants -- a record number.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of program agenda for Annual School Nurse Conference and other continuing ed offerings.				X
2. Clinical and administrative consultation, training and TA to school districts, LHDs, and hospitals.				X
3. Collection and analysis of data regarding health needs, resources and program services.				X
4. Development of standards, guidelines and procedures.				X
5. Dissemination of new nursing and school health related information.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 2004-05 North Carolina Annual School Health Services report for Public Schools was distributed to school nurses, key decision-makers in local and state government, statewide advocates for school health, and media, and was also made available on the www.nchealthyschools.org website. The six RSNCs, along with the state School Nurse Consultant, continue to monitor progress of the SNFI which began in 2004-05. One of the requirements for local health departments, school systems, and hospitals receiving SNFI allocations is to develop Action Plans for each of the funded nurses. The RSNCs work with local school health programs to assist the funded nurses in developing Action Plans, monitoring their progress, and completing the Annual Report. The Annual Report was revised this year to better address the overall progress toward meeting outcomes, activities and strategies utilized in six basic school health service areas. The Action Plan template was similarly revised for 2006-07. Several LEAs have adapted the Action Plan for their non-SNFI nurses. The initial two-year period of SNFI ends June 2006. The two-year positions have been extended for an additional year and the Governor has included funds in his budget to change these 65 positions from time limited to permanent.

In addition to working with school systems employing SNFI nurses, the RSNCs continue to work within their regions to promote the development and expansion of school health services. They collaborate with representatives of other components of the Coordinated School Health Program such as teachers, school administrators, PTA members, students, community leaders, and state agencies and organizations. The RSNCs also collaborate with AHECS and the NC Institute for Public Health to plan, develop, implement and evaluate continuing education activities for school nurses across the state. In addition to workshops on Documentation, Physical Assessment, New School Nurse Orientation, Diabetes Training, School Nurse Certification Review, and the 22nd Annual School Nurse Conference, a Leadership Institute was developed specifically for experienced lead school nurses and supervisors. The Leadership Institute provided training and networking over three two-day sessions and received enthusiastic evaluations. The RSNCs have actively promoted implementation of a law regarding school vending standards that was passed and partially implemented this year. This law was one of two passed this year that build on the State Board of Education's Healthy Active Children policy, adopted in 2003 and updated in 2004.

c. Plan for the Coming Year

Data from the NC Annual School Health Services Report for the 2005-06 school year will continue to be summarized, analyzed and used to identify trends in student needs and service delivery and to support recommendations for increased school nurse positions. In addition, the report will be distributed to school nurses and key decision-makers in state and local government, as well as others who wish to advocate for school nurses and school health, and will be made available through the www.nchealthyschools.org web site. The NC student population is increasing by approximately 20,000 students annually. This increase will require 27 new school nurse positions to maintain the existing ratio. Additional positions to not only maintain, but also improve, the ratio are a priority of DPH. The RSNCs will continue to monitor the SNFI nurses by reviewing and approving their Action Plans at the beginning of the school year, having mid-year discussions about progress, and reviewing Annual Reports at the conclusion of the school year. This ongoing evaluation process will strengthen the SNFI program and provide documentation of the program's success. The RSNCs will continue to serve on committees that affect school health, such as the NC Asthma Alliance, the NC Diabetes Advisory Council, the School Nurse Association of North Carolina (SNANC) Standards and Best Practices committee, Tobacco Free Schools Task Force, and the Kindergarten Health Assessment Review Committee. The RSNCs will be instrumental in assisting LEAs in their respective regions to implement the additional provisions of the school vending law that will go into effect this year. They will also assist with promoting school nutrition standards that legislation is requiring the State Board of Education to develop, and they will promote full functioning of School Health Advisory Councils and mandatory physical activity requirements for grades K-8. They will also continue to provide technical assistance and develop, promote and evaluate continuing education opportunities for school nurses statewide. The 23rd Annual School Nurse Conference will be held in September 2006.

State Performance Measure 8: *Percent of women with live, term births who gain within the Institute of Medicine (IOM) Recommended Weight Gain Ranges.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			33.2	33.0	33.6
Numerator			11880	11664	12429
Denominator			35823	35361	36981
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	34	35	36	37	38

a. Last Year's Accomplishments
Support and education of clients regarding adequate and appropriate prenatal weight gain is an inherent component of prenatal care. During FY05, additional activities to assure women gain adequate and appropriate weight during pregnancy included: enrolling women in the WIC Program as early in pregnancy as possible; hiring a new Women's Health Nutrition Consultant who could focus on prenatal weight gain issues and activities; distributing client educational materials including "Healthy Mom, Healthy Baby"; and monitoring prenatal weight gain data among women who participated in WIC during pregnancy. In response to an initiative of the National Office of Women's Health, a 5 person NC Healthy Weight Healthy Women Team was established and participated in national training for state teams. The NC team includes representatives from several groups with DPH and a representative from the University of North Carolina system.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Staff training				X
2. Client education and awareness		X		
3. Anthropometric data collection and assessment	X			
4. Data analysis				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During FY06, activities to promote adequate and appropriate prenatal weight gain in addition to the ongoing monitoring of prenatal weight gain among women who participate on WIC prenatally included: enrolling women in the WIC Program as early in pregnancy as possible; distributing client educational materials; assuring that staff working in prenatal health support and educate women on adequate and appropriate prenatal weight gain; supporting and enhancing activities of the NC Healthy Weight Healthy Women Team; adding items to the FY07 LHD Agreement Addenda for the WIC Program, the Maternal Health Program, and the High Risk Maternity Health Program which focus on clients achieving gestational weight gain within the IOM recommended guidelines; collaboration among the Women's Health Branch and Nutrition Services Branch to

update and distribute guidance for health practitioners on how to weigh and measure adults; and analyzing the effects of gestational weight gain among NC women on pregnancy outcome.

c. Plan for the Coming Year
New activities planned for FY07 include revising the maternal health flow sheet to include an assessment of prepregnancy BMI and a woman's prenatal weight status (i.e., underweight/normal/overweight/obese) and increasing the awareness of health care staff about the importance of helping pregnant women achieve prenatal weight gain consistent with the IOM recommendations through planned workshops and in-services.

Ongoing activities during FY07 will include supporting and enhancing activities of the NC Healthy Weight Healthy Women Team; distributing client education materials; and collecting and analyzing prenatal weight gain data.

State Performance Measure 9: *Percent of non-pregnant women of reproductive age who are overweight/obese (BMI>26).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator			44.9	45.9	46.3
Numerator			18366	18600	19693
Denominator			40905	40522	42533
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	45	44	43	42	40

a. Last Year's Accomplishments
During FY05, the new Women's Health Nutrition Consultant was hired and oriented, during which time she assessed local provider needs relating to women's health and nutrition. Additionally, in response to an initiative of the National Office of Women's Health, a five person NC Healthy Weight Healthy Women Team was established and participated in national training for state teams. The NC team includes representatives from several groups with DPH and a representative from the University of North Carolina system. Discussions continued about ways to strengthen and enhance the data collection of weights and heights of non-pregnant women of reproductive age. Ongoing activities included routine client education about weight through the WIC Program (with postpartum women) and family planning.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Client assessment	X			
2. Client education		X		
3. Staff training				X
4. Data collection and assessment				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
It appears that the rate of non-pregnant women of reproductive age with a BMI>26 is increasing each year, putting greater emphasis on the need for activities and initiatives focusing on managing and reducing the prevalence of overweight and obesity among women in North Carolina.

During FY06, a variety of activities, many collaborative in nature through the efforts of the NC Healthy Weight Healthy Women Project Team, focused on strengthening public health efforts to address the issue of overweight and obesity in women of reproductive age. Informal surveys of health care staff (i.e., nutritionists, family planning nurses, health educators) were conducted regarding practitioners' knowledge and attitudes about BMI assessment and weight management counseling. A clinic self-assessment tool for identifying barriers and solutions to assessing BMI and practitioner attitudes about the management of overweight and obesity in women was also designed and promoted. Additional activities during FY06 included:
- providing BMI calculator wheels to public health agencies;
- expanding the selection of client educational materials in both English and Spanish and promoting the use of the Eat Smart Move More website (http://www.eatsmartmovemorenc.com/) by staff for useful client education tools;
- adding an item to the FY07 LHD Family Planning Program Agreement Addenda which requires determining BMI status of clients with subsequent weight management follow-up with overweight/obese clients;
- increasing awareness of public health practitioners about the issues of overweight/obesity among women through conference presentations and agency in-services;
- updating and distributing guidance for health practitioners on how to weigh and measure adults; and
- exploring ways to increase the reporting of weights and heights of women through the NC HSIS.

c. Plan for the Coming Year
During FY07, a variety of activities, many collaborative in nature through the efforts of the NC Healthy Weight Healthy Women Project Team will focus on further strengthening efforts to address the issue of overweight and obesity in women of reproductive age. New activities planned for FY07 will include:
- revising the maternal health flow sheet to include an assessment of prepregnancy BMI and a woman's prenatal weight status (i.e., underweight/normal/overweight/obese);
- designing a tool kit for health care practitioners to utilize in assessing and managing overweight in women;
- providing a workshop for health care practitioners (repeated three times across the state) entitled "Healthy Weight, Healthy Women Workshop" and distributing the tool kit at these workshops;
- providing regional workshops for practitioners working in public health clinics which focus on weight issues in women and motivational interviewing techniques (these workshops are focusing on staff skill building related to changes in requirements of the FY07 Family Planning Agreement Addenda); and
- increasing the awareness of health care staff about the importance of helping pregnant women achieve prenatal weight gain consistent with the IOM recommendations through planned workshops and in-services.

Ongoing activities during FY07 will include supporting and enhancing activities of the NC Healthy Weight Healthy Women Project Team; expanding and distributing client education materials, and expanding data collecting and analysis.

E. Health Status Indicators

/2007/The WCHS uses the Health Status Indicators (HSI) in a variety of ways. They provide information on the residents of NC which assists in public health efforts, but they are used by the WCHS primarily as a surveillance or monitoring tool as they are updated each year for the MCH Block Grant application and as evaluative measures. Taken as a whole, they were certainly an important part of the data reviewed during the five-year Needs Assessment process. The attached Excel worksheet was created early during the process and referenced by the Needs Assessment Team throughout the process.

In addition, many individual HSI are used for monitoring purposes. Some are cited in the WCHS Logic Models as intermediate or end outcomes (e.g., reduce child deaths due to unintentional injury and decrease the percent of live births weighing less than 2500 grams). Logic models have been created for each of the WCHS Core Indicators for use in performance based contracts and are updated annually.

Other indicators are used in community monitoring sessions at local health departments. Child health and women's health nurse consultants and social work consultants work together in teams to provide program consultation to county health department and community agency staff. County and state level data are available for use in these monitoring sessions.

In addition, some of the indicators were used in the Shared Indicators for School Readiness project which is part of the Early Childhood Comprehensive Systems grant.

The Health Status Indicators used by the WCHS have been a substantial influence on the Division of Public Health's efforts to implement a statewide accountability process. It is hoped that in this way the HSIs will have a substantial impact thoughout public health in North Carolina by promoting the use of data in public health management and decision-making and in promoting accountability.//2007//
An attachment is included in this section.

F. Other Program Activities

MCH Hotline - NC's Family Health Resource Line has evolved from a prenatal care hotline to a multi-program resource. The hotline averages 3,500-4,000 calls a month and operates during general office hours on weekdays. It offers bilingual and TTY services, and offers information, referral, and advocacy services.

In 1990, NC launched First Step, an infant mortality public awareness campaign, which included a statewide toll-free number. The line responded to calls related to preconceptional, prenatal, postpartum, and infant care; breastfeeding and nutrition; and Baby Love (Medicaid for pregnant women). In 1994, the Health Check Hotline (Medicaid for children) was launched. The line was co-located with the First Step Hotline, using the same staff but a separate toll-free number. With this expansion, the hotline's mission broadened to encompass child health topics. That same year, the First Step Hotline added a focus on prenatal substance use prevention and treatment. In 1998, programs pooled resources to create the NC Family Health Resource Line. The state's Smart Start Program, a public-private initiative that provides early education funding to all of the state's counties, became a partner and contributed early child development and parenting resources, and the Health Choice Program (SCHIP) marketed the line as their "call to action" to learn more about free and low-cost health insurance. In 2002, the NC Child Care Health and Safety Resource Center was merged into the NC Family Health Resource Line, again expanding breadth of services and resources. The NC Family Health Resource Line is funded by state dollars, federal Medicaid matching dollars and MCH grant funds.

The Family Health Resource Line is now administered through the University of North Carolina at Chapel Hill. There are 12 individuals who staff the consolidated lines and the resource center. Families with young children who have developmental concerns or other special health care needs are linked to services directly and referred to the Title V CSHCN hotline and the Early Childhood (Part C) hotline, which is operated (but not funded) by Title V.

Targeted campaigns have increased public awareness of the line, most notably the "First Step" campaign to reduce infant mortality, "Back to Sleep" SIDS-prevention, "Veggies and Vitamins" birth defects prevention, and "Health Check/Health Choice" child health insurance campaign. As hotline administrators noted, the hotline must be continuously marketed to be effective.

Collaboration is a key strength of the NC Family Health Resource Line. The hotline is one of the few that has an advisory committee exclusively dedicated to oversight. Members of the committee include representatives from UNC-Chapel Hill, Title V, Medicaid, CSHCN, the resource line and other key lines. With the hiring of a full-time parent liaison in the C&Y Branch and her work with the Family Advisory Council, the resource line will have greater parental involvement.

The hotline also serves as a key policy tool in that it helps MCH staff identify populations served, the success or failure of outreach efforts, service gaps, and barrier issues. Frequently staff learn about programmatic issues from callers. For example, the state's SCHIP program initially had a 2-month uninsured waiting period. Through the hotline, staff learned that families of children with special needs were choosing to go without insurance to qualify for the more comprehensive, public health insurance. With this data, the program eliminated the uninsured waiting period.

The hotline also offers advocacy services beyond those typically offered, as it links families with medical assistance and resolves barrier issues. Through calls to the line, program staff can identify procedures that are not being implemented appropriately at the local level or by the insurance intermediary.

The NC Sudden Infant Death Syndrome (SIDS) Program is administered through the WHB. Grief counseling and support services are provided to families who have lost an infant to either suspected or confirmed SIDS by either a local or regional SIDS Counselor. Educational outreach and prevention awareness services are provided to health care providers, child care providers, community groups, and first responders. In FY99, the SIDS Program continued to expand its efforts to support primary prevention of SIDS deaths by promoting public awareness of the importance of proper infant sleep positioning. The campaign was designed to complement the national "Back to Sleep" campaign by ensuring access to national public education materials through the hotline and other local sources. A photo-novella targeting African American multigenerational families was developed and distributed which received very positive reviews.

/2007/ The "Back to Sleep" campaign continues. In FY2006, the photo-novella targeting African American multigenerational families was revised, reprinted, and distributed to continue to promote placing babies on their backs to sleep.//2007//

G. Technical Assistance

See Form 15 for specific technical assistance requests.

V. Budget Narrative

A. Expenditures

/2006/ Total state partnership expenditures in 2004 were more than $20 million over 2003. The primary reasons for this were the inclusion of over $12 million in dental health services for children paid by the state Medicaid program in local health departments. These expenditures were not reported in 2003, so this is not necessarily a true increase in expenditures. Another major difference was the increased expenditure of infant formula rebates for recipients of WIC services. This was a true increase amounting to approximately $5 million. Expenditures of MCH Block Grant funds accounted for about $2 million of the total increase./2006/

B. Budget

/2004/The most significant change in North Carolina's MCH Block Grant budget/expenditure plan for FY02 was to change the way the state accounted for the federal funds and the required match, and secondly the way the federal funds were drawn from open awards. Before FY02, the state had budgeted/expended all the federal funds in unique cost centers that identified funds as 100% MCH Block Grant dollars. State funds used for MOE/match were budgeted and expended in different cost centers. This allowed the Title V agency to designate federal funds into program areas that would help maintain the 30%/30% requirements. However in FY02, the state required 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 drew the appropriate number of federal dollars to reflect the 4:3 match rate. While this method assured the state of meeting the required match, it created a challenge for the agency to align budgets for supported programs to continue to meet the 30%/30% set asides. However, this was achieved and the attached table (FY03 MCH Block Grant Budget Justification by Program/Activity by Type of Service) reflects the distribution of Maternal and Child Health Block Grant funds anticipated in 03-04 according to the targeted programs.

A second change occurred in FY02 that was concurrent with the change in the accounting method. Before FY02, the expenditure of MCH Block Grant funds could be designated from particular awards. This practice led to large unobligated balances after the first year of an award, as expenditures were charged to the new grant at the time of the award. The state had to then designate unobligated funds for relevant maternal and child health projects to insure the expenditure of those funds in the second year of the budget period. In FY02, the state began expending funds from the earliest open grant award on a first in, first out basis. This assured the state that the full amount of the award would be expended by the end of the second year of the budget period.

The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $39,427,038. This includes state funds used for matching Title V funds, which, for the FY04 application, is $12,887,306.//2004//

/2005/The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $38,515,199. This includes state funds used for matching Title V funds, which, for the FY05 application, is $13,143,054.//2005//

/2006/The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $41,825,405. This includes state funds used for matching Title V funds, which, for the FY06 application, is $13,077,417.

The attached table (FY06 MCH Block Grant Budget Allocation of Funds by Program/Activity by Type of Service) reflects the distribution of Maternal and Child Health Block Grant funds anticipated in 05-06 according to the targeted programs.//2006//

/2007/The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $51,372,967. This includes state funds used for matching Title V fund, which for the FY07 application, are $12,611,401. Primary reasons for the increase include increased state funding for school nurses and vaccines.//2007

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.