

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **NC**

APPLICATION YEAR: **2005**

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to 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 510, 1330 St. Mary's Street, 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; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

/2004/Public input on the MCH Block Grant will be obtained in two different ways. Members of the Family Advisory Council reviewed portions of the block grant application specific to CSHCN and a conference call was held June 30, 2003 to receive their feedback. In addition, the grant application will be posted on the WCHS website in July and partnering agencies (including Healthy Start Foundation, March of Dimes state chapter, Area Health Education Centers, etc.) will be asked to review it and provide feedback to the Section Office.//2004//

/2005/Public input on the MCH Block Grant will be obtained in two different ways. A brief presentation was made to the Family Advisory Council on May 20, 2004, regarding the block grant and they were asked to review and revise the portions of the narrative relevant to children with special health care needs. In addition, the grant application will be posted on WCHS website in July and partnering agencies (including Healthy Start Foundation, March of Dimes state chapter, Area Health Education Centers, etc.) will be asked to review it and provide feedback to the Section Office.//2005//

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

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.

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.

The estimated total state population on July 1, 2000 was 7,617,000, a 14.9 % increase from 1990 census population. African-Americans remain the largest racial/ethnic minority group in the state, however the Hispanic/Latino population continues to rise. Reliable estimates of the size of this population will be available with 2000 census data. NC's Hispanic/Latino population is comprised of several sub-groups. The majority are Mexican or Mexican-Americans who come to the state for agricultural work. Many remain in the state for extended periods, or establish permanent roots here. While the state attracts many highly educated Hispanic/Latino professionals, the majority of the Spanish-speaking population in most counties is comprised of new arrivals with limited English language skills. The impact of this population on the organization and delivery of health care services varies across the state, but can be profound. In some counties, three-quarters or more of the women and children seeking personal health services in local health departments are Hispanic/Latino. These agencies are coping with these changes in the face of many obstacles, not the least of which is difficulty in obtaining local support for allocating resources to meet the special needs of this burgeoning population.

/2002/ 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 North Carolina General Assembly is currently conducting its bi-annual long session and the budget for FY02 is being debated. The state is facing a major budget shortfall and many cuts to health and human services have been proposed; however, until a final budget has been ratified, which may not occur until late summer, it is hard to say exactly how maternal and child health services will be directly affected. It is possible that the state child health insurance program, Health Choice for Children, will receive expansion funds and that Medicaid reimbursements to dentists will increase. However, cuts in Medicaid reimbursement rates to physicians and added regulation for prescriptions currently paid for by Medicaid have also been proposed. Funding for mental health services and facilities are being hotly contested and decisions on these issues could greatly affect how mental health services are provided in this state.

/2003/ The 2001 Legislative Session of the North Carolina General Assembly was the longest in North Carolina history, beginning on January 24, 2001 and lasting 317 days. With a large budget shortfall, the General Assembly was the only legislature in the nation to raise taxes. The tax increase, which will amount to \$1.2 billion dollars over two years, included a half-cent increase in the state sales tax, a temporary two-year increase in the income tax on the wealthy, and sales tax hikes on liquor. Fiscally, the WCHS was impacted by reductions in state funding for sickle cell program education counselors and the newborn screening program, although increased Medicaid receipts are anticipated for these two programs to make up the difference. The contract to the Healthy Start Foundation, a nonprofit organization that conducts public awareness campaigns and funds community-based programs to reduce infant death and illness, was also reduced. Two programs, the Certified-Nurse Midwifery Program (provided start-up funds for midwifery practices) and the Rural Obstetrical Care Incentive Program (paid a portion of malpractice insurance for doctors in rural areas to encourage them to treat Medicaid patients), were eliminated. Expansion funds were allocated for the following programs or areas which impact WCHS: Asthma Education, Folic Acid Education, Office of Minority Health, Birth Defects Monitoring Program, Health Choice (State Child Health Insurance Program), Dental Rate Increase, HIPAA Compliance Funds, Purchase of Varicella Vaccine, and Sickle Cell Program. An additional act of the General Assembly was that in October of 2001 the state's Early Intervention program was moved to the Women's and Children's Health Section (WCHS), leading to the formation of the Section's fifth branch, the Early Intervention Branch.

The 2002 Legislative Session opened May 28, 2002. The state faces an even worse budget crisis than originally expected, with a shortfall of nearly \$2 billion. How this shortfall will impact services provided by WCHS remains to be seen.

/2004/ The North Carolina Department of Health and Human Services (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 WCHS, the most direct impact is felt by priorities one and four.

The North Carolina Infant-Toddler Program, through DPH, is the state lead agency for Part C of the Individuals with Disabilities Education Act (IDEA). The program serves very young children with, or at risk for, developmental disabilities aged birth to three year and is administratively housed in the Early Intervention Branch (EIB) of the WCHS. The EIB also holds the Developmental Evaluation Centers (DEC), which are 18 regionally based agencies (13 state agencies and 5 contract centers) which historically have focused on evaluation of young children. Except for Mecklenburg County, which is a single county DEC, all the DECs serve a multi-county catchment area. Currently the DECs, along with the Area Program Mental Health, Developmental Disabilities, and Substance Abuse Programs, and the Local Health Departments, are responsible for the Infant-Toddler Program. This interagency group meets as a consortium to agree on eligibility of children for the Infant-Toddler Program and to plan services such as: service coordination, evaluation and assessments; specialized instruction; speech, physical, or occupational therapy, as well as other services specified under IDEA. Beginning in July 2004, however, in response to study to evaluate early intervention services required by the 2001 NCGA, all DECs will become Children's Developmental Services Agencies (CSDAs). The responsibilities of the CSDAs are to provide oversight of all the NC Infant-Toddler (IT) program services in the appropriate catchment area, assuring the availability of all the required types of early intervention through direct provision or contract with other public and private agencies. This includes receiving all referrals for the NC IT program, contacting families of young children with special needs who may be eligible for the program, determining eligibility status of children referred, and providing initial and continuing services through their staff and public and private contract agencies, including the provision and appropriate review of the Individualized Family Service Plan (IFSP) for each child and family served under the Program. Effective July 1, 2003, four of the current DECs will become CSDAs serving 16 counties. In addition to the CSDAs, the Early Intervention Design Plan calls for the creation of the Children's Developmental Services Councils, which are comprised of local representatives of all the different agencies involved in early intervention, private providers, and parents. The functions of the Councils include developing plans for how the catchment area wants to implement and evaluate child find and public awareness and assessment of the local services system, identifying gaps and developing plans for services to address these gaps. The DHHS also established an oversight group comprised of representation of all involved DHHS Divisions and the North Carolina Interagency Coordinating Council, Smart Start, Juvenile Justice, Department of Public Instruction, and other stakeholder organizations to monitor and evaluate the reorganization process..

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.

Additional unique challenges for the delivery of Title V services persist in North Carolina. During the 2002-2003 Session of the NC General Assembly (NCGA), the state once again faced huge budget

shortfalls, thus NCDHHS took a lot of hits in the FY03 budget. Major cuts in the FY03 budget impacting the WCHS included the elimination of 3.45 positions, reduction in funding for the development evaluation centers (now called Children's Developmental Services Agencies), and the reduction of contracts for services to support direct care. One-time funding for certain programs (asthma education, Health Start Foundation, adolescent pregnancy prevention, folic acid, and Prevent Blindness) was included in the expansion budget, however there is not guarantee that this funding will be available in FY04. The outlook for the FY04 budget is even more dismal with at least a \$1 billion dollar shortfall anticipated.

One major concern is the continuing struggle to ensure access to care, particularly for children. Currently pregnant women up to 185% of poverty are eligible to receive Medicaid. However, in the current 2003-2004 session of the NCGA, proposals were made to decrease the eligibility levels to 150% of poverty have been made, as well as a proposal to eliminate coverage for pregnant women who are 18 or 19 years of age. Fortunately, these proposals did not pass. At the same time, however, WCHS is currently in the final phase in the implementation of a 1115(a) demonstration Medicaid waiver, which would extend eligibility for family planning services to all women and men over age 18 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 Medicaid waiver is to reduce unintended pregnancies and improve the well being of children and families in North Carolina.

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 Wood's 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.

NC has enjoyed great success in enrolling uninsured children into Health Choice, but state budget problems continue to prevent all eligible children from being enrolled. Data used to prepare the state's Child Health Insurance Plan indicated that approximately 220,000 children ages 0-18 years were uninsured. Approximately one-third were estimated to be eligible for Medicaid, but not enrolled. Another one-third were estimated to be eligible for Health Choice. By September 30, 1999, 56,840 (80%) of the estimated 71,000 children potentially eligible for Health Choice were enrolled. By the end of June to early July 2000, those involved in administration of the Health Choice Program realized that the state would reach its budgetary cap by mid-year. Despite the estimated number of children

potentially eligible for NC Health Choice, as the program neared that number of enrolled children it became apparent that enrollment was not slowing down and that our projected numbers were incorrect. Since it is a non-entitlement program, legislative action was required to increase the budgetary cap. However, at that time, North Carolina began to experience a serious budgetary shortfall. At the start of the January 2001 session of the NCGA, North Carolina had enrolled 72,024 children in NC Health Choice and had been forced to freeze enrollment effective January 1, 2001. The NCGA, struggling with the budget shortfall, was unable to raise the cap on the SCHIP Annual Budget for FY01. Despite this setback, work continued to improve the Health Check/Health Choice enrollment and re-enrollment processes, and to minimize the negative consequences of a freeze on Health Choice enrollment. Various letters were developed during FY01 to explain the freeze and the waiting list to families. The 2001-2002 NCGA appropriated an additional \$8 million for SFY02 and \$12.5 million for SFY03 to provide coverage to up to 82,000 children. The freeze on new enrollment that went into effect in January 2001 was officially ended for new applicants on October 8, 2001. The 2001-2002 session of the NCGA also eliminated the Health Choice uninsured waiting period for all children. By July 1, 2002, there were 84,286 children enrolled in Health Choice and the Department announced that they would again have to freeze enrollment effective September 1, 2002. Families and local staff were notified through a variety of communications. At the same time, DHHS Secretary Carmen Hooker Odom asked the NC Institute of Medicine to convene a Task Force to develop options to ensure the long-term financial solvency of the program. Anticipating the NC IOM Task Force Report, the NCGA appropriated an additional \$7.74 million in non-recurring funds to keep the program open and cover 100,000 children in SFY03. The anticipated freeze on new enrollment was called off less than 48 hours from the implementation date, but word of the freeze had already been disseminated and had to be undone through outreach efforts.

The IOM Task Force made specific recommendations to the NCGA and DHHS on how to cover all eligible children and to avoid yet another freeze on enrollment. The first recommendation was that the NCGA should appropriate, on a recurrent basis, at least the current annual appropriations of \$45.1 million (includes the \$7.7 one-time non-recurring appropriation) for NC Health Choice. While the Governor's budget supports this recommendation, as there is not yet a final budget from the NCGA for FY04, it is unknown whether this recommendation will be accepted.//2004//

***/2005/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 a final report is expected in the fall which will translate into the first NC Public Health Improvement Plan to guide public health efforts in the next two to three years. 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 Interim Report can be found at the following URL:
<http://www.dhhs.state.nc.us/dph/taskforce/docs/TaskForceInterimReport.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.//2005//**

B. AGENCY CAPACITY

The Women's and Children's Health Section (WCHS) is comprised of four Branches, Children and Youth (C&Y Branch), Immunization, Women's Health (WHB), and Nutrition Services. The Section Management Team, which is comprised of the Chief, Deputy Chief, Special Assistant, and four 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. There have been a series of changes in the WCHS management team over the past two years. During that time, there has been turnover in the Section Chief, Deputy Section Chief, and within three of the Section's four branches (C&Y Branch, WHB, and Immunization). Most of these changes came because of the retirement or promotion of seasoned MCH professionals who had served NC for many years. The combination of these transitions, and the organizational changes associated with placement in a new Department and a new Division, has created an on-going series of challenges to the WCHS.

In addition to the four branches, the WCHS also houses the Office of Women's Health (OWH) and will soon house the Office of Genomics. The OWH was first placed in the WHB in FY98 when the Office

was created by the NC General Assembly and charged to plan and facilitate ways of improving women's health throughout the life cycle. The Office was moved to the State Health Director's Office in FY00. During FY01, the Office returned to WCHS and placed in the Section Office. While the OWH is currently vacant and a lack of funding continues to present major constraints, work has continued by WHB staff to continue to foster collaboration with other women's health agencies, such as the NC Primary Health Care Association, and to support applications for Depression Screening and Intervention and Interconceptual Counseling funds under the federal Healthy Start initiatives.

WCHS has received grant funding from the MCHB for the development of a comprehensive state genetics plan for NC that will both assess the state's current service provision system and position the state to meet the needs emerging from the revolution in genomics currently occurring. The grant will also support ongoing efforts to achieve earlier identification and early intervention for all children with special health care needs. This funding will run from June 1, 2001 through May 31, 2003. Funds will be used to hire a full time Project Manager who will become the head, and initially the sole member, of the Office of Genomics.

/2003/ As mentioned previously, the Early Intervention Branch (EI Branch) was moved to the WCHS in October 2001. This change increased the number of staff within WCH by approximately 350 and increased the WCH budget approximately \$45 million. The transfer of the Early Intervention (EI) program to WCHS has already begun to pay dividends through closer collaboration between EI and other WCH programs, particularly CSHCN. WCH staff are working hard to realize the synergies available to the state because of this organizational change; staff feel there are now great opportunities to serve children in these two programs more effectively and efficiently.

In process at the present time (7/02) is work on creation of a sixth branch, tentatively named the School Health Branch. This branch will pull together resources throughout the DPH that address school health issues in order to provide a more focused approach to this critical area. The most significant component of this reorganization will be the incorporation of the division's Oral Health Section into the new School Health Branch. Key oral health objectives will be retained, but in addition, many Oral Health staff will use their health education skills to promote a broader range of health issues of importance to the school age population. This plan is still in development, but has the support of the State Health Director, the Secretary of DHHS and the NC Senate. It represents an aggressive effort to strengthen our ability to improve the health and ultimately the learning readiness and academic achievement of the state's children, with a particular focus on the children attending the state's lowest performing schools.

The OWH remains unstaffed at this time. However, staff in the WHB continues to collaborate and strengthen relationships with other women's health agencies. The Office of Genomics has been moved out of the WCHS to the Health Promotion and Disease Prevention Section, however many staff from the WCHS will continue to serve as part of the matrix team helping to develop the genetics plan. The Project Manager began work in early June 2002.

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 86 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 15 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.

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.

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 sector, 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.

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 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.

/2004/ 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.

Instead of establishing a School Health Branch, a School Health Matrix Team (SHMT) was created 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.

WCHS is committed to ensuring that culturally competent care is provided to the populations it serves. One recommendation by DPH in their Health Disparity Implementation Plan was to "promote customer friendly services that meet the needs of underserved populations (i.e., low-income and minority groups)." Action steps that the WCHS came up with under this recommendation include continuing to provide culturally appropriate outreach materials, developing clear policies and strategies for serving people with disabilities, developing a family-friendly website for Health Check/Health Choice, promoting the use of non-traditional hours by service sites, and conducting customer service trainings to LHDs and community-based organizations.//2004//

/2005/Over the past year, the C&Y Branch has 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 has 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.

The WCHS has received continued funding for two federal Healthy Start projects covering nine counties in eastern and central NC. A renewal application was submitted for funding to cover the five counties in northeastern NC, but grants have not been awarded at this time.//2005//

C. ORGANIZATIONAL STRUCTURE

The North Carolina Title V program is housed within the North Carolina Department of Health and Human Services (DHHS) which 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). H. David Bruton, MD serves as Departmental Secretary. His term will end this year and a new Secretary will be appointed by the incoming Governor who will take office in January 2001.

The DHHS Assistant Secretary for Health and State Health Officer is Dennis McBride, MD, MPH. He has oversight of the three DHHS health divisions: Mental Health, Developmental Disabilities, and Substance Abuse Prevention; Facility Services; and Public Health. Dr. McBride is also serving as Acting Director of the Division of Public Health with the retirement of Dr. Ann Wolfe on July 1, 2000. The Division of Public Health (DPH) is comprised of the Director's Office and four Sections. The Director's Office houses units with Division-wide impact, including:

- State Laboratory
- State Center for Health Statistics
- Office of Chief Medical Examiner
- Office of Local Health Services
- Office of Healthy Schools
- DPH Budget Office
- DPH Personnel Office (staffed by DHHS Division of Human Resources)

Other programs and services are operated out of the four Sections: Epidemiology; Chronic Disease Prevention and Control; Oral Health; and Women's and Children's Health.

/2002/ Carmen Hooker Buell was appointed as Secretary of the Department of Health and Human Services (DHHS) by the new Governor, Mike Easley, in February 2001. She appointed Jim Bernstein, formerly the director of the Office of Research, Demonstrations, and Rural Health Development, as the Assistant Secretary for Health in April 2001. Also in April 2001, the State Health Director, Dennis McBride, was reassigned as a senior advisor to DHHS on public health policy and project development at the UNC School of Public Health. Serving as Interim State Health Director and Acting Division Director for the Division of Public Health is Dr. Leah Devlin, Chief of the Health Promotion and Disease Prevention Section.

/2003/ The Secretary of DHHS changed her name to Carmen Hooker Odom as the result of her marriage. Dr. Leah Devlin continues in her role as Interim State Health Director, but has been named permanent Division Director for the Division of Public Health.

/2004/ 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. 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, C&Y Branch Head is the CSHCN Program Director. While the completion of the MCH Block Grant requires collaboration from staff from all units of the WCHS, Section office staff assume coordinating responsibilities for its submission.

Organizational charts for DHHS and DPH are attached. *//2004//*

D. OTHER MCH CAPACITY

The Section employs over 550 staff members responsible for management and administration of programs and services for the MCH population. The Section does not currently have positions designated for parents of special needs children, however the Children and Youth Branch (C&Y) has an active Parent Advisory Committee that is utilized extensively by the Children's Specialized Services Unit. The Children and Youth Branch also channels funding through the Family Support Network at the University of North Carolina in Chapel Hill to 13 local family support programs. Local program coordinators attend PAC meetings, provide assistance to local child service coordinators, and help individual families.

/2002/ The Section is in the process of reconfiguring a system for assuring parental input into WCHS programs and policies. These activities are currently centered in the C&Y Specialized Services Unit and are related to the Children with Special Health Care Needs program.

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.

Deputy Chief - Dorothy Cilenti assumed the duties of Deputy Section Chief in December 1998. After completing an undergraduate degree in psychology (Duke University, cum laude, 1985), she earned masters degrees in social work and public health from UNC-Chapel Hill in 1989. She has held increasingly responsible positions in state and local public health agencies. Prior to joining the Women's and Children's Health Section management team, she served as Head of the (then) Maternal Health Branch.

/2002/ Ms. Cilenti left the Deputy Section Chief position in the fall of 2000. Peter Andersen assumed this position, which has been renamed the Section Business Operations Manager position, in March 2001. Mr. Andersen has a masters degree in Health Education from the University of Virginia (1976) and a masters in 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.

Special Assistant - Cheryl Waller serves as Special Assistant for Program Planning and Development. She completed her nursing education at the University of Rochester (NY) in 1975 and earned an M.P.H. from the UNC School of Public Health, Department of Public Health Nursing in 1978. Her public health and MCH experience includes work at the county, regional, state and Federal levels, where she has worked as a nurse practitioner, regional nurse consultant, and program consultant.

/2002/ Ms. Waller took a position as Unit Supervisor with the Children's Specialized Services Unit in the Children and Youth Branch (C&Y) in January 2001. The special assistant position was eliminated as part of organizational changes necessitated by major budgetary realignments and cuts in the spring of 2001.

Data Specialist/Needs Assessment Coordinator - At time of grant preparation, Section is in final stages of hiring new staff person to coordinate data and needs assessment activities for the Section. That process will be complete by the time of the HRSA Field Office review in August.

//2002/ Sarah McCracken began working as the Data Specialist/Needs Assessment Coordinator on July 1, 2001. 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.

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 Section Chief. 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.

//2003/ Early Intervention Branch Head - Duncan Munn worked as the Infant-Toddler Program Director from 1987 until 1999, when the Division of Early Intervention and Education was formed and he continued in this new agency in a similar position. Beginning in FY02, the Early Intervention Branch was made a part of the Women's and Children's Health Section and Mr. Munn now serves as its Branch Head.

//2004/ During FY03, the C&Y Branch established a Family Liaison Specialist position, with the expectation that this position would be filled by a family member of a child or adolescent with special needs. This position will be posted during FY04. The person in this position will serve as staff to the Family Advisory Council, which works extensively with the staff of the C&Y Branch. He or she will train, assist and advise 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. This individual will assist and advise WCHS families on an as-needed basis on issues related to children with special needs. //2004//

/2005/In FY04, reorganization continued in two of the branches of WCHS which should improve coordination of services throughout the Section. In addition, several new staff positions were established and/or filled that should benefit the Title V programs. Branch restructuring began in the C&Y Branch in FY03 resulting in the creation of six units: Specialized Services (SSU); Health and Wellness; School Health; Genetics and Newborn Screening; Access to Care; and Best Practices. Unfortunately, as a result of position freezes and a high degree of staff turnover due to retirement and attrition across the C&Y Branch, 3 of the 6 Unit Supervisor positions were vacant throughout all of FY03. Two of the other 3 Unit Supervisor positions - Specialized Services and Health and Wellness - were filled by veteran C&Y staff in the last quarter of FY03. At this time, the Access to Care Unit Supervisor position is still vacant, but new staff have been hired to supervise the School Health and Genetics and Newborn Screening Units. Two new positions have been created and filled in the SSU, the Family Liaison Specialist and the Transition Program Manager. The Family Liaison Specialist will serve as staff to the Family Advisory Council and assist and advise WCHS families on issues related to CSHCN while the Transition Program Manager will provide a programmatic focal point for transition and school health issues for CSHCN. The SSU has redefined, and is in the process of recruiting for, a vacant Social Work Consultant position which will serve as coordinator for the Medical Home Initiative for CSHCN in NC. Also, in October 2003, an individual was hired in a new permanent position to target Health Check/NC Health Choice outreach to minority populations and to support the C&Y Branch in efforts to administer programs in a culturally competent manner with the goal to eliminate health disparities. The Women's Health Branch reorganized slightly as well, returning to two units now called 1) Family Planning and Reproductive Health and 2) Perinatal Health and Family Support Services. Positions recently filled in the Women's Health Branch include an evaluator for Perinatal Health programs (newly designed position), a data coordinator for the Healthy Start Baby Love Plus projects (new position), a Nutrition Consultant, and the Baby Love Program Manager. A position for the Head of the Office of the Women's Health Network is being established at present with the hope that it will be filled in early FY05. The position will be responsible for activities and initiatives to improve the health system's ability to respond to the unique needs of women of all ages.

Statewide implementation of the Early Intervention Design Plan will occur in July 2004. During FY04, four pilot sites have already transitioned to the new design plan and much has been learned and shared from their experiences. One major step in the implementation of the plan occurred with the approval by the General Assembly of 278 positions for the Children's Developmental Service Agencies (CDSAs) to assume their responsibilities as the early intervention lead agency and primary provider of service coordination. Examples of different types of positions include service coordinators (Habilitation Specialist), service delivery program managers (Habilitation Program Supervisor), Quality Improvement Coordinators, Interpreters, Business Managers, and Reimbursement Clerks. The actual numbers and types of positions vary by CDSA. Starting dates for employments were in May for service program managers and throughout June for service coordinators. In addition, six staff support positions for the Regional Interagency Coordinating Councils (RICCs) were funded as contract positions through the Division of Child Development. Eighteen RICCs were established by the General Assembly, and they will be responsible for development of the regional early intervention design plan for a designated catchment area. The RICCs and CDSAs will work collaboratively within a catchment area to implement the plan to deliver services. In May 2004, three regional training/orientation conferences were held to provide a detailed perspective on the Early Intervention Design Plan and its implications for early intervention agencies and organizations, for the early childhood community, and for parents of children with special needs. The agenda included an update on the status of implementing the design plan and lessons learned from the pilot sites; roles and responsibilities of the major partners in the design plan; major system goals and planned performance measures for the NC Early Intervention System; and other system issues impacting early intervention such as the federal requirements that children under three with substantiated abuse/neglect be referred to early intervention.*//2005//*

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.
- Division of Educational Services. This is a newly created Division that houses services for the deaf and blind, and selected early intervention services. Management and oversight of the state's network of 18 Developmental Evaluation Centers was transferred from the Division of Public Health/WCHS to this Division in March 2000 to consolidate major early intervention programs in a single Division. At that time, an intra-agency work group was established to assure coordinated planning and implementation of DHHS early intervention services. Key staff members from WCHS are included in this workgroup. /2002/ The name of this Division was changed in FY01 to be the Division of Early Intervention and Education. The North Carolina General Assembly has directed that the early intervention programs shall be moved to WCHS in FY02.

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.)
- Children's Specialized Services 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.

/2003/ Per the direction of the General Assembly, the Early Intervention Branch was created in WCHS on October 1, 2001.

Coordination of WCHS with EPSDT, Other Federal Grant Programs, and Providers of Services to Identify Pregnant Women and Infants Eligible to Receive Title XIX

North Carolina expanded the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (which has been in existence since Medicaid began) to form the Health Check program in 1993. The DMA and WCHS work collaboratively to ensure the success of this program (described in other sections of the grant application), as well as with other programs serving pregnant women and infants eligible to receive Title XIX funds. As the WIC program is housed in the Nutrition Services Branch of the WCHS, collaboration is assured.

Coordination with Social Services Administration, State Disabilities Determination Services Unit,

Vocational Rehabilitation, and Family Leadership and Support Programs

As described earlier in this section, these programs are all housed in the same state department as WCHS, the NCDHHS. Thus, coordination among these programs remains strong.

Coordination with the Regional Poison Control Center

Carolinas Poison Center, a division of Carolinas Medical Center in Charlotte, North Carolina, is the designated Statewide Poison Center for North Carolina and certified as a Regional Poison Control Center by the American Association of Poison Control Centers. The WCH Section Chief, Dr. Kevin Ryan, met with Dr. Marsha Ford, the medical director of the Poison Control Center, in 2001, and identified several areas in which the two agencies could work together. These areas include:

1. Ensuring that the information concerning perinatal exposure to drugs, legal and illegal, provided through the state's 1-800-FOR-BABY hotline is communicated accurately and actively.
2. Providing local health department and health care providers with written information relating to perinatal drug exposure.
3. Working with the state network of perinatal and neonatal outreach educators/trainers to include poison prevention in their "menu of topics."
4. Providing local health department staff with training in the "Caution Curriculum."
5. Providing local health departments with specific poisoning exposure data that will allow them to effectively target poisoning prevention efforts in their counties.

//2004/ There were no major changes in coordination of services between state agencies in FY03, although ongoing budget constraints have promoted increased collaboration between agencies. //2004//

//2005/In 2004 the Division of Public Health obtained the support of NC DHHS Secretary Carmen Hooker Odom for use of the State Early Childhood Comprehensive Systems (SECCS) grant as a core vehicle for increasing coordination and collaboration within and outside the department with respect to early childhood issues. Secretary Hooker Odom also established the Children's Services Committee to address children's issues throughout the department, and this committee has chosen to focus its attention on early childhood systems issues, in large part because of the resources available through the SECCS grant and because of the work the WCHS has done relating to early childhood issues. Several WCHS staff are members of the Children's Services Committee, which is chaired by an assistant secretary of DHHS, Jackie Sheppard. The Children's Health Services Committee expects to use lessons learned from its analysis of early childhood issues to address systems challenges for older children and their families in future. WCHS expects that this initiative will allow North Carolina to make significant progress in addressing the critical issue of more seamless integration of health and human services for children and families.//2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

//2004/ Data are available for all of the Health System Capacity Indicators through a variety of sources, but primarily through the State Center for Health Statistics (SCHS) from birth files, hospital discharge records, Medicaid records, linked/matched datasets, and various surveillance systems. Specific information regarding each indicator is found below.

HSCI#1 - The rate of children hospitalized for asthma (10,000 children less than five years of age). Trend data for this indicator is very erratic as it has fluctuated between 81 and 61 per 10,000 children since FY95. 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. In addition to using hospital discharge data to monitor the prevalence of asthma in children, in 2000, the Asthma Alliance of North Carolina, in collaboration with its partners, one of which is the C&Y Branch, conducted an asthma prevalence survey of 192,000 seventh and eighth graders from public schools. The results of this point in time study continue to guide the work of the Asthma Program Manager working in the C&Y Branch and the Asthma Alliance.

HSCI#2 - The percent Medicaid enrollees whose age is less than one year who received at least one initial periodic screen. Data for this measure are provided by the Division of Medical Assistance. This percentage has steadily increased from 69% in FY94 to a high of 89% for FY02, which is consistent with trends in other Medicaid eligibility and participation rates.

HSCI#3 - The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen. Data for this measure have been harder to obtain due to the recent initiation of the program and ongoing work on the databases to be able to view data strictly on Health Choice enrollees. However, data are now available for FY00-FY02. The number of participants in Health Choice who are less than one year of age is very small as infants up to 185% of poverty are eligible for Medicaid, so Health Choice only picks up those infants between 185% and 200%. As with any rates based on small numbers, these rates are unstable and should be interpreted with caution.

HSCI#4 - The percent of women (15 through 44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. This percentage has constantly remained high at 88% for the past 10 years. Local health department maternal health services and strong collaborations between WCHS and the North Carolina chapter of the American College of Obstetrics and Gynecology have helped maintain these rates, as well as the Medicaid expansion which occurred in the late 1980s.

HSCI#5 - Comparison of health indicators for Medicaid, non-Medicaid, and all populations in the State. Data are available for 2002 for all of these indicators except for b) infant deaths, for which only 2001 data are available. In all of the indicators, outcomes for the Medicaid population are worse than the non-Medicaid population or the population as a whole.

HSCI#6 - The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women. The percentages reflected on Form 18 for this measure are current as of June 2003; however, there is discussion in the NC General Assembly to decrease some of these levels, which could negatively impact many women and children in NC.

HSCI#7 - The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. The Division of Medical Assistance provides these data. While there was an increase from 19.6% in FY01 to 28.4% in FY02, data from future years is necessary in order to tell if this increase will continue. 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. Since the task force released its report, nine of the 23 original recommendations show indication of being implemented.

HSCI#8 - The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs Program. 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, WHCS 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.

HSCI#9(A) - The ability of States to assure Maternal and Child Health to policy and program relevant data/information. It is fortunate for WCHS that the SCHS has a long history of linking data with infant birth certificates; thus, WCHS can answer all but one category with 3, that the agency always has this ability. The one data linkage that does not presently occur is that of birth records and newborn screening files. Currently, the Vital Records System Automation Project is underway which will probably move the Electronic Birth Certificate system from a DOS based system to a web based

system which should make a future linkage with birth records possible.

HSCI#9(B) - The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month. North Carolina participated in the Youth Risk Behavior Survey (YRBS) in 2001 and 2003, thus does have some data on adolescent tobacco use. In addition, North Carolina has also participated in the Youth Tobacco Survey sponsored by the Centers for Disease Control and Prevention (CDC) since 1999. This biennial survey provides data on many topics, including type of tobacco use, age of initiation, media awareness, youth access, and cessation behavior.

HSCI#9(C) - The ability of States to determine the percent of children who are obese or overweight. In addition to YRBS data on obesity and overweight, WCHS has instituted a Nutrition and Physical Activity Surveillance System which provides data on body mass index and health behaviors on children who have received child health or WIC services at a local health department or a school-based health center. One of the three primary components of the CDC grant-funded Healthy Weight Initiative in NC is to enhance this system and identify methods to increase the number of children included in the system.//2004//

/2005/ Data are available for all of the Health System Capacity Indicators through a variety of sources, but primarily through the State Center for Health Statistics (SCHS) from birth files, hospital discharge records, Medicaid records, linked/matched datasets, and various surveillance systems. Specific information regarding each indicator is found below.

HSCI#1 -- The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than five years of age.

The prevalence of current asthma in children is 13.9 percent (NC BRFSS 2002). NC Medicaid claims from 1997-98 provide comparable estimates with an overall prevalence for children 0-14 of 13 percent (Jones-Vessey, 2001). Trend data for this indicator is very erratic, as it has fluctuated between 81 and 61 per 10,000 children since FY95. 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. The state prevalence, hospitalization and mortality data indicate significant disparities by race/ethnicity, age, gender, and geography. In the overall population, nonwhites had a rate that was 4 to 5 times higher than whites; females were more frequently hospitalized than males; and young children, followed by seniors (over age 65), had the highest rates of hospitalization. Rural areas had higher hospitalization rates than urban areas, and eastern NC had the highest rates of any geographic region. The rate of hospitalizations was 2.75 times higher in nonwhite children (mostly African American) compared to white children. In 2000, the Asthma Alliance of NC, in collaboration with its partners, one of which is 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) shows 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 continue to guide the work of the Asthma Program Manager working in the C&Y Branch and providing staff support to the Asthma Alliance of North Carolina (AANC). The State Asthma Program office has been involved in community projects such as Tools for Schools, A is for Asthma and Integrated Pest Management to reduce children's exposure to asthma triggers. In addition, the Asthma Program Manager in partnership with the AANC has plans to develop a Comprehensive State Asthma Plan aimed at reducing the burden of asthma in North Carolina.

HSCI#2 -- The percent Medicaid enrollees whose age is less than on year during the reporting year who received at least one initial periodic screen.

Participation rates remained at 89% for FY03, equaling the highest rate since data was first reported for FY94. 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 obtaining services.

HSCI#3 -- The percent SCHIP (for NC, Health Choice) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

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.

HSCI#4 - The percent of women (15 through 44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

This percentage of women remains high at 87.5% for FY03. 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 Coordination (MCC) components. During FY03, the Baby Love Best Practice Pilot begun exploring and evaluating a standardized service provision process for Maternity Care Coordination and Maternal Outreach Worker services in eleven local provider agencies. The pilot has 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 is 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.

HSCI#5 - Comparison of health indicators for Medicaid, non-Medicaid, and all populations in the State.

Data are available for 2002 for all of these indicators except for b) infant deaths, for which only 2001 data are available. In all of the indicators, outcomes for the Medicaid population are worse than for the non-Medicaid population and the population as a whole.

HSCI#6 - The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

These levels have stayed consistent since the state SCHIP program, Health Choice, began in 1998. However, in cooperation with staff from DMA, the FPRHU is currently in the final phase in the implementation of a 1115(a) demonstration waiver. The Medicaid waiver will extend eligibility for family planning services to all women and men over age 18 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.

HSCI#7 - The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

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. While there was an increase from 24.4% in FY01 to 34.6% in FY03, data from future years is necessary in order to tell if this increase will continue. 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. Since the task force released its report, nine of the 23 original recommendations show indication of being implemented and some action has been taken on 61% (14) of the recommendations.

HSC#8 - The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs Program.

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.

HSC#9(A) - The ability of State to assure MCH Program Access to policy and program relevant data/information.

It is fortunate for WCHS that the SCHS has a long history of linking data with infant birth certificates; thus, WCHS can answer all but one category with 3, that the agency always has this ability. The one data linkage that does not presently occur is that of birth records and newborn screening files. Currently, the Vital Records System Automation Project is underway which will probably move the Electronic Birth Certificate system from a DOS based system to a web based system which should make a future linkage with birth records possible.

HSC#9(B) - The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

North Carolina has also participated in the Youth Tobacco Survey sponsored by the Centers for Disease Control and Prevention (CDC) since 1999. This biennial survey provides data on many topics, including type of tobacco use, age of initiation, media awareness, youth access, and cessation behavior. The preliminary data from the 2003 survey show that among middle school students there has been a 38% decrease in cigarette use (from 15.0 in 1999 to 9.3 in 2003), but among high school students current tobacco use has remained about the same between 1999 and 2003. There was a very high response rate among the schools and students participating in the survey in 2003, and there were over 6000 middle and high school students who responded from 216 schools in 87 school districts. North Carolina also participated in the Youth Risk Behavior Survey (YRBS) in 2001 and 2003 which provides further information about tobacco use in teens.

HSC#9(C) - The ability of States to determine the percent of children who are obese or overweight.

In addition to YRBS data on obesity and overweight, WCHS has instituted a Nutrition and Physical Activity Surveillance System (NC-NPASS) which provides data on body mass index (BMI) and health behaviors on children who have received child health or WIC services at a local health department or a school-based health center. One of the three primary components of the CDC grant-funded Healthy Weight Initiative in NC is to enhance this system and identify methods to increase the number of children included in the system. During FY04, much work has been done to enhance a screen on the health information system used by local health

departments in order to collect variables from a physical activity and nutrition behaviors questionnaire being used in local health departments to monitor trends. A working group which included DPH epidemiologists, UNC-CH faculty, nutritionists, and physical activity specialists developed the questionnaire. This group conducted a literature review for behavioral determinants of weight and then a national search for tested, validated questions on selected behaviors. The questions were then piloted in some local health departments and revisions made accordingly. The new data entry screen will be available to local health departments in July 2004.

Trend data in the NC-NPASS system shows that for almost every age group, 2 to 4 years, 5 to 11 years, and 12 to 18 years, there has been a steady increase between 1995 and 2003 in the percentage of children who were overweight (BMI-for-age percentile \geq 95th percentile) or at risk for overweight (BMI-for-age percentile \geq 85th percentile and $<$ 95th percentile). Overweight percentages in the 12 to 18 year age group have leveled off somewhat in the past four years but remain high at 26.5% in 2003. The 5 to 11 year age group is not much lower at 22.8%, and in the 2 to 4 year age group, 14.4% of children were overweight.//2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

/2004/ 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. //2004//

/2005/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.//2005//

B. STATE PRIORITIES

The current list of priority needs was developed in 1998, based on review of the 1995 needs assessment, and existing priorities (including gubernatorial and legislative initiatives) for each Section. These priorities will remain in place pending in-depth review of the NC Comprehensive Child Health Plan (our five-year needs assessment), and development of WCHS response. Current priorities are:

1. Strengthening public health infrastructure at state and local level.
2. Improving pregnancy outcomes for all women.
3. Assuring access to care for low income, uninsured and other vulnerable segments of the MCH population.
4. Improving availability and quality of health and health education services available in school settings.
5. Improving nutrition and fitness among children and adolescents.
6. Reducing occurrence and severity of injuries (particularly unintentional injuries) among children and adolescents.
7. Reducing unintended pregnancies
8. Improving childhood immunization coverage (through full implementation of a statewide computerized tracking system)
9. Enhancing monitoring, consultation and technical assistance to regulated child care centers to assure conditions that protect and promote health status of children
10. Assuring coordination of existing and planned home visiting and family support services

/2002/ Based on further review of the NC Comprehensive Child Health Plan (our five-year needs assessment), the list of priority needs has been slightly modified during FY2001. The following list is the revised list of priority needs (also found in Form 14).

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.

/2004/ Tables I, II, III, and IV are attached and show the following relationships between priority needs and national and state performance measures:

Table I - Relationship Between Priority Needs and WCHS Activities

Table II - Relationship of National Performance Measures to Priority Needs

Table III - Relationship of State Performance Measures to Priority Needs

Table IV - Relationship of National Performance Measures to State Performance Measures //2004//

/2005/Tables I, II, III, and IV are attached and show the following relationships between priority needs and national and state performance measures:

Table I - Relationship Between Priority Needs and WCHS Activities

Table II - Relationship of National Performance Measures to Priority Needs

Table III - Relationship of State Performance Measures to Priority Needs

Table IV - Relationship of National Performance Measures to State Performance Measures//2005//

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

/2005/Newborn screening for hypothyroidism has been implemented as planned in order for each infant screened to receive T4 and TSH screening simultaneously. Evaluation of cut-off levels for abnormal screens continues to be discussed by the State Laboratory for Public Health with the Newborn Metabolic Screening Advisory Committee. Tandem mass spectrometry (MS/MS) has been implemented as well for all infants born in North Carolina. Information about newborn screening is available on the website for the State Laboratory for Public Health (<http://slph.state.nc.us/>)

Initial planning has begun to develop a database for Sickle Cell Counseling. Analysis of the database developed for newborn hearing screening has shown it to be a model that can be used for this development. Further development of the newborn hearing screening database will include high-level planning for the sickle cell database. Investigation of the same type of high-level planning for a genetic counselor database will be completed.//2005//

b. Current Activities

/2005/A coordinator for follow-up activities for newborn metabolic screening was hired in September 2003. This coordinator uses data provided by the State Laboratory for

Public Health to track infants who have abnormal results on screening for Congenital Hypothyroidism (CH), Congenital Adrenal Hyperplasia (CAH), and Galactosemia. The infant's health care provider is called and the report of an abnormal screen is made, along with recommendations for further screening, testing, and care (e.g., through connections to an endocrinologist or metabolic specialist). Data for the first six months of these activities are being compiled into a summary report that will indicate the numbers of infants followed as well as the number of infants with confirmed conditions and receiving treatment. Protocols for follow-up coordination for Congenital Adrenal Hyperplasia (CAH) will be complete by the end of the fiscal year. Protocols for follow-up coordination for Galactosemia have been through an initial draft and review. The coordinator is also working with regional genetic counselors on collaborative efforts for public awareness and education regarding newborn metabolic screening. A job description for the coordinator has been developed, based on the activities noted.//2005//

c. Plan for the Coming Year

/2005/Newborn screening will continue with additional attention paid to revision of abnormal cut-off levels for Congenital Hypothyroidism. Initial data indicates over 500 infants followed for Congenital Hypothyroidism (CH) during the November 2003-March 2004 time period, as compared to less than 20 each for Congenital Adrenal Hyperplasia (CAH), and Galactosemia. Further examination of these data will be performed. In addition, the follow-up protocols for Galactosemia will be completed.

Collaboration between the coordinator for newborn metabolic screening and the regional genetic counselors will continue to be developed as educational presentations and materials are developed regarding newborn screening and genetic conditions. Coverage for follow-up coordination activities when the coordinator is away will be implemented through training of regional genetic counselors. The coordinator will be responsible for development and implementation of this training. The Unit Manager will continue to help focus efforts on outcomes for the program, including evaluation of data, protocol, and coverage implementation.

Investigation of database development for newborn hearing screening, sickle cell counseling, and possibly genetic counseling will continue.//2005//

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)*

a. Last Year's Accomplishments

/2005/During FY03, Family Advisory Council (FAC) members increasingly participated in C&Y Branch, EI Branch, and interagency work groups and committees. Members contributed to the development of a plan for the recycling of assistive technology equipment; early development of a toolbox of parent resources for EI service coordinators; revisions to the Infant-Toddler personnel certification system; design and implementation of a medical child care demonstration project; and consultation on various aspects of the statewide EI system redesign plan. They also educated staff and each other through sharing their own stories. Of great significance, the FAC reviewed and provided input into the Family Liaison Specialist and EI Service Coordinator draft job descriptions and engaged in advocacy efforts around pertinent policy/legislative issues. Two FAC members participated in the annual AMCHP meeting. Another member served on the advisory board of the Early Intervention in Neonatal Intensive Care Units

project and represented the EI Branch at a Focused Monitoring and Parent Involvement Forum in Louisville, KY. A member of the FAC took a lead role in working with staff of Exceptional Children's Assistance Center (ECAC) and WCHS to strengthen the Family Voices presence in NC. Council members received a stipend for time spent in meetings and other FAC-related assignments as well as mileage reimbursement. In addition, the diversity of the FAC was increased with the addition of several new members.

The Family Liaison Specialist position was established and filled. The position has been designed to serve as staff to the FAC and assist and advise WCHS families on an as-needed basis on issues related to CSHCN. She will also train, assist and advise staff on the development and promotion of family related issues such as family perspectives, family centered care, care coordination, transition planning, medical home and educational/community resources.

Family Voices continued to be administered by a staff member of ECAC with the assistance of a volunteer coordinator.

In addition to the FAC, other mechanisms within WCHS provided opportunities for family involvement. Parents of CSHCN continued to represent the family perspective on the NC Commission on CSHCN.

The toll-free Help Line for Children with Special Needs continued to be an avenue for receiving input from family members and a source of information for families and providers. Summary data on calls are 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 continued to be in key NCODH staff positions and engaged as consultants and trainers. The Office's initiatives to improve access to health promotion and disease prevention services positively influenced systems of care for CSHCN.

//2005//

b. Current Activities

/2005/In FY04, the Family Liaison Specialist position was filled with an exceptionally qualified individual who has extensive background in family advocacy and family involvement. In addition to being a parent of two children, one of whom has special health care needs, this individual served in a parent training/technical assistance role for over 8 years with the NC Exceptional Children's Assistance Center. Through the help of the Family Liaison Specialist, family involvement across programs and initiatives within the C&Y Branch has been increasing. An additional focus of the Family Liaison Specialist has been collaborating with key C&Y Branch staff engaged specifically in efforts to eliminate racial, disability and ethnic disparities.

The FAC has continued to develop its roles of advising, planning, and advocacy. Particular activities have included working with stakeholders to strengthen Family Voices and working with C&Y Branch staff on the development of logic models for the WCHS Core Indicators. In addition, a major objective was the development of strategies for expanding parent/family participation at the local and regional levels in issues related to children with special needs. Leadership development has also continued to be an outcome of Council activities. As the present co-facilitators prepare to rotate out of these leadership positions, other Council members are preparing to assume these roles.

Also in FY04, the NCODH has continued to provide technical assistance and support toward ensuring a life span oriented approach to both C&Y Branch and DPH health

promotion and service delivery initiatives. Adults with disabilities have continued to provide insight and guidance as to how services can be improved for children and adolescents with disabilities and chronic health conditions. The NCODH has 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.//2005//

c. Plan for the Coming Year

/2005/During FY05, leadership for proceeding with NPM#2 and components of Outcome Measure #1 in the SSU Logic Model will be provided by the new Family Liaison Specialist. In addition to the FAC, she will assemble teams of internal and external advisors to assess what has been accomplished to date and the extent to which additional need assessments should be undertaken. Funding has been budgeted for grassroots involvement and for the first Annual FAC Planning Retreat. Specific outputs for the coming year include the following:

- Utilize input from the WCHS FAC on an ongoing basis in developing policy within the C&Y Branch;***
 - WCHS FAC members and other family members of Children and Youth with Special Health Care Needs participate in planning, implementation and evaluation of Branch and Section programs and initiatives on an ongoing basis;***
 - Conduct an assessment of how state CSHCN programs are engaging parents as partners and report findings to the WCHS FAC by the end of FY05. Explore linkages to the EI Branch efforts on family involvement data as part of this assessment;***
 - Develop, expand, and review/revise strategies and mechanisms that assure that FAC members function as liaisons between parents in local communities and the C&Y Branch;***
 - Ensure annual attendance of parent representatives at the AMCHP Annual Meeting;***
 - Develop and 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 CSHCN 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 to be responsible for the following:***
 - 1. Determine the racially/ethnically/culturally and linguistically diverse groups served by the CSHCN Program.***
 - 2. Identify and begin collaboration with consumers, community-based organizations and informal networks of support to identify benchmarks/standards and develop new approaches for delivering family-centered care in a culturally and linguistically appropriate manner.***
 - 3. Conduct an organizational cultural competence self-assessment in conjunction with other Units of the C&Y Branch.***
 - 4. Conduct an assessment of current C&Y Branch direct service practices regarding cultural competence, and identify ways to share effective strategies and enhance efforts.***
 - 5. Develop a mission statement for the CSHCN Program that commits to cultural competence, being family centered, access and inclusion as integral components of all of its activities.***
- Finally, the SSU will develop an integrated and complementary work plan for family involvement with other key SSU initiatives including but not limited to Medical Home and Transition by the end of FY05.//2005//***

a. Last Year's Accomplishments

/2005/In FY03, Power to the Parent Workshops were conducted in four regional sites. As part of the training, parent participants received materials that could be used to replicate the training in their own communities. Simultaneously, workshops targeting pediatricians and family physicians were held to provide information on the state's early intervention system and the importance of regular developmental screening. Elements of the medical home training were incorporated into these sessions as well. Enrollment in Medicaid and Health Choice continued to climb in FY03. CSHS continued in its role as the prior approval agent for DMA when mobility devices were recommended for CSHCN enrolled in Medicaid. CSHS also continued to provide prior approval for wrap-around services (services for children with special health care needs that are outside of the core package for the NC Health Choice (SCHIP) Program).

Toward the end of CY02, the lead SSU staff member coordinating Medical Home efforts for CSHCN in NC went out on maternity leave and subsequently resigned. That position remained frozen through the end of this reporting period. Additional critical positions in the SSU were also vacant during this period, precluding additional progress on Medical Home objectives. This was also the time that the National Initiative for Children's Healthcare Quality (NICHQ) issued an invitation to participate in the Medical Home Learning Collaborative; however, full NC CSHCN participation was not possible until the FY04./2005//

b. Current Activities

/2005/The NC Medical Home Initiative for CSHCN was reinvigorated during FY04 with SSU staff making this a priority area of focus for planning, collaboration and resource development. Conceptually, the NC Medical Home Initiative integrates with the existing Title V and primary care infrastructure and uses processes and approaches with demonstrated efficacy in building systems of care for children and their families in this state. This Initiative can be segmented into eight dimensions of complementary planning including:

- Title V Staff support**
 - Advisory Board to the Medical Home Initiative for CSHCN**
 - Public Education Campaign**
 - Parent Training and Education**
 - Provider Training and Education**
 - Demonstration Project through Chapel Hill Pediatrics**
 - Demonstration Project through the NC Office of Research, Demonstrations, and Rural Health Development (NCORDRHD)**
 - Linkage with the Medical Centers that house pediatric residency programs.**
- The SSU has redefined (and is in the process of recruiting for) a vacant Social Work Consultant position which will serve as coordinator for the Medical Home Initiative for CSHCN in NC. Interviews are scheduled to take place in May 2004.**

During this period, the SSU Unit Manager has worked intensively with the NICHQ and the NC Pediatric Society to develop and provide training for providers regarding Medical Homes for CSHCN. In addition, she has been engaged in negotiations with key collaborators. Major accomplishments to date include the following:

- Continuing to support the work done at Chapel Hill Pediatrics. The practice team there has participated in a 15 month Learning Collaborative on implementing the concepts of Medical Home for CSHCN in a primary care pediatric practice.**
- Collaborate with the NCORDRHD to begin negotiating how Community Care of NC**

networks can develop capacity to support their network of community-based practices to serve as Medical Homes for CSHCN. Guilford Child Health has agreed to be the first Community Care network accepting this challenge. Engaging one network as an initial partner and then expanding to other sites is the process historically used by the NCORDRHD in introducing innovation in the Community Care networks.

-Negotiate a contractual scope of work with the NC Healthy Start Foundation to develop additional Medical Home Campaign materials for use in the Health Choice/Health Check project sites and in the state "The Right Call Every Time" Campaign. This initiative will focus on the integration of CSHCN into the existing campaign and also develop other specific educational resources for parents of CSHCN.

-Develop a contractual scope of work with the Family Support Network-NC to expand capacity to train parents on different aspects of promoting the Medical Home Initiative for CSHCN.//2005//

c. Plan for the Coming Year

/2005/During the upcoming year, the SSU Manager will continue to dedicate .10 FTE to ensure integrated development of medical home and other systems building activities for CSHCN. The Family Liaison Specialist will serve on the Advisory Board to the Medical Home Initiative for CSHCN and ensure a family-centered approach at the state and community level in conjunction with the FAC and the Family Support Network-NC. The SSU Transition Program Manager, the CSHCN Medical Director, the Health Check/Health Choice Minority Outreach Consultant and the Health Check/Health Choice Clinical Coordinator will have medical home project activities integrated into their work plans in FY05.

The administrative and advisory structure for the Medical Home Initiative for CSHCN will be formalized during FY05. This will be accomplished by engaging the NC Commission on CSHCN to embrace Medical Home as part of its official charge, and through developing an Advisory Board for the Medical Home Initiative for CSHCN in NC. Additional activities will include:

-Contract with Chapel Hill Pediatrics to continue the Medical Home project there.

-Provide funding to the NCORDRHD to facilitate the development of Community Care of NC (previously referred to as Access II/III) networks in developing capacity to serve as Medical Homes for CSHCN.

-The NC Healthy Start Foundation will launch the new Medical Home Campaign materials through "The Right Call Every Time" Campaign. This initiative integrates CSHCN into the existing campaign which emphasizes selection and support of a Medical Home for children on the Health Choice and Health Check Programs in NC. Additional educational resources for parents of CSHCN are also slated to be designed.

-The Family Support Network-NC will begin training parents on different aspects of promoting the Medical Home Initiative for CSHCN. This will include integrating educational information and referral resources on Medical Homes for CSHCN into the Central Directory of Resources and toll free hotline and website and serving as a trainer, mentor and coordinator for parent team members of community-based practices participating in the Medical Home Initiative for CSHCN. Staff of the Family Support Network-NC, the C&Y Branch and the NC Family Health Resource Line will collaborate around database development issues in relation to the State's Medical Home Campaign directed toward all children.

-The SSU Social Worker will work with the C&Y Healthy Child Care Consultant to provide education to child care providers and with the CSC Program Manager to provide education to CSC staff in local health departments regarding Medical Home for CSHCN.//2005//

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)*

a. Last Year's Accomplishments

/2005/During FY03, outreach efforts to provide health insurance to CSHCN continued (see NPM#13). The UNC Sheps Center study survey results were analyzed and released in a report entitled "A Cross-Insurance Comparison of NC Children with Special Health Care Needs." Primary findings showed that Health Choice appears to provide better access to services for CSHCN than does Health Check and is comparable to that of the State Employees' Health Plan(SEHP). For those children in need of medical equipment and supplies, Health Choice had the most barriers to accessing these items. Other key findings include reported access to medical care, both general and specialty care, was relatively good for children in all three programs; few children had no general provider; and about half received care from a medical specialist. Other important findings specific to children on Medicaid were that they were most likely to be reported to be in less good health by their parents; were significantly more likely to be reported as in need of specialized therapies; faced the greatest barriers in accessing needed dental care; had more logistical problems with transportation and inconvenient office hours; were significantly more likely to have problems accessing ADD/ADHD or mental health/substance abuse services; and were more likely to receive care in the public sector than were children in either of the other insurance groups. Finally, the study found that children in the Medicaid group used the emergency department (ED) more frequently than did children in the other two insurance groups, with use being the lowest among children enrolled in the SEHP. Parental report of the reasons for such use indicate the need for more extensive primary care coverage, parental education, and family-friendly office policies such as evening and weekend hours.

For CSHCN, having insurance that covers a good benefits package is a critical factor. The integrated programmatic approach adopted in NC for Medicaid and Health Choice has allowed our state to continue to create positive change for children insured in both publicly sponsored programs. Since the benefits package for Health Choice was modeled to match those in the Medicaid program (Health Check), it is assumed that CSHCN participating in either Health Choice or Health Check have a source of insurance for comprehensive primary and specialty care.

Outreach efforts for Medicaid and Health Choice were slowed during FY03 as the Health Choice Minority Outreach Coordinator and the Health Choice Special Needs Program Manager positions were both vacant. In spite of this, informational articles were included in newsletters, materials were made available to family agencies, and presentations were made to families and health care providers. Staff partnered with organizations serving CSHCN to let families know about the free or low cost insurance available through these plans and about the rich benefits package available.//2005//

b. Current Activities

/2005/During FY04, WCHS has continued to use the results of the Sheps Cross-Insurance study to determine how the Health Check and Health Choice Programs can be improved to better meet the needs of CSHCN. Differences between Medicaid, Carolina Access, and Health Choice have been further assessed in the context of the NC Medical Home Initiative. Carolina Access was established for the primary purpose of creating linkages for most Medicaid children to a medical home. Children are linked at the time of enrollment or re-enrollment for Medicaid benefits. While this did not assure the level of coordination associated with the federal definition of a medical home, it did serve as an

important structural element in building a system of care for most Medicaid eligible children. Prior to the program, most children had to seek primary care from the ED. In contrast, Health Choice is a fee-for-service open indemnity program. Enrollees are free to choose any provider willing to accept Health Choice. No legislative provisions were made for establishing a medical home, and this has served as a challenge in assuring that enrollees are linked to a primary care provider who can serve as a medical home. The Medical Home Campaign currently under development (see NPM #13) is intended to strengthen early linkages to primary care providers.

NC has made several important attempts to identify CSHCN in the Medicaid Program. In 2000, the Living with Illness screening questions were included in the HC/NCHC Application. The hope was that parents would complete this at the time of application and allow for a flagging mechanism to be entered along with enrollment data into the Eligibility Information System. Unfortunately, the experience to date has been that this section of the application has not been consistently completed. In lieu of these data, DMA has been forced to rely on the federal operational definition of CSHCN, or 13% of the Medicaid population of children who meet the criteria which includes the following categories: blind/deaf, out of home placement, SSI eligible, on Health Choice and having mental retardation. Currently, DMA is conducting a retrospective chart audit of Medicaid child recipients to assess the prevalence of children meeting the above definition.

To improve the quality of the HC/NCHC mental health benefit, WCHS led an effort to redefine the standards for who can provide Level III Group Home Care. Concerns had been raised about the high cost of Level III Group Home Care and about the quality of services these homes delivered.

The Special Needs Toll-free Helpline continues to be the focal point for information on state and local programs and resources for CSHCN. From October 1998 (kickoff for our state's SCHIP) through March 2004, the Helpline handled 11, 251 calls. For the majority of callers, health insurance issues are central to the conversation.//2005//

c. Plan for the Coming Year

/2005/ During FY05, leadership for proceeding with NPM#4 and components of Outcome Measure #1 in the Specialized Services Unit (SSU) Logic Model will be provided by the Access to Care Unit Manager (to be filled) in collaboration with the C&Y Branch Head and the SSU Manager. He/she will collaborate with internal and external partners, including the Commission for CSHCN, to assess what has been accomplished to date in NC and the extent to which additional assessments of need should be undertaken. Specific outputs for the coming year include the following:

- Collaborate with the Access to Care Unit to evaluate the number of CSHCN who have inadequate or no insurance coverage. Use the information found in the January 2003 study from the Sheps Center and utilization data from Medicaid and the SEHP;**
- Assure integration of CSHCN coverage into insurance studies undertaken by the SCHS;**
- Collaborate with the NC Interagency Coordinating Council (NC-ICC) on the promotion of insurance legislation for children in early intervention;**
- Collaborate annually with consumers, community-based organizations and other stakeholders, including the Commission on CSHCN and the FAC, to identify and advocate for third party coverage of services required for CSHCN, as well as provide support for reasonable fees and reimbursement policies for services already covered;**
- Continue clinical and programmatic review of requests for CSHS/POMC Program, metabolic requests, the Health Choice Special Needs Program, and the Assistive Technology funds.**
- Collaborate with the Access to Care Unit and the Commission for CSHCN to assess the needs of Youth with Special Health Care Needs age 18 and older for ongoing health care**

coverage; and

-Promote increased awareness of the importance of health insurance for young adults with special health care needs above age 21 in being able to pursue employment, secondary education and independent living on an ongoing basis.//2005//

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)*

a. Last Year's Accomplishments

/2005/During FY03, funding cuts to the Community Transition Coordinators program occurred. The program office worked with CTC staff to train other staff in the hospitals to assist in screening children who are admitted or born there. Stronger family support programs in the hospital have been encouraged to assist families with understanding and becoming linked with both the EI and CSC programs prior to discharge. Policy revisions regarding referrals and linkages to the EI and CSC programs were implemented and training occurred for CTC staff. In addition, training for pediatric practices across the state was implemented to ensure that referrals for services are made through the medical home.

Also in FY03, funding was received from both the Duke Endowment and NC Smart Start to implement EI programs in seven of the major hospitals in the state. The CTCs were the primary link between the hospital and the EI community-based system. Orientation programs for the Hospital Early Intervention staffs occurred and will be ongoing.

The CSC program underwent major changes during FY03. The Health Insurance Portability and Accountability Act (HIPAA) regulations made changes in billing necessary to conform to national CPT coding. This required revision of policies within the program to ensure that all services continued to be available to families. Significant training and re-training for CSC staff in local health departments and other community-based agencies has been required. Definitions of Risk Indicators and Diagnosed Conditions were revised, although they have not received formal approval from DMA. CSHS clinics, ATRCs, and the Special Needs Helpline services continued throughout FY03. Also, a position description for a Family Liaison Specialist was developed to integrate family perspectives for children with special needs broadly across these programs.//2005//

b. Current Activities

/2005/During FY04, the NC Early Intervention system has been piloting major changes in four of the state's DECs (now known as Children's Developmental Services Agencies - CDSAs) as they become the primary portal of entry for children into the EI system. The CSC Program continues to serve children at risk for developmental delay and the CDSA provides the required Early Intervention services through a network of contracted providers for those children eligible for early intervention.

The Hospital Early Intervention programs began operation July 1, 2003, with project development occurring over the fiscal year. The Advisory Board will continue to meet to ensure that these programs are working closely with community based services.

Also in FY04, the CSC program policies were reviewed in conjunction with DMA, and are in the process of being revised. The CSC Program has begun sending out CSC Updates to community-based staff regarding program interpretation and practice. This has been

extremely well received by local management and direct service staff. The program continues to work with DMA to implement the revised definitions to Risk Indicators and Diagnosed Conditions, along with a revised Identification and Referral Form.

Further evaluation of CSHS Clinics, the ATRC programs, and the Special Needs Helpline is ongoing in the context of C&Y Branch re-organization and the development of the Logic Models. A new priority that has been established is to work with the ATRCs and the Regional Physical Therapy staff on the development of a program to re-cycle Assistive Technology Equipment. Another initiative that has begun is to revise the CSHS Administrative rules. Finally, in order to assure more opportunity for family input, a Family Liaison Specialist was hired in February 2004. This has already resulted in significant improvement in the integration of parents and family members in the development, implementation and assessment of programs and policies and systems of care.//2005//

c. Plan for the Coming Year

/2005/ During FY05, leadership for proceeding with NPM#5 and components of Outcome Measure #1 in the SSU Logic Model will be provided by a number of individuals within the C&Y Branch. Specific outputs for the coming year include the following:

-An in-depth analysis of the NC SLAITS data for CSHCN will be undertaken to determine characteristics associated with comprehensiveness and satisfaction with systems of care among NC CSHCN.

-Ensure consistent SSU participation and/or staff support to the following: the Commission for CSHCN, the NC Pediatric Society, NC Partnership for Children, Family Resource Health Line, Family Support Network, ECAC, NC Developmental Disabilities Council, State Collaborative for Children and Families, the Early Childhood Comprehensive Systems Grant Task Force, and the Behavioral Health Committee.

-Work with the NC-ICC and its committees (e.g., Children and Families, Transition, etc.) to improve services for children age 0-5 with special needs and their families.

-Participate in and provide leadership, technical support, and resources to statewide family support/family involvement initiatives.

-Develop, expand, and review/revise strategies and mechanisms that assure that FAC members function as liaisons between parents in local communities and C&Y.

-Work with a wide variety of stakeholders and partners to plan and implement the statewide Early Childhood Comprehensive System Planning Grant.

-Identify specific strategies and mechanisms for enhancing prevention, intervention and treatment for CSHCN through the Healthy Childcare and Medical Childcare initiatives, the School Health Initiative, well child and adolescent clinics, Children's Special Health Services clinics, Children's Special Health Services Rules, Purchase of Medical Care, and other CSHS Programs.

-Identify and strengthen the age-specific activities and strategies that the CTC Program, Special Infant Care Follow-Up Clinics, CDSAs, and CSC Program contribute to a coordinated system of prevention, intervention and treatment for CSHCN.

-The CSC Program will be available on an ongoing basis in every county via the Local Health Department or other provider to offer case management/care coordination for families of children at risk for or diagnosed with developmental delays.

-Evaluate and revise the CSC Program through the revision of the DMA Bulletin.

-State and Regional Consultants will improve the service system through consultation, technical assistance and training by increasing awareness among families, private therapists, and provider agencies regarding resources that are available at the state and community level and how to access those supports on an ongoing basis.

-Partner with a variety of private and public agencies/organizations support cultural diversity training and other means of assuring that families receive family centered, accessible, inclusive and culturally sensitive services on an ongoing basis.//2005//

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

/2005/During FY03, the SSU and C&Y Branch proceeded further with reorganization. In the context of major transitions in Branch leadership, the strategic planning process in Specialized Services was slowed dramatically due to staff changes. WCH leadership, C&Y Branch staff, the Family Advisory Council, and other key constituency groups such as the Commission for CSHCN continued to be extremely supportive of the new leadership and organizational model.

One key area where successful advocacy occurred during FY03 was in regard to the NC DHHS focus on Eliminating Health Disparities. This initiative, one of the DHHS Secretary's four departmental priorities, was initially focused only on racial and ethnic minorities. 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 plans submitted by DPH programs and other DHHS divisions.

Another component of transition related work that staff contributed to during this FY was assisting vocational services and developmental disability services at the state and community level with transition and youth leadership development activities. This included participating in the development of a transition related grant with the Division of Vocational Rehabilitation. The C&Y Branch advocates for inclusion of a health perspective in these more vocational and independent living oriented initiatives. Similarly, staff have participated in coalitions such as NC Partners for Active Youth, and have successfully influenced policy development and programmatic initiatives to be more inclusive of youth with disabilities. For example, in developing a "walk to school" initiative, staff were consulted to ensure that the needs and experiences of youth with mobility and other disabilities would be addressed. NCODH staff also participated in focus groups and informational interviews with the CDC to help inform national physical activity efforts and health promotion to be disability inclusive. Staff have also continued to compile transition resources for youth, parents, and health care providers. In particular, efforts to identify and modify information for youth with disabilities have been made during this period./2005//

b. Current Activities

/2005/During FY04, there has been strong, sustained commitment within the NC CSHCN Program and the C&Y Branch to provide a greater focal point for transition services and diffuse transition responsibilities across the Branch. As anticipated, one of the vacant positions in the SSU was redefined to provide a programmatic focal point for transition and school health issues for CSHCN. This position, Specialized Services Unit Transition Program Manager, is being given lead responsibility for implementation of Goal 5 in the SSU Plan and for engaging collaborators both within and external to the WCHS in addressing this national performance measure. An individual with strong public health background and experience in health disparities as they affect youth was hired for this position and began in late April 2004. In addition, several other critical positions in the C&Y Branch, such as the Family Liaison Specialist, the Health Choice Program Manager for CSHC, and the new NCODH Program Consultant all have transition as a component of their job responsibilities.

The C&Y Branch continues to benefit from the expertise, health communications, and technical assistance resources of the NCODH program which is housed in the Branch. The NCODH has continued to provide consultation to WCH staff on the ADA and universal design of health care, fitness and health promotion environments. Adult disability consultants and staff with the NCODH have also actively participated in the planning of transition related initiatives, to further ensure a disability focus shaped by principles of independent living and self determination. NCODH staff have also provided consultation and technical assistance to the NC Developmental Disabilities Council as it further develops demonstration efforts in youth leadership development and access to health care. Additional emphasis has been on continuing to work with the School Health Program and other C&Y Branch initiatives to increase their ability and effectiveness in including youth with disabilities within state and community health promotion and health education activities. This will also include risk reduction initiatives such as those focused on obesity prevention and promotion of physical activity (e.g., Healthy Weight Initiative, Move More, Eat Less, and NC Partners for Active Youth). Activities to promote medical homes for CSHCNs, targeted toward both health care provider and parent audiences, has continued to include a focus on transition. The C&Y Branch is using baseline data from the SLAITS national survey in planning transition efforts and further galvanizing support for addressing health transition more comprehensively in NC. Finally, the WCHS and the C&Y Branch are continuing to use the DHHS focus on Eliminating Health Disparities as a platform for disseminating information and technical assistance as to strategies for improving outreach, access, and inclusion of the disability population in health and human services.//2005//

c. Plan for the Coming Year

/2005/During FY05, leadership for proceeding with NPM#6 and Outcome Measure #2 in the SSU Logic Model will be provided by the new Transition Program Manager. 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 of need should be undertaken. If indicated, funding has been budgeted to conduct community forums/focus groups on transition. A review of state programs and resources in regard to transition services and supports for youth will be conducted. Transition materials, curricula and tools will be compiled and efforts to make these resources available to various MCH constituents (including families, youth and medical providers) will be initiated. Health related transition for NC youth with special needs is the focus of Outcome Measure #2 of the SSU Logic Model. Specific outputs for the coming year include the following:

- Review the focus group report on youth and young adults with special health care needs to assess how the recommendations can be met through transition activities sponsored by SSU;**
- Synthesize the current information and the types of transition supports that are being provided (in NC and through other Title V/CSHCN Programs) and engage C&Y Branch staff in better defining how the different units can contribute to transition planning for Children/Youth with Special Health Care Needs;**
- Identify strategies for DPH to support efforts of the NC Pediatric Society and the NC Medical Society regarding transition for C/YSHCN;**
- Explore the accessibility, beginning with other WCH/DPH Programs such as Family Planning or Prenatal Care, for young adults with special health care needs, and make recommendations to improve policies, programs, and public education;**
- Provide staff support and resources to consumers, agencies, providers and community-based organizations for consultation and technical assistance about transition issues related to therapy, durable medical equipment and assistive technology; and**

-Assess the need and approaches for establishing youth/young adult/family advisory structures for the SSU Transition Initiative.

Finally, the SSU will develop an integrated and complementary work plan for transition with other key SSU initiatives, including but not limited to Medical Home and Family Involvement, by the end of FY05.//2005//

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.*

a. Last Year's Accomplishments

/2005/The FY 2003 NIS results showed that NC coverage remained high as 85.6% 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 FY03 included work with LHDs to raise rates by using the Clinical Assessment Software Application files that are sent bi-monthly. Also, LHDs 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 FY03, AFIX visits had been made in 78 counties. LHDs and private providers were encouraged to use the Provider Access to Immunization Registry Securely (PAiRS) database, which links records from public and private sources in a database accessible through secure Internet connections. A significant achievement was the completion of Phase I of the North Carolina Immunization Registry (NCIR) project. The IB, in collaboration with DMA, the Division of Information Resource Management (DIRM), and a private vendor, finalized a list of required modifications to be made to the Wisconsin Immunization Registry(WIR) in order for it to meet NC UCVPD standards/needs. In addition, staff members began preparing local health department staff and private providers for the registry through a series of presentations and the development and distribution of "registry readiness" materials and tools. The IB contracted with the NC Pediatric Society to hire nurses and a physician to do registry promotion in private provider offices beginning in June 2003.//2005//

b. Current Activities

/2005/During FY04, the IB collaborated with DMA and DIRM to develop a Request for Proposal (RFP) to customize the WIR for use in NC. The RFP was placed on competitive bid in February 2004. The contract is expected to be awarded to a private vendor in June 2004. The development phase of the contract should begin in June 2004. The pilot phase is scheduled to begin in early 2005. Implementation strategies for the pilot phase and subsequent statewide system rollout are currently being developed by the IB. In addition, the IB continues to work with the NC Pediatric Society on registry promotion efforts in private provider offices.//2005//

c. Plan for the Coming Year

/2005/During FY05, the new North Carolina Immunization Registry will be piloted in four counties in the local health departments and with private providers. Planning will continue for statewide registry implementation and the transition of the remaining 82 local health departments from the existing mainframe registry to the new web-based

system. Ongoing activities meant to help increase immunization coverage rates will continue.//2005//

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

a. Last Year's Accomplishments

/2005/Teen pregnancy and birth rates continue to decline in NC, consistent with the national trend. In 2002, the birth rate was 28.6 per 1000 for teens aged 15-17 and the pregnancy rate declined to 38.3. In FY03, the Teen Pregnancy Prevention Initiative (TPPI) funded a total of 53 projects . These projects include 29 secondary pregnancy prevention programs which target pregnant and parenting teens using a single model intervention best described as a youth development/mentoring model. While the primary focus of the Adolescent Parenting Program (APP) is in reducing unintended pregnancies among ever-pregnant teens, it is also focused on promoting parenting skills, preventing child abuse and neglect, and ensuring high school graduation among its participants. The Adolescent Pregnancy Prevention Program (APPP) continues to emphasize the use of best practice models in primary pregnancy prevention among its 24 currently funded projects. In this year's request for application process, the TPPI prescribed 13 best practice models. Applicants are strongly encouraged, though not required, to use the prescribed models. A total of 53 projects were funded in FY03. In addition, 21 projects were funded with special TANF funds. Similar in focus to APPP, these projects employ best practice models and encourage abstinence and delayed sexual initiation among teens who are at risk of early, unintended pregnancies. Rather than going through a competitive application process similar to the one used for APPP funding, counties with high teen pregnancy rates and few resources are targeted to receive funding for their projects. Finally, the Family Planning and Reproductive Health Unit (FPRHU - formerly named the Women's Preventive Health Unit) 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.//2005//

b. Current Activities

/2005/While teen pregnancy and birth rates in NC continue to decline, a number of challenges remain. Data from the 2003 NC YRBS suggest that NC youth continue to engage in behaviors that put them at risk for unintended pregnancies and STDs. The survey results show that while only 10% are sexually active before age 13, by 12th grade, 73.5% of NC youth are ever sexually active and over 22% of 11th and 12th graders have had four or more sexual partners, putting them at greater risk of acquiring STDs and unintended pregnancies. However, YRBS data also indicate that 62% of teens grades 9-12 used a condom during last intercourse in the past three months, while 18% were using birth control pills. As the sexual behavior questions were not included in the surveys conducted after 1997 and since the survey sampling techniques have been modified during that time period, it is difficult to compare the 2003 data with the 1997 data; however, data from 2003 indicate perhaps slight improvements in behavior or at least no significant change. National studies 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.

In addition to continuing the current initiatives under TPPI, there is also an ongoing

emphasis in DPH in identifying and implementing interventions to reduce racial disparities in health indicators, including teen pregnancies and STDs. As a first step, FPRHU staff have formulated objectives for local grantees that specifically address the reduction and elimination of health disparities in their respective programs. These objectives, based on the Division's health disparities reduction plan, are formally included as part of the scope of work in the contractual agreement between the state and the local providers in FY05.

The Statewide Family Planning Program continues to place greater emphasis on recruiting teen patients. The number of teens served have been declining in the last three years. However, in CY03, 39,100 teens were enrolled in the program, which is a 5.2% increase over CY02 total. Mid-year data indicate that this trend is continuing. More significantly, 73% of the teens enrolled in the program are using more effective methods of contraception, the pill and Depo Provera.//2005//

c. Plan for the Coming Year

/2005/Rule changes resulting from legislative action in 2002 will continue to be a challenge for the program. The TPPI program will search for additional funding to support Hispanic/Latino teen pregnancy prevention initiatives. The efforts to identify specific program objectives that address reductions in racial disparities in health indicators at the local level will continue. The FPRHU will support the funding of agencies to provide teen pregnancy prevention programs using best practice models which demonstrate proven means of reducing unintended teen pregnancies. Program evaluation activities, a requirement for all TPPI projects, will continue. 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.//2005//

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

a. Last Year's Accomplishments

/2005/Last school year data was not collected on the proportion of children who have dental sealants because of budget constraints. 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. Educational exhibits promoting the use of sealants were used with 28,922 adults.//2005//

b. Current Activities

/2005/This year, the Oral Health Section had to reduce the number of sealant activities due to the time commitment required by the statewide dental survey of children to evaluate our community-based preventive programs. This will give information on the prevalence of dental sealants across age groups. The statewide dental assessment will give us specific information on fifth grade children as we have had in the past, but the school year is not over so data are not yet available. In cooperation with volunteer private dental practitioners, 5,073 dental sealants were provided for 1,142 children at high risk for dental decay. Educational exhibits promoting the use of sealants were used with 571 adults.//2005//

c. Plan for the Coming Year

/2005/ During the upcoming year, the Oral Health Section will once again focus on providing dental sealants for children at high-risk for dental decay. With funding from the Preventive Health and Health Services Block Grant, we plan to provide 20,000 sealants. The educational exhibits will continue to be used by staff to educate parents and decision-makers about dental sealants. //2005//

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

a. Last Year's Accomplishments

/2005/ The rate of deaths due to motor vehicle crashes for children <=14 years old declined to 5.3 in 2002. The Local Child Fatality Prevention Teams (CFPT) reviewed all 90 deaths and submitted reports to the state Team Coordinator. State agencies involved in child passenger safety issues have formed a coalition called the Safe Kids/Safe Communities Coalition. This coalition includes staff from the NC Child Fatality Task Force (CFTF), the Injury Prevention Unit, and the Governor's Highway Safety Program among others. In FY03, the coalition continued its efforts to raise awareness about NC child safety laws, sponsoring car safety check programs and supporting the newly enacted Child Bicycle Safety Act. This legislation requires children <16 to wear bicycle helmets when riding bicycles as an operator or passenger on public streets. Another successful activity to increase awareness of child motor vehicle safety was the continued purchase of the "Kids First" specialty license plate. //2005//

b. Current Activities

/2005// During FY04, the Local CFPT reviewed deaths of children <=14 years caused by motor vehicle crashes. Many counties continued to provide child safe driving education, car seat and bicycle helmet distribution programs for their communities.

The local teams continue to support the Graduated Driver's License Law and reported decreases in motor vehicle crashes since the law was passed in 1997. One study of the effects of this law was published in JAMA in October 200, entitled "Initial Effects of Graduated Driver Licensing on 16-Year-Old Driver Crashes in North Carolina." This study showed that crash rates declined sharply for all levels of severity among 16-year-old drivers after the NC Graduated Driver's License System program was implemented. Comparing 1996 and 1999 data (the most current) showed a 57% decrease in fatal crashes, nighttime crashes were 43% less, and daytime crashes decreased by 20%.

"Kids First" license tags were introduced and made available to the public in 2002. Since that time 1409 tags have been sold for a total of \$21,135//2005//

c. Plan for the Coming Year

/2005/ Local CFPTs will continue current activities in FY05. Legislation, known as the Booster Seats Bill, which recommends those children between the ages of four and eight and less than 80 pounds in weight who are occupants of passenger vehicles be properly secured in belt-positioning booster seats, was passed in the 2004 session of the General Assembly and becomes effective January 1, 2005. In the period 2000-2002, the SCHS confirms that 43 children ages 5 to 8 who were occupants of passenger vehicles were killed by motor vehicle crashes, and the data from the UNC Highway Safety Research Center indicate that approximately 200 additional children were seriously injured. Based on police reports, only 7% of these children were reported to be in booster seats. To garner continued support, a letter with a list of the Committee Members looking at this

legislation was sent to all 100 Local Child Fatality Prevention Teams asking them to contact the Committee and support the Booster Seats Legislation.//2005//

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

/2005/ The breastfeeding initiation rate of women participating in WIC in FY03 was 46.7%, which is about the same as in FY02 (46.3%). Specific activities undertaken in FY03 to increase breastfeeding rates included co-sponsoring the NC Lactation Educator Training Program (NCLETP) which had 58 participants; continuing the "Mother-Friendly Business" recognition program for businesses that support breastfeeding at the worksite (31 businesses recognized); distributing 25 hospital strength electric breast pumps and 718 accessory kits to local WIC Programs; continuing a free-of-charge Vitamin D (Tri-Vi-Sol(r) Vitamin 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; distributing breastfeeding resources to local WIC agencies, several of which can be found on the Branch website at www.nutritionnc.com; developing and distributing the "Breastfeeding Promotion and Support Guidelines for Healthy Full Term Infants" for use as a reference and training tool for local public health agency staff; producing nine new parent breastfeeding education materials (culturally sensitive, appealing, and available in English and Spanish) for use by local public health agencies; and sponsoring a Perinatal Regional Lactation Teams Strategic Planning Workshop where new training materials were distributed to participants and plans were developed by each regional team for providing breastfeeding promotion and lactation management education to other health professionals within their region.//2005//

b. Current Activities

/2005/The following strategies were implemented in FY04 to support increasing breastfeeding initiation and duration rates: co-sponsoring the NCLETP which had 74 participants and obtaining approval for 59.5 continuing education credits (L-Cerps) from the International Board Certified Lactation Consultant Examiners (IBCLCE) for Board Certified Lactation Consultants attending this training; distributing an additional 166 hospital strength electric breast pumps, 97 pedal pumps, and 6382 manual pumps and accessory kits to local WIC Programs; continuing a free-of-charge Vitamin D (Tri-Vi-Sol (r) Vitamin 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 training to 200 Children and Adult Care Food Programs (CACFP) Sponsors via a teleconference "How to Support Breastfeeding in a Child Care Center"; providing training to 80 local and regional WIC and community leaders on Breastfeeding Peer Counselor Programs; and providing professional resources to local WIC staff.//2005//

c. Plan for the Coming Year

/2005/New activities planned for FY05 include: completing the "North Carolina Blueprint for Action on Breastfeeding" which will include the hosting of a statewide task force to assist in the development of recommendations and strategies for the promotion and support of breastfeeding; developing the "Breast Pumps Issuance and Loaning Guidelines," a self-study training manual for local public health staff; completing the new infant feeding parent educational materials; expanding and enhancing the

breastfeeding peer counselor program; and having a strategic planning and training meeting of local WIC Program Breastfeeding Coordinators.

On-going breastfeeding support activities will be continued, including:

- co-sponsoring the NCLETP;**
- the free-of-charge Vitamin D (Tri-Vi-Sol Vitamin A,C,D drops) distribution program;**
- distributing additional hospital strength electric breast pumps and accessory kits to local WIC Programs;**
- providing breastfeeding client education materials and professional resources to local public health agencies;**
- promoting World Breastfeeding Week and recognizing "Mother-Friendly" Business Leaders;**
- supporting accurate breastfeeding data collection and analysis; and**
- promoting breastfeeding support activities in child care agencies.//2005//**

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

a. Last Year's Accomplishments

/2005/All 94 hospitals/birthing facilities in North Carolina continued to provide hearing screening to each newborn before hospital discharge resulting in a 99.4% screening rate. These hospitals/birthing facilities were able to begin using the website for the North Carolina Newborn Hearing Screening Program (www.ncnewbornhearing.org) to enter quarterly reports on the numbers of infants screened. A checklist was revised and standardized for monitoring hospital/birthing facilities' newborn hearing screening programs. The number of hospitals that did their own re-screens for infants who did not pass their first hearing screening increased. A Pediatric Audiology Survey was used to ask audiologists across the state about their experience and expertise in providing audiologic evaluation and amplification fitting to very young children. Guidelines for speech and hearing were developed for Assistive Technology and for the Children's Special Health Services Program. Speech-Language and Audiology Consultants began presenting information at the statewide Child Health Nurses Training.//2005//

b. Current Activities

/2005/All 94 hospitals/birthing facilities continued to provide newborn hearing screening, and an increased number used the website for their quarterly reports. Annual monitoring of hospital programs continued. The numbers of hospitals doing their own re-screening continued to increase. In December 2003, a Unit Manager was hired for the Genetics and Newborn Screening Unit, which combines newborn hearing screening, newborn metabolic screening, genetic counseling, genetic services, and birth defects monitoring programs. This Unit Manager has expertise in Speech-Language Pathology, Audiology, and Child Development, and has worked in public school, medical, university, and early intervention settings and programs. Also in December, one Audiology Consultant retired and another resigned after maternity leave. Current staff are covering those regions, with the help of part-time "work-against" staff. An orientation and training for new staff members is being planned.

The Pediatric Audiology Survey was completed and data were presented to the Early Hearing Detection and Intervention Advisory Board. These data were used to develop content for a grant application to CDC for conference funds focused on 1) timely and appropriate referrals and 2) involving families in decision-making about their child's hearing loss intervention. The Early Hearing Detection and Intervention Advisory Board

now has a formal chair, who is a university professor in the field of audiology. Speech Language and Audiology Consultants shared information with providers about the Assistive Technology and Children's Special Health Services Program and reviewed speech and hearing requests for both these programs as well as for the Health Choice Program. Presentations at the Child Health Nurses Training continued.

Collaboration among Unit staff on issues of genetics and hearing loss has begun, with presentations made to inter-agency partners for genetic referral protocols. In addition, collaboration for identifying children at risk for late onset hearing loss has begun. Training and otoacoustic emissions hearing screening equipment is being provided to Early Head Start/Migrant Head Start Centers through a grant with the National Center for Hearing Assessment Management. Planning is underway to use similar training protocols and purchase otoacoustic emissions hearing screening equipment for local health departments for use in hearing screening on children birth-21 years of age through periodic well child checks and/or when a hearing loss is suspected.//2005//

c. Plan for the Coming Year

/2005/In the coming year, hospitals/birthing facilities will continue their newborn hearing screening programs and quarterly reporting and annual monitoring of those programs will continue. Formal agreements for collaborative consultant efforts and for referring children identified with permanent hearing loss to early intervention resources are underway. CDC grant funds have been targeted to database development for web-based entering of individual child data into a statewide tracking system. Although this development has experienced delays, new progress is being made, and a pilot of this web-based entering of data is scheduled for October 2004. Plans are underway to hire candidates for the two Audiology Consultant positions and have them trained by Fall 2004.

If the CDC conference grant is obtained, the Pediatric Audiology Conference will be held; if the grant funding is not obtained, staff will investigate the possibility of such a conference through inter-agency collaborative funding/staffing efforts. Speech Language and Audiology Consultants will continue to provide reviews of Assistive Technology, Children's Special Health Services, and Health Choice requests. Presentations to the Child Health Nurses Training will continue.

Collaboration on genetics/hearing loss and on identifying children at risk for late onset hearing loss will continue. The training/equipment efforts for otoacoustic emissions hearing screening will continue. The Early Hearing Detection and Intervention Advisory Board will be expanded to include more family representation and implement supports for families involved as board members. With the focus on database development, training/consultation, and increasing provider awareness/expertise regarding hearing loss in very young children, a portion of the MCHB newborn hearing screening grant funds have been targeted to development of an overall program evaluation plan which would be implemented to focus summarized data from these various sources into outcome measurements.//2005//

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

a. Last Year's Accomplishments

/2005/By July 1, 2002, there were 84,286 children enrolled in Health Choice. NCDHHS announced that enrollment would have to be frozen effective September 1, 2002. At the same time, the DHHS Secretary asked the NC Institute of Medicine (NCIOM) to convene a

task force to develop options to ensure the long-term financial solvency of the program. Anticipating this report, the NCGA appropriated an additional \$7.7 million in non-recurring funds to keep the program open and cover 100,000 children in FY03. The freeze was called off less than 48 hours from the implementation date, but word of the freeze had already been disseminated. Notices were sent out statewide via any accessible electronic mail addresses stating that the freeze was off. Within 30 days, a more in-depth newsletter with programmatic updates was mailed to the 600+ on the statewide mailing list. Anticipating the need for future urgent communications, a HC/NCHC database and email list serve was initiated. DPH staffed the NCIOM task force meetings and responded to various drafts of their report. The final report is posted on their web site at www.nciom.org.

In FY03, DMA published a Spanish version of the revised HC/NCHC Application Form. Although family-friendly versions of the Re-enrollment Form and notices have been drafted, the project was put on hold due to lack of staff. State positions have been frozen and other positions lost. The DMA Eligibility Unit was at a critical staffing level, thus thwarting progress on several fronts. WCHS worked with the NC Healthy Start Foundation (NCHSF) to develop a HC/NCHC web site, develop new outreach materials, and participate in planning sessions. A HC/NCHC Outreach web site where "lessons learned", "best practices", and updated program information can be shared was planned and development work was begun in July 2003. Two HC/NCHC Campaign Coordinators and one Latino Outreach Coordinator were hired by the NCHSF. WCHS and the NCHSF were also involved in the planning and development of a campaign to educate HC/NCHC families regarding appropriate use of a medical home. A HC/NCHC Minority Outreach Position was been made a permanent position in the C&Y Branch and interviews conducted. This position will do targeted outreach to special populations (minority and CSHCN).

WCHS staff worked closely with 2 grant-funded projects, the CK&F Grant and the Wake Rex Foundation Project, in order to create comparable data sets for HC and NCHC that inform WCHS outreach, enrollment, and coordination efforts. Staff also worked with the Health Insurance Underwriters Association to promote outreach for HC/NCHC with their membership and contribute to the overall state outreach effort. Local outreach coalitions have been encouraged to link with a stable, ongoing coalition (such as Healthy Carolinians) who can provide an infrastructure for sustaining this work.//2005//

b. Current Activities

/2005/By July 1, 2003, 100,436 children were enrolled in the NC Health Choice Program, and an additional 110,193 children had been enrolled in the Medicaid for Infants and Children Program since our SCHIP began in October 1998. This year there was no immediate threat of a freeze on enrollment. Recommendations made by the NCIOM Health Choice Task Force in early 2003 have mostly been implemented. Those recommendations not implemented include moving children age 0-5 with family incomes < 200% FPL into the Medicaid program and the enrollment of children eligible for NC Health Choice into the Community Care Program. However, 2002 data from the Kaiser Family Foundation show that 12% of children age 18 and under in NC remain uninsured. The NCIOM Report has documented the lack of reliability of these data, but certainly the economic downturn over the past few years has negatively impacted this measure.

In FY04, many changes were implemented to institutionalize outreach and improve communication. A list serve was developed that includes ~700 key state and local partners and has enhanced our capacity to provide targeted communications or to broadcast "New News" (our electronic newsletter). In November 2003, the WCHS, through work with the NCHSF, launched the HC/NCHC Outreach Website

(www.nchealthystart.org/outreach). The website's goal is to be a one-stop shop of resources to help local staff and their partners and it also provides a forum for sharing outreach experiences. Evidence of success is that local staff have begun networking with each other for technical assistance and are sharing experiences via the website. Another major initiative done in partnership with the NCHSF has been the development of materials (general brochure, topic specific cards, coloring book, a magnet with medical home contact information, and draft radio PSAs) to support a statewide Medical Home Campaign to be launched in FY05. With diversified funding and partners, the campaign will promote the idea of a primary care medical home for both well and sick care; provide education about inappropriate use of the Emergency Room; and instruct parents, particularly those with children with special needs, on how to become an active partner in the care of their child.

In October 2003, a person was hired to target HC/NCHC outreach to minority populations and to support the C&Y Branch in efforts to administer programs in a culturally competent manner. This individual has already had a tremendous impact by networking with a wide variety of CBOs who serve the Latino, American Indian and Hmong communities and by using GIS mapping to target outreach activities. This position is also involved in the development of a pilot faith-based lay health advisor program.

The WCHS continues to sustain efforts to operate the NC Family Health Resource Line and the Special Needs Helpline and to support the work of the RWJ (Covering Kids and Families) and Rex Foundation Grant-Funded Initiatives.//2005//

c. Plan for the Coming Year

/2005/In FY05, a focal point of the HC/NCHC programs will be targeted outreach to children with special health care needs. A work plan will be developed to institutionalize and sustain outreach to this population. The data required to support ongoing analysis/evaluation will be assessed and routine access requested. The NC Health Choice Children with Special Health Care Needs position that had been frozen during the State budget crisis has recently reopened and recruiting is underway.

The Medical Home Campaign will be launched in FY05 and additional materials will be developed, particularly to support families of children with special needs. This will be complementary to pilot projects being developed through the Special Needs Unit and the Community Care Program to develop provider capacity to serve as Medical Homes for CSHCN. Staff of the NC Family Support Network, the C&Y Branch and the NC Family Health Resource Line will collaborate around database development issues in relation to the State's Medical Home Campaign directed toward all children.

Targeted outreach to minority populations will continue to be a major focus of the HC/NCHC programs as WCHS continues work with sister agencies on Title VI compliance issues and culturally competent outreach strategies and materials. Work with community based organizations, faith-based initiatives, and other minority outreach venues will also continue.

An ongoing focus in all outreach will be institutionalized efforts to sustain outreach for publicly-funded children's health insurance programs.//2005//

Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

a. Last Year's Accomplishments

/2005/It was projected in the FY03 Annual Plan that Health Check Coordinator (HCC) positions would be reallocated so that 88% of counties would have HCC services by the end of FY03. However, due to the state budget crisis, as HCC positions have been vacated, the positions have been frozen, so the original goal has not been met to date. In April 2003, DMA sent out a letter to notify counties with vacant existing positions or new reallocated positions that the freeze was being lifted. As of May 1, 2003, there are 74 counties with one or more HCC, but by the end of FY03, it was anticipated that 86 counties would have a HCC. Smart Start funds 9 of the 74 counties that currently have an HCC position. In Smart Start-funded counties, the emphasis is on improving utilization of preventive services for the 0-5 age group and their siblings.

Due to HCC positions not being filled, quarterly introductory trainings for new supervisors/staff were cancelled. Training was held for newly hired staff in July 2003. Regional meetings of HCC staff continued to be held for programmatic updates and information sharing. The Annual Managed Care/HCC Conference was not held in FY02 or FY03 due to lost funding and managed care positions being cut.

The role of HCC has been shifting and expanding in recent years. Their primary responsibility continues to be focused on utilization of preventive services, but since the 1998 implementation of Health Choice, HCC have assumed a greater role in relation to HC/NCHC outreach. Several counties now list their HCC as the lead local outreach coalition contact. In addition, ACCESS II/III Managed Care Demonstration Projects, with their enhanced case management component, have become an emphasis in the political arena due to their potential to reduce inappropriate utilization and costs. HCC are now being asked to join the managed care team in an effort to improve access to the primary care provider/medical home, decrease emergency room use, and reduce cost. This shift in job responsibility was the primary reason that these positions were unfrozen.

From the perspective of the provider community, further updates related to HIPAA and the CPT Conversion occurred in 2003. These changes were disseminated through a "2003 Health Check Billing Guide" and workshops were held for private and public providers throughout May 2003. Fortunately, the changes were not nearly as extensive as those made in 2002./2005//

b. Current Activities

/2005/The lifting of the hiring freeze for HCCs in April 2003 meant that counties could recruit staff for new and vacant positions. As of May 2004, 88 of 100 counties in NC offer HCC services. There are currently 117 HCCs statewide with the number of positions per county varying based on the number of Medicaid-eligible children. The primary job responsibility for an HCC continues to be assuring that Medicaid recipients access preventive health screenings. To curb emergency room use, HCCs follow-up with ER mis-users to educate parents about the importance of using their child's Medical Home for routine preventive and primary care visits. Also, in most counties the HCCs are the lead contacts HC/NCHC outreach. In FY02, there were 775,535 children enrolled in Medicaid, an increase of 231,747 (or 43%) over the past decade since the Health Check Program was enhanced by HCCs and the Automated Information and Notification System to improve program enrollment and participation in well child care. With the recent downturn in the economy, NC's seamless approach to HC/NCHC outreach, enrollment and reenrollment has paid off as children move back and forth between the two programs as their family incomes fluctuate.

HCCs are an integral part of state planning in relation to HC/NCHC. They, along with family representatives, provide assistance with the development and enhancement of

campaign materials through surveys and/or focus groups. HCCs have been integral to the development of a suite of materials to support a statewide Medical Home Campaign to be launched early next year. The new materials will be of tremendous value to HCCs as they follow-up with families who misuse the ER. The three primary diagnoses involved when children use the ER inappropriately - fever, ear infections, and colds and flu - are all specifically addressed in the Medical Home materials.

HCCs also served on the committee that assisted the state in the development of the HC/NCHC Outreach Website (www.nchealthystart.org/outreach). Through information they provide in an Annual HC/NCHC Outreach Survey, the website is being used to share local contact information and "lessons learned".

WCHS supports this work by:

- Serving as the lead agency for HC/NCHC outreach;***
- Contracting with the NCHSF for their campaign, materials and website development expertise;***
- Developing a list serve of HCCs, their supervisors and state staff to hot link staff to "New News" posted on the HC/NCHC Outreach Website;***
- Administering, through a contract with UNC, the NC Family Health Resource Line (our state toll-free Title V line and the "action step" in all HC/NCHC materials);***
- Participating in quarterly introductory trainings for HCC staff and providing technical assistance in relation to general and targeted minority outreach activities; and***
- Contributing to the development of state EPSDT policies and drafts of the annual "Health Check Billing Guide".//2005//***

c. Plan for the Coming Year

/2005/In FY 05, a major initiative will be the launching of our Statewide Medical Home Campaign and parallel efforts to enhance the quality of the Medical Home experience in the provider community. HCCs will be critical to the success of our family outreach effort as they do community outreach for HC/NCHC, promote initial access to a medical home for preventive services, and follow-up with families who misuse the ER for routine primary care services.

Another focused effort will be HC/NCHC outreach to minority populations and to families of children with special health care needs. Through the quarterly introductory trainings for new staff and day to day technical assistance, HCCs will be involved in these targeted outreach activities.

HCCs are a critical part of the solution to our overall goal to institutionalize and sustain outreach for publicly-funded children's health insurance programs. They are the one stable factor in our community-based grassroots outreach. Initially, with the kick-off of our SCHIP, local communities formed HC/NCHC Outreach Coalitions with diverse representation. Many of these local coalitions met for two or three years and then faded away. A goal for WCHS in the coming year will be to seek support for HCCs in their outreach efforts by encouraging linkages with community based organizations and existing diverse community coalitions that share the mission to reduce the number of uninsured. Healthy Carolinians Coalitions, whose focus is the achievement of Healthy People 2010 Objectives, is a good option in many communities.

HCCs will also be critical to the continued development and success of our HC/NCHC Outreach Website. They are realizing the power of this medium for local sharing and for keeping abreast of programmatic changes and updates.//2005//

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

/2005/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 Coordination (MCC) components. During FY03, the Baby Love Best Practice Pilot begun exploring and evaluating a standardized service provision process for Maternity Care Coordination and Maternal Outreach Worker services in eleven local provider agencies. The pilot has 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 is 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.

NC continues to have four federally funded Healthy Start Programs in the state. Three of these sites are coordinated through the state Title V agency - Eastern, Northeastern, and Triad Baby Love Plus. Fourteen counties are covered by Baby Love Plus and three additional counties are part of Healthy Start Corps. During FY03, the Baby Love Plus sites provided intensive outreach to over 50,000 individuals, with the primary focus being African American and American Indian families. Approximately 2800 women were screened at delivery to determine the level of care needed during the two year interconceptional period. Other accomplishments include the following:

- Faith Partnership - Pastors and their congregants were trained in the Ministry of Health concepts. On-going technical assistance was provided to previously trained churches.***
- Lay Health Advisor Training - Barbers and beauticians were trained to serve as lay health advisors encouraging health promotion for women of childbearing age.***
- Community-Based Organization Partnership - Seven community-based programs are funded to assist in providing mentoring, educational, and support services to women of childbearing age and their families.***
- Cultural Diversity Training - In collaboration with the Office of Minority Health and Health Disparities, cultural diversity training for health and human service providers was sponsored. Additionally, the African-American Cultural Diversity train-the-trainer program was initiated.***
- Consumer Advocacy - Leadership development training was provided to consumers in advocacy and empowerment skills***
- Family Violence - Violence screening and counseling was provided for women during each trimester of pregnancy. Intensive training and technical assistance was provided to local health department staff.//2005//***

b. Current Activities

/2005/Baby Love Pilot agencies have implemented the new service provision model based on best practices. Standard formats are provided for addressing pertinent issues such as early prenatal care, nutrition, smoking cessation, substance use. Additional psychosocial issues (i.e. financial resources, education, employment, housing, and mental health) are also addressed based on individual needs. Evaluation of year one of the pilot is currently being conducted through a review of the triaging process implementation, individual record reviews, focus groups with pilot agencies, and agency assessment of community resources and systems. The eleven local provider agencies have provided rich feedback on the pilot implementation to date. Overall, the new triaging process has been integrated into their services and is resulting in improving the ability of the agency to focus their services on the clients who have greater needs. Suggestions have been made relative to revising the current triaging tool to result in

more appropriate initial identification of individual needs. A standardized assessment and care planning process based on best-practice models has provided additional guidance on effective service provision. Positive feedback has been received from the agencies on this process. A home visiting component has resulted in a change in service provision for some agencies. Further revision of the home visiting component may improve the effectiveness of the MCC and MOW services provided.

During FY04, the Baby Love Plus Program continues to provide the core services of outreach and client recruitment, case management including depression screening, interconceptional care for women of childbearing age and their families. In addition, program participants will continue to benefit from the provision of health education and transportation services. The 7th Annual Healthy Start Training Institute is scheduled for July 29-31, 2004. This family-oriented institute will focus on maternal and child health issues, individual and family empowerment, and community advocacy. There is also a separate track for teens, along with a full service Children Enrichment Center.

North Carolina's Minority Infant Mortality Reduction Program, Healthy Beginnings, consists of 14 community-based organizations, local health departments, and community health centers whose focus is to reduce infant deaths and reduce the disparity among minority populations. The existing projects participated in a request for application (RFA) process in October 2003. The majority of the projects will be re-funded for three additional years. A skillbuilding workshop was held on April 7, 2004 in collaboration with the NC Baby Love Plus Projects to discuss best practice methods as related to infant mortality and developing the most effective evaluation components of a program.//2005//

c. Plan for the Coming Year

/2005/The eleven Baby Love Best Practice provider agencies will continue with the pilot for the coming year. Based on evaluation results at the end of June 2004, the pilot protocol will be reviewed and revised. The final evaluation results at the end of the coming year will be used to guide implementation of a statewide quality improvement process for standardized service provision of MCC and MOW services.

The Baby Love Plus program will continue to implement the core services, and strengthen existing partnerships. They will also work with the March of Dimes to co-sponsor the "Changing the Face of Prematurity in North Carolina" conference scheduled for October 12, 2004. This resource sharing conference is designed to focus on clinical best practices around maternal and child health. They will also provide leadership in conducting a series of focus groups with ministers around family violence issues.

The Targeted Infant Mortality Reduction (TIMR) program, designed to conduct community-wide efforts to reduce infant mortality and morbidity in their county, also has re-focused its efforts. Agencies are now required to involve representatives from the community in the development of their plan. Local health departments receive this funding through an RFA process. Their primary focus will be smoking cessation, SIDS reduction, breastfeeding, and folic acid consumption.//2005//

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

a. Last Year's Accomplishments

/2005/The Youth Suicide Prevention Task Force (YSPTF) conducted 6 regional

workshops across the state to increase awareness of the problem of youth suicide and train adults who work with youth to detect early suicide signs and symptoms. The average attendance at each workshop was approximately 60 participants. During the workshops, the participants received the most recent youth suicide data facts and a copy of the workshop presentation on CD-ROM, which included an overview of the national strategies with state examples and resources. In June 2003, the Task Force conducted a week-long Livingworks Training. The goal of the Livingworks Training is to increase the number of certified gatekeeper trainers (currently there are five) in NC. The certified trainers can then conduct Applied Suicide Intervention Skills Training (ASIST) workshops which train the participants to recognize the signs and symptoms of suicide and how to ascertain risk and keep children at risk safe until professional assistance is available. Participants will include teachers, probation officers, youth ministers, juvenile justice staff, court counselors, and mental health workers.//2005//

b. Current Activities

/2005/During FY04, a six month follow-up evaluation was conducted with the participants of the six regional workshops held in the Spring of 2003 to ascertain how the information was used and any long lasting effects. A survey was also conducted to monitor the progress of the newly certified Livingworks Trainers.

The YSPTF published their Executive Summary in April 2004 called "Saving Tomorrows Today: North Carolina's Plan to Prevent Youth Suicide." The plan issues 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.

The YSPTF sought professional, non-profit, and community organization endorsement of the plan. The LivingWorks trainers who were certified in FY03 are conducting ASIST workshops throughout the state. Twelve workshops are anticipated to be provided by June 30, 2004. The NC CFTF continues to take part in the work of the YSPTF and supports their prevention plan.//2005//

c. Plan for the Coming Year

/2005/The YSPTF grant will end June 2004; however, continuation of activities is anticipated. The Injury and Violence Prevention Branch, which serves as the lead agency for the YSPTF, has received a CDC grant to implement the NC Violent Death Reporting System. This system will include collection of data on youth suicide which will address the YSPTF goal of increased surveillance. The Injury and Violence Prevention Branch is also slated to receive the technical support necessary to establish a state wide list serve for organizations involved in youth suicide prevention efforts and also create a branch website.

LivingWorks trainers continue to schedule ASIST workshops throughout the state. Thus far, six workshops are scheduled from July through November 2004.

In addition, a YSPTF member organization is actively seeking grants to conduct awareness campaigns and hold a state youth suicide prevention conference.//2005//

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

a. Last Year's Accomplishments

/2005/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.

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 birthweight infants born in tertiary centers. During FY03, over 7,500 health care and human service providers from across the state received training through this program.//2005//

b. Current Activities

/2005/From July 1, 2003 through January 2004, the Neonatal Bed Locator Service had 560 total calls for requests to locate neonatal and maternal bed space.

The NOETs' primary focus areas included: substance abuse (includes smoking); breastfeeding; resuscitation and stabilization; the care and discharge of convalescing newborns; and the promotion of best practices in neonatal care.//2005//

c. Plan for the Coming Year

/2005/During the upcoming year, the Neonatal Bed Locator service will continue to provide a 24 hour per day 7 day per week 365 day per year service to field calls to locate neonate and maternal bed space in North Carolina hospitals.

During FY05, efforts will continue specifically by the NOETs to inform providers and encourage Neonatal Bed Locator service utilization.//2005//

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

a. Last Year's Accomplishments

/2005/The NC Family Health Resource Line (MCH Hotline) worked in conjunction with the First Step Campaign to continue to answer questions from callers about pregnancy and getting appropriate prenatal care. The First Step Campaign, which is administered by the NC Healthy Start Foundation, distributed educational materials to consumers, healthcare providers and childcare providers. The materials developed and disseminated information focused on prematurity and low birthweight issues; evidence-based practices on disparity in perinatal health; and awareness of safe sleep practices to help decrease infant mortality in NC. The First Step Campaign focused on increasing public awareness and developing private and public partnerships at the state level with the goal of improving the health status of NC mothers and babies.

The federally funded Healthy Start sites (Baby Love Plus and Healthy Start Corps) continued to provide intensive outreach and client recruitment services in seventeen of NC's 100 counties. The Baby Love Plus sites employ Community Health Advocates who are specially trained members of the community. They provide community outreach door-to-door, through house parties, and through other venues. Over 50,000 individuals were served during FY03 with outreach and educational messages.//2005//

b. Current Activities

/2005/The First Step Campaign has continued to promote the NC Family Health Resource Line (MCH Hotline) and encouraged women to seek early and continuous prenatal care services. The Campaign's current focus is on prematurity and low birthweight issues; evidence-based practices on disparity in perinatal health; and awareness of safe sleep practices. Several new educational pieces were developed. They include Thanks for Asking, an informational piece about stress and pregnancy; Providing Hope for a Brighter Future, a brochure specific to Sickle Cell Disease and trait along with Folic Acid reminder items designed specifically for the 18-24 year old female population; and a Spanish Back to Sleep Lightswitch Cover for new parents and child caregivers (Spanish speakers).

The Minority Infant Mortality Reduction Program, Healthy Beginnings, continued to provide outreach, home visiting, transportation, and other support services. The majority of the families served were African American, Hispanic and/or American Indian.//2005//

c. Plan for the Coming Year

/2005/The First Step Campaign will 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. In conjunction with the March of Dimes and N.C. Folic Acid Council, educational information and materials will be distributed that promote good health during women's childbearing years and raise awareness of consuming folic acid as a way to reduce birth defects. There are also plans to increase awareness of the state Sickle Cell Program and its services, particularly to Latino populations. A focus will also include raising awareness of the dangers of smoking and secondhand smoke by promoting individual behavior change for pregnant teens, their families and friends. Plans are also underway for development of web-based information and 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 will be used to develop information and appropriate format.

Healthy Beginnings, Baby Love Plus, Targeted Infant Mortality Reduction, and Healthy Start Corps are in the process of forming a statewide infant mortality prevention network to focus on community-based perinatal health issues. This will strengthen community partnerships and ensure that efforts are enhanced rather than duplicated in communities.//2005//

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE

Pyramid Level of Service

| | DHC | ES | PBS | IB |
|---|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| 1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State. | | | | |
| 1. Initial newborn screening test performed on all blood spot samples received. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Follow-up of borderline results with a letter to physician. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Follow-up of abnormal results with a phone call to physician. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. Testing of repeat blood spots received following a borderline or abnormal screen. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5.5. Continued interaction of state laboratory staff and medical center staff as relates to questionable results. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Contracts providing statewide coverage for consultation related to metabolic conditions. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Work towards development of data linkage of newborn screening records and birth certificates | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8.8. Purchase of special formula for individuals with certain metabolic disorders through Nutrition Services. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Monitoring of phe/tyr ratios in blood spots received from individuals with PKU | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 10. Newborn screening advisory committee quarterly meetings. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
| | DHC | ES | PBS | IB |
| 2) 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) | | | | |
| 1. Involvement of families of CSHCN in WCHS activities through FAC and Family Liaison Specialist. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Toll-free Help Line will continue to provide information and support for families of CSHCN. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Parent members will continue work with the NC Commission on Children with Special Needs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. At least two representatives from the Family Advisory Council will attend annual AMCHP conferences. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
| | DHC | ES | PBS | IB |

| | | | | |
|--|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| 3) 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) | | | | |
| 1. Educate the families of children enrolled in HC and NCHC on the importance of medical home. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Support systems of care that assure children are screened early and often for special needs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Maintain toll-free Help Line for referral of CSHNC to appropriate programs, services and providers. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Roster qualified MDs willing to provide ongoing health care within a multidisciplinary approach. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Conduct presentations on the Medical Home Initiative at statewide professional meetings. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Support systems of care that assure CSHCN are linked with a medical home for follow-up. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 4) 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) | | | | |
| 1. Analysis/implementation of recommendations from Sheps study on CSHCN and insurance. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Maintain HC/NCHC Outreach Campaign through the NC Healthy Start Foundation. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Maintain NC Family Health Resource Line as a bilingual informational telephone hotline. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. Develop HC/NCHC Outreach web site. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Develop HC/NCHC educational campaign regarding medical home/ER use/preventive care. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Support grant-funded initiatives: NC Covering Kids and Families and Wake Rex Foundation Project. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Simplification of enrollment/re-enrollment forms and development of family-friendly notices. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Development of comparable data sets for HC and NCHC. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Targeted outreach to special populations (including minority and CSHCN). | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 5) 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) | | | | |
| 1. Continue Community Transition Program. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Continue Child Service Coordination Program. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Continue provision of Early Intervention services and implementation of system design changes. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Intensive Home Visiting projects. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Continue CSHS Clinics. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Continue Special Needs Helpline. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Continue Child Care for children who are medically fragile. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Implement Hospital Early Intervention Projects. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Develop program for re-cycling Assistive Technology devices. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Hire Family Liaison Specialist. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|--------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey) | | | | |
| 1. Provide a greater focus on transition and diffuse transition responsibilities across C&Y Branch. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Redefine vacant position in Specialized Services to provide programmatic focal point for transition. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Include transition component in job descriptions of several positions being filled in C&Y Branch. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. NCODH training and TA to WCHS re: ADA, universal design, fitness, and health promotion environments. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Active participation by adult disability consultants and NCODH to plan transition initiatives. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Staff provides TA on youth leadership development to the NC Developmental Disabilities Council. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Collaborate with School Health Program to include youth with disabilities when planning activities. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Activities to promote medical homes for CSHCNs will focus on transition. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Utilization of baseline SLAITS data in planning transition efforts and galvanizing support. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. DHHS Eliminating Health Disparities Initiative. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 7) 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. | | | | |

| | | | | |
|---|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| 1. Maintenance of the Universal Childhood Vaccine Distribution Program. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. LHD assessment and tracking activities. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Complete at least 130 AFIX visits in calendar year 2004. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Update the new Immunization Branch web site as necessary. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Continue to offer the interim registry solution (PAiRs) to providers. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Continue planning for statewide registry implementation and the transition of the remaining 96 LHDs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years. | | | | |
| 1. Ongoing support provided for the Teen Pregnancy Prevention Initiative projects. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Primary prevention projects participate in annual evaluation process. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. All TPPI projects participate in a web-based process evaluation program. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Annual Teen Pregnancy Prevention Symposium (with Adolescent Pregnancy Prevention Coalition of NC) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Annual Adolescent Parenting Graduation Conference. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth. | | | | |
| 1. Statewide dental assessment of oral health status conducted in alternate school years (even years). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Staff driven and community-based sealant projects conducted. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Educational services provided in various settings. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|-----|--------------------------|--------------------------|--------------------------|--------------------------|
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. | | | | |
| 1. Continued review of child deaths due to motor vehicle crashes on the state and local levels. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Enactment of the Graduated Drivers License Restriction law. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Community car seat distribution programs. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 11) Percentage of mothers who breastfeed their infants at hospital discharge. | | | | |
| 1. Support the efforts of Breastfeeding Peer Counselor Programs. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Promote and recognize World Breastfeeding Week. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Offer the North Carolina Lactation Educator Training Program. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Seek nominations for "Mother-Friendly Business Leaders". | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Distribute electric breast pumps and accessory kits to local WIC agencies. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Enhance and support accurate breastfeeding data collection and analysis. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Maintain a free-of-charge Vitamin D program for infants (>=6 weeks)and mostly breastfeeding. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Provide client education materials & professional resources including training | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 9. Training and consultation targeted toward childcare industry on breastfeeding and pumped breastmilk. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Complete a North Carolina plan for promoting and supporting breastfeeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 12) Percentage of newborns who have been screened for | | | | |

| | | | | |
|---|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| hearing before hospital discharge. | | | | |
| 1. Enhancements to the Newborn Hearing Screening Data Tracking and Surveillance System. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Technical support to the local newborn hearing screening programs in birthing/neonatal facilities. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Identification of needs and training opportunities for pediatric audiologists. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Regional staff ensuring that all infants have access to screen and rescreen. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Infants tracked through screening, evaluation and amplification process to assure no children missed | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 13) Percent of children without health insurance. | | | | |
| 1. Maintain HC/NCHC Outreach Campaign through the NC Healthy Start Foundation. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Maintain NC Family Health Resource Line as a bilingual informational telephone hotline. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Develop HC/NCHC Outreach web site. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. Develop HC/NCHC educational campaign regarding medical home/ER use/preventive care. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Support grant-funded initiatives: NC Covering Kids and Families and Wake Rex Foundation Project. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Simplification of enrollment/re-enrollment forms and development of family-friendly notices. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Development of comparable data sets for HC and NCHC. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Targeted outreach to special populations (including minority and CSHCN). | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. | | | | |
| 1. Statewide distribution of Health Check Coordinators based on reallocation of existing positions. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Coordinators' use of AINS to track and follow Medicaid-eligible children. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Link families who have utilized the ER for non-emergent care to their | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|
| medical home. | | | | |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|--------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 15) The percent of very low birth weight infants among all live births. | | | | |
| 1. Collaborate with March of Dimes and NCHSF to reduce prematurity and low birthweight. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Work with MIMRP sites to develop lessons learned and best practices. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Provide combined skillbuilding training for MIMRP, Baby Love Plus, and Healthy Start Corps. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|--------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19. | | | | |
| 1. Livingworks Training conducted. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Development of a surveillance plan. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Development and implementation of a listserve. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| NATIONAL PERFORMANCE MEASURE | Pyramid Level of Service | | | |
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| | | | | |

The Child Fatality Prevention Team (CFPT) Office completed a pre-application for a grant from the Governor's Crime Commission for support of a "Decriminalizing Infant Abandonment Training " program. The purposes of this project were to provide instruction to professionals on their role when an infant is surrendered, to develop a statewide protocol to ensure consistency in practice for agencies to follow, and to promote public awareness of the Infant Homicide Prevention Act enacted October 1, 2002.

The final report of the Child Well Being and Domestic Violence Task Force was completed during January 2003. Several of the Task Force's recommendations were included in bills introduced during the legislative session of the General Assembly. Some of the recommendations were also slated to be addressed by the Public Health Alliance Against Violence Against Women, which is staffed by the Injury and Violence Prevention Unit of the DPH and includes active participation of WCH staff.

The NC Parent Education Network (NCPEN), a collaborative organization of state leaders in parenting and human development provided quarterly newsletters to service providers and a pull out section for parents. As of June 30, 2003, parenting education was no longer a Medicaid reimbursable service. These services continued to be provided in group sessions with little to no interruption for the families. Additionally, MCC and CSC staff in local health departments were able to provide limited one-on-one parenting services.

WCHS staff collaborated with the non-profit organization, NC Practitioners Network for Fathers and Families, to host a statewide fatherhood conference in June 2003 in Winston-Salem. Over 240 participants attended capacity-building workshops and presentations including the featured keynote from Kirk Harris, Director of the National Family Support Network. WCHS staff also worked to enhance collaborations in an effort to support the targeted campaign by the US Department of Agriculture to encourage African American males to support their partners in breastfeeding.//2005//

b. Current Activities

//2005/During FY04, state funding of the IHV Initiative was eliminated by the legislature. Funding for APP projects has been uncertain, but an RFA process was completed keeping the project number at 29. The CFPT Office received a Governor's Crime Commission grant to implement the Decriminalizing Infant Abandonment Training initiative.

Prevent Child Abuse North Carolina (PCANC), in collaboration with the NC Council for Women and the Domestic Violence Commission, was given the responsibility of coordinating and monitoring the implementation of recommendations from the Legislative Child Well Being and Domestic Violence Task Force. The Public Health Alliance Against Violence Against Women will also be involved in implementation of some recommendations involving health agencies and plans to expand its focus to more comprehensively address child well being.

Through a grant from the Governor's Crime Commission, the Title V Program contracted with PCANC to develop recommendations for the prevention of child maltreatment in children birth to age three. PCANC is facilitating an interagency workgroup that has met for 8 months and plans to release a report in the summer of 2004. The group includes representatives from state/local agencies, medical providers, and university research specialists.

Parenting education activities for FY04 included: the 2nd annual Parenting Education

Institute; collaboration with NCPEN; revision of program resources; and advocacy for the inclusion of fathers/men in resources and services provided by WCHS. The following on-going activities of the Fatherhood Project took place in FY04: Fatherhood Development Curriculum training session in three counties; development of a speakers bureau; updating of a resource directory of male focused/fatherhood programs across NC; convening a Men's Preventive Health Symposium; educating policy makers to better represent the issues and concerns of the population; and conducting an assessment of the WCHS on father-friendly practices and services coordination.

During FY04, the SSU has worked with DSS to implement the DSS Multiple Response System and with the EIB to develop a plan to implement the Child Abuse and Prevention Treatment Act. In addition, the SSU continues to work with the State Collaborative for Children's Mental Health in the development of the System of Care for young children with mental health issues. This included work with the Administrative Office of the Courts to develop a new initiative in 5 counties on planning for the development of Family Drug Treatment Courts. In these courts, parents who have substance abuse issues and who are in danger of having their parental rights terminated must comply with a treatment plan in order to be reunited with their children. The planning process involves assisting the court system to recognize health issues for children who have been victims of substantiated abuse/neglect and those transitioning through the foster family program.//2005//

c. Plan for the Coming Year

//2005/The CFTF's agenda for the next fiscal year will include restoration of the CFTF staff position (eliminated by the legislature in 2003). The CFPT Office intends to apply for a second year of funding through the Governor's Crime Commission for a statewide public awareness education campaign on the Decriminalizing Infant Abandonment Program to be conducted during September 2004 - August 2005.

PCANC will continue to take lead responsibility for coordinating and monitoring the implementation of recommendations from the Legislative Child Well Being and Domestic Violence Task and also to implement the recommendations for the prevention of child maltreatment in children.

NC Parent Education Network (NCPEN) continues to provide quarterly newsletters that feature emerging resources and information relevant to parenting educators. In addition, a one-page insert developed specifically for parents is included. The information is available on line at www.ncpen.org.

The following activities are prioritized for FY05:

- 3rd Parenting Institute**
- Development of program web site**
- Regional forums on "inclusion" (fatherhood/male involvement)**
- Men Are Nurturers, Too statewide fatherhood conference focusing on faith-based organizations and expanding family support networks and services**
- Two Fatherhood Curriculum trainings**
- Continued collaboration with NCPEN**
- On-going support for North Carolina Fatherhood Development Advisory Council**

The Specialized Services Unit will continue to work with DSS in the implementation of the Multiple Response System and with the EIB to implement the plan to meet the Child Abuse and Prevention Treatment Act. In addition, the SSU will continue to work with the State Collaborative for Children's Mental Health in the development of the System of Care for young children with mental health issues.

The EIB has worked closely with DSS to implement the new federal requirement that all infants and toddlers substantiated for child abuse and neglect be referred to the Early Intervention program.//2005//

State Performance Measure 2: *Percent of children less than 6 with elevated blood levels (greater than or equal to 10 micrograms/dL) of lead (SPM#4)*

a. Last Year's Accomplishments

/2005/In CY03, there were 121,697 children ages six months to six years screened for elevated blood levels. Screenings by private medical providers, including community and rural health centers exceeded screenings conducted by LHDs, as LHDs screened 37,463 children and private clinics performed 84,234 screenings. These numbers remain high, chiefly due to the fact that the State Laboratory of Public Health has offered blood lead analysis at no charge since 1994. A targeted approach within LHDs continues. Children with the highest statistical risk for elevated blood lead levels, based on policies promoted by the CDC, are a major focus. Almost every child 12 and 24 months old attending LHD well child clinics was screened for blood lead. The screening rate for 1- to 2-year-olds receiving Medicaid was 54.5%. There were 467 confirmed cases ≥ 10 micrograms/dL and 38 confirmed cases ≥ 20 micrograms/dL. Enhanced follow-up for children with screenings ≥ 10 micrograms/dL continued as 9 regional specialists working with children with elevated blood lead levels made a total of 742 site visits.//2005//

b. Current Activities

/2005/ To better serve the state's increasing Latino population, the Hispanic Task Force continues to meet on a quarterly basis. The state lead program supports initiatives designed to enhance outreach to the Latino population, including participation in El Flora Latin and LA Fiesta del Pueblo (annual events designed for outreach). Amendments were passed to the state lead law which make environmental hazard and cleanup standards consistent with those of EPA; clarify the requirement that laboratories report all blood lead test results; and require the department to offer home investigations for all children with blood lead elevations (≥ 10 microgram/dL). A strategic planning committee with the mission of designing a plan to eliminate lead poisoning in North Carolina's children by 2010 through health and housing initiatives is meeting, with the final draft of the plan due for completion by June 2004.//2005//

c. Plan for the Coming Year

/2005/Continued collaboration and increased public awareness of the hazard of lead in children is expected with a special emphasis on the Latino population. Focused education for families of at-risk children will promote a decrease in overall numbers of cases of elevated blood lead levels. Implementation of North Carolina's plan to eliminate childhood lead poisoning by 2010 will continue. Duke University's Nicolas School of the Environment will continue toward the completion of a GIS-based lead risk models for 33 of North Carolina's 100 counties including the largest population centers and those counties at highest risk. This will foster the identification of houses at risk for lead hazards to children. Activities will be implemented to enhance the participation of health care providers in the provision of blood lead screening and appropriate follow-up care. A bill will be drafted on tax incentives to eliminate or control lead hazards in housing. //2005//

State Performance Measure 3: *Percent of women who gained <15 pounds during pregnancy (SPM#5)*

a. Last Year's Accomplishments

/2005/The Baby Love Program, specifically through the Maternity Care Coordinators (MCCs) and Maternal Outreach Workers (MOWs), provides case management and support services to pregnant women. These services are also designed to support women and provide education on the importance of adequate weight gain during pregnancy. The MOWs and MCCs also work with women to ensure they have nutritious food available in the home.

During FY03, the Perinatal Outreach and Education Training (POET) Program has focused on several primary areas of emphasis, including perinatal HIV; substance abuse (includes smoking); health disparities; breastfeeding; preconceptional and interconceptional health; stress, anxiety and depression; and the promotion of best practices in perinatal care. This is inclusive of programs on appropriate weight gain./2005//

b. Current Activities

/2005/The Women's Health Nutrition Consultant position was vacant during the majority of FY04. Basic activities included monitoring local health departments and high risk maternity clinic to determine appropriate interventions were being provided for pregnant women. The "Healthy Mom, Healthy Baby" educational booklet continued to be distributed by local maternal health providers. This included information on nutrition and pregnancy. 2005//

c. Plan for the Coming Year

/2005/During the coming year, the new Women's Health Nutrition Consultant will provide guidance and technical assistance on women's health and nutrition, with a focus being on appropriate weight gain during pregnancy. This position will focus on best practice efforts and provider training on nutrition issues. This position will also be instrumental in working with the high risk maternity clinic's nutritionist, local health department staff, and outreach workers with community based organizations, in the provision of education and support surrounding appropriate weight gain for pregnant women./2005//

State Performance Measure 4: *Percent of children 5-18 who are obese (BMI greater than or equal to 95th percentile) (SPM#6)*

a. Last Year's Accomplishments

/2005/The following activities related to childhood overweight were accomplished with combined funding from CDC, USDA, MCHB, and state appropriations through the NC Healthy Weight Initiative (HWI):

-There was unprecedented media coverage of childhood overweight and the Healthy Weight Initiative including TV, radio and print media.

-A second printing of Moving Our Children Toward a Health Weight (2000 copies) was published in June 2003 which included an addendum with an update on actions taken to move forward on plan recommendations.

- The formative research into policy changes within the WIC and CACF Programs was completed and a report drafted.**
- Color Me Healthy, a nutrition and physical activity curriculum originally developed for children in child care settings was tested in six local WIC Programs. The program was well received by clients and staff.**
- Significant progress was made in developing a pilot intervention in child care centers. This included researching recommendations and standards for practice that impact childcare settings as well as models for assessment tools. A Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) instrument was drafted.**
- Work continued on the development of standards for all foods served in schools in collaboration with NC affiliates of the American Heart Association and Action for Healthy Kids.**
- Collaboration continued with the Healthy Schools Initiative on the implementation of a new school-board policy that all children in elementary and middle school have at least 150 minutes of physical activity each week.//2005//**

b. Current Activities

/2005/In FY04, many activities were undertaken related to childhood overweight, including funding opportunities, surveillance system improvements, and new interventions. Local communities were awarded \$220,887 by DPH to implement recommendations from Moving Our Children Toward a Healthy Weight? Finding the Will and the Way and the Blueprints for Changing Policies and Environments in Support of Healthy Eating and Increased Physical Activity. In addition, the Health and Wellness Trust Fund Commission, chaired by the Lieutenant Governor, released an RFA based on the HWI recommendations. Grants in amounts of \$75,000 to \$150,000 for each of three years were awarded to 12 community organizations and 4 regional/statewide organizations. The focus of these grants is obesity prevention in children and people who influence them. The NC Nutrition and Physical Activity Surveillance System is being enhanced to monitor trends in key nutrition and physical activity behaviors, with computer programming to be completed in June 2004. The Nutrition and Physical Activity Self-Assessment for Child Care intervention was implemented in six counties throughout the state, with two additional counties serving as controls. Twelve intervention centers and four control centers participated in this pilot intervention. The model for this intervention includes use of a local health professional, the Child Care Health Consultant, who is typically a registered nurse, to provide individual guidance, continuing education and targeted technical assistance to the child care centers in that county.//2005//

c. Plan for the Coming Year

/2005/Activities planned for FY05 include:

- Continuing work on the NAP SACC intervention by disseminating the program to an additional 10 counties; completing a reliability/validity study on the NAP SACC assessment tool; developing web-based training on NAP SACC for child care health consultants; providing training and technical assistance to child care providers on personal wellness and role modeling; and developing parent education materials for child care and WIC providers that are consistent with messages in NAP SACC and Color Me Healthy.**
- Monitoring key physical activity and nutrition behaviors in children and youth through the automated health services information system and continuing to monitor trends in BMI by age group.//2005//**

State Performance Measure 5: *Percent of adolescents in public schools with access to services of a school-based or school-linked health care center (SPM#8)*

a. Last Year's Accomplishments

/2005/The percentage of North Carolina students in grades 6-12 with access to SB/SL Health Centers receiving partial funding from the NC Division of Public Health decreased slightly from FY02 to FY03, going from 9.6% to 6.8%. Communities have not been as successful as was initially hoped in sustaining funding after the Making the Grade program funding ended and state budget constraints have not permitted an increase in state funds. Eight counties dropped some or all of their centers -- a total reduction of 14 sites in FY03 from FY02.

The quality of services available to students in the SB/SL Health Centers continued to improve. The credentialing program encourages centers to participate in on-site evaluations to determine their compliance with quality performance standards. Five centers were credentialed in FY03, bringing the total number of credentialed centers to 13. Some progress was made in quality assurance as centers became better trained and skilled to identify their strengths and weaknesses. Additional work is needed and will be done in FY04.

The Finance Technical Assistance Team continued to provide important services by conducting in-depth practice assessments and generating Center Assessment Reports. Workshops on "Managing Your Center: Monitoring Financial Performance and Maintaining Privacy" and "Playing the Insurance Game: Coding, Fee Schedules and Claims Filing" were conducted in the spring of 2003.//2005//

b. Current Activities

/2005/Six credentialing reviews were made to centers first credentialed in 2001 and ten credentialing reviews were made to centers requesting first-time credentialing. One of the previously credentialed centers and one of the first-time centers did not meet the standards and have requested a second review in Fall 2004. Other centers either met the standards in the site review or were given the chance to remedy gaps in service through a 3-month corrective action plan. To date, 8 of these 10 centers have been credentialed and two are still completing corrective action. Reviews were done in one-day visits by a team of 4 reviewers comprised of DPH staff and peer reviewers from centers with best practice in the areas they reviewed. Two follow up team meetings were held to identify and incorporate enhancements to the credentialing system and to refine the existing monitoring process.

CQI was an important component of the credentialing process and center staff received valuable technical assistance in this area during the reviews. Because staff turnover is high in SB/SL Health Centers, it is likely that training and technical assistance will need to be on-going. Annual visits by Regional School Nurse Consultants provided technical assistance to all SB/SL Health Centers that did not have a credentialing review this year. The Finance Technical Assistance Team continued to provide financial practice assessment site visits and training to center staff.

A 4-year funding plan was developed which provides a transitional year to move toward the new NC DHHS requirement that all contracts be performance based in FY06, and it lays the groundwork for a new 3-year RFA that will be issued in the fall of 2004. A Performance Based Funding Advisory Committee was convened to provide insight and recommendations for the formula. Benchmark standards related to productivity, charges and receipts were developed and used in the formula. All Centers have been notified of new funding levels.

The State Health Director has established School Health as a top priority and a new School Health Initiative has been launched. Due to state budget constraints and a strong push for much needed school nurses, it is unlikely that an increase in state funding for SB/SL Health Centers will become available. However, the School Health Initiative is providing an opportunity for greater visibility of the value of SB/SL Health Centers and fostering greater collaboration among the centers, schools, and community providers. One of the SB/SL Centers will be part of Grand Rounds at UNC-Chapel Hill School of Medicine in June.

Progress on the data system has been delayed this year due to a vacancy in the School Health Program Manager position since September 2003. The position has been released from the freeze, posted twice and interviews have begun. The staff vacancy also resulted in no data training being conducted for center staff in FY04./2005//

c. Plan for the Coming Year

/2005/Plans are underway to hire a temporary business liaison specialist to do a comprehensive review of data needs of the SB/SL Health Center Program, analyze the current data system, make recommendations and help implement those recommendations. The improved data system will have a critical role in tracking progress and problems in centers, identifying training and technical assistance needs, showcasing successes, and supporting performance based funding.

The four-year funding plan provided for two categories of funding in the 3-year RFA to be released in the fall of 2004. One category will be for centers that are credentialed and one category will be for non-credentialed models that target identified community needs and address school health priorities of the WCHS. One currently funded example of this alternative model is a Mental Health Case Management Center. Credentialed centers will receive a higher level of funding overall than alternative models because they provide comprehensive services and have met quality standards.

A meeting has been scheduled for staff of all non-credentialed centers to discuss community needs, level of demonstrated community support, appropriateness of interventions and other issues of concern to the centers that will assist the state in the development of the RFA for alternative models.

Six non-credentialed centers have expressed interest in a credentialing review in August or September 2004. Upon submission of adequate assurances of compliance with the standards, the reviews will be made. If centers are successful, they will be eligible to apply for funding in the credentialed category of the RFA.

CQI consultation targeted to meeting performance measures will be the focus of training and technical assistance in FY04. A team approach is planned, led by the full time clinical services coordinator. Completing the team will be a licensed clinical social worker (part-time), a nutrition consultant and physical activity specialist scheduled to be hired in the near future for the School Health Unit, the Finance Technical Assistance Team, and Regional School Nurse Consultants./2005//

State Performance Measure 6: Percent of women who smoke during pregnancy (SPM#9)

a. Last Year's Accomplishments

/2005/During FY03, the Guide for Counseling Women Who Smoke was revised and

updated to include the 5 A's best practice approach for counseling women who smoke, as well as additional sections and resources. A videoconference was held on May 12, 2003 to present the revised guide across the state. Over 180 participants attended at eighteen videoconference sites across the state. The revised guide will be used for training programs and will be distributed to health care and human service providers across the state.

The Program Consultant continued to manage the Women's Health and Tobacco Use (WHTU) Program's activities. The WHB received funding from the Health and Wellness Trust Fund Commission of NC to develop and implement the Smoking Cessation for Pregnant Teens Project (SCPTP) for a three-year period. 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. Under the SCPTP, the WHB has provided funding to the NC Healthy Start Foundation 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 continues to collaborate 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 in the fall of 2003. Data collected from this survey will be used to determine future WATCH initiatives.//2005//

b. Current Activities

/2005/ During FY04, the Guide for Counseling Women Who Smoke was distributed to over 600 health care and human service providers across NC, as well as to other states in the nation. The Guide continues to be used for training programs across the state.

Under the SCPTP, the maternity clinic staff at all three project sites were trained to provide smoking cessation counseling to pregnant women, specifically targeting pregnant teens. The project was fully implemented in September 2003. Counseling services for smoking cessation and secondhand smoke are being provided at all three project sites. A SCPTP database was developed and implemented to collect and track program data. The Program Consultant conducts quarterly Program Coordinator meetings and biannual site visits at each project site. The new smoking cessation educational material for pregnant teens was printed and distributed across the state, specifically targeting the SCPTP counties. The development and design for the new secondhand smoke educational material for pregnant teens was completed and will be printed by June 2004.

The NC Collaborative Survey on Smoking Cessation During Pregnancy was distributed to over 1,600 prenatal care providers in October 2003. Two follow-up mailings were completed and additional telephone follow-up was conducted through May 2004 to increase the response rate. As of April 1, 2004, the response rate was 51%. Preliminary survey results were shared with WATCH members during their quarterly meeting in April 2004. A report of the final survey findings will be developed and printed by September 2004. This report will be distributed to survey respondents, health care and human service providers, and other interested parties.

In March 2004, the Program Consultant was invited by ACOG to give a presentation on

the Women and Tobacco Coalition for Health in Washington, DC. This presentation was given to several state teams under a new partnership project formed with ACOG, Planned Parenthood and the Association of Maternal and Child Health Programs.//2005//

c. Plan for the Coming Year

/2005/During FY05, the Program Consultant will continue to facilitate and manage WATCH activities and quarterly meetings. The Program Consultant will continue to manage and support the SCPTP and oversee the development and distribution of new age-appropriate educational materials. The Survey Action Team will work to develop the final report of the survey results. New action teams will be developed to lead specific WATCH activities based upon survey findings. Existing partnerships will be strengthened and new partnerships will form to support WATCH initiatives. Distribution of the revised Guide for Counseling Women Who Smoke will continue and training programs will be provided across the state.//2005//

State Performance Measure 7: *Percent of women giving birth in the state whose pregnancy was unintended (SPM#11)*

a. Last Year's Accomplishments

/2005/The most current PRAMS data available for this measure are from CY01 and show that 42.6% of pregnancies were unintended. This is a slight decrease from the weighted percentage from CY00 (45.3%), but is still much higher than desired.

The Family Planning and Reproductive Health Unit (FPRHU - formerly Women's Preventive Health Unit) continues to provide comprehensive family planning services through a network of approximately 140 service sites throughout the state which served 142,802 unduplicated patients in CY03. The number of patients served in CY03 increased by only 635 when compared to CY 2002; a modest .5% increase. However, this is the third consecutive year that the program has shown positive growth in patients served in spite of severe budget cuts and significant increases in the cost of contraceptives and other supplies (Thin Prep) this past year. The increase in the patient census in the past three years appears to be the culmination of a series of local outreach initiatives supported with special initiative funds to improve access to services, reduce unintended pregnancies, and increase patient numbers. The incremental and targeted process began in FY99, and has continued through FY03. The success of the demonstration projects enabled the FPRHU to formally adopt a performance based funding strategy in distributing additional funds in FY04, which awarded health departments "bonus" funds commensurate with long term and short term patient increases.

In conjunction with the Division-wide accountability initiative, the FPRHU participated in the development of 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.//2005//

b. Current Activities

/2005/In cooperation with staff from DMA, the FPRHU is currently in the final phase in

the implementation of a 1115(a) demonstration waiver. The Medicaid waiver will extend eligibility for family planning services to all women and men over age 18 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.

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. The FPRHU is also currently implementing the specific action steps prescribed for the unit in DPH's Recommendations for Eliminating Health Disparities. Implicit in these action steps is also the reduction of unintended pregnancies in the minority populations.

The FPRHU is continuing to develop an internal capacity to apply social marketing principles to its programs, as well as provide consultation and technical assistance to local delegate agencies wishing to use this approach. These efforts are intended to further the goals of the program to prevent unintended pregnancies by enhancing the ability of local providers to recruit clients and provide outreach and education to the communities they serve. Specific to the implementation of the Medicaid waiver, the FPRHU has entered into a contract with a private social marketing firm that will conduct a series of focus groups across the state to help the Unit design a social marketing plan on the best methods to publicize the Medicaid waiver in order to recruit the eligible patient population.

Funding for sterilization services, temporarily suspended in FY03, has been restored in FY04 at approximately \$500,000, thereby improving the program's success in reducing unintended pregnancies.

A recent reorganization of the Women's Health Regional Nurse Consultants (RNCs) facilitates the continuing implementation of the aforementioned divisionwide accountability system. In addition, the new structure 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. In addition, RNCs will work closely with the four regional Women's Health Social Work Consultants (RSWCs) to decrease unplanned pregnancies in NC//2005//

c. Plan for the Coming Year

/2005/The FPRHU is anticipating the final approval of the 1115(a) demonstration waiver by October 2004. Implementation of the Medicaid waiver will follow soon after and may take the remainder of this year and most of next year to be fully established. Data from the social marketing contract will be carefully analyzed by Unit staff and the contract agency, and results will shape future social marketing activities for the Medicaid waiver. Regional Nurse Consultant 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 Initiatives will continue to expand with the restoration of TANF funds. This is significant in light of the high rates

State Performance Measure 8: *Percent of women of childbearing age taking folic acid regularly (SPM#12)*

a. Last Year's Accomplishments

//2005/In collaboration with other partners, the NC Folic Acid Council and Awareness Campaign has completed a structured strategic planning process, strengthened infrastructure, and increased membership capacity. An Eastern Folic Acid Campaign Coordinator was hired to complement the coordinator in the western part of the state. In addition to infrastructure and planning there was increased focus on education for young women aged 18-24. Activities included social marketing and consumer testing of folic acid and multivitamin promoting messages (to form the basis of future marketing work) and the use of geodemographic analysis. The Community Ambassador (consumer peer education) program reached over 2500 consumers through health and bridal fairs and other community events. Over 474,000 education and incentive items were distributed to public health, medical, and educational institutions across the state. Eighty thousand households were reached through a two-county cable media campaign in the far western part of the state targeting Latino communities. In addition, a radio media campaign was done in the Charlotte market.//2005//

b. Current Activities

//2005/State funding of \$300,000 continues to support and expand activities from previous years. Current emphasis is on improving/enhancing the market message to break through the 35- 40% level of multivitamin intake and will focus tightly on messages and communication channels for women 18-24 years. Activities include: 1) a redesign of the web site, www.getfolic.com, based on consumer feed back and stages of change theories; 2) developing new campaign materials (e.g. posters, PSAs, informational brochures, etc. are going out to bid to a marketing agency); 3); standardization and publication of training tools; 4) capacity, infrastructure and partnership building for the Eastern region campaign; 5) continued support of Fullerton Genetics Center's Western Region Campaign; and 6) continued distribution of materials through the NC Healthy Start Foundation and the NC Health Resource line.

Much of the planning efforts are directed at the \$3 million settlement from a multi-state vitamin anti-trust lawsuit. These funds have been allocated to the Folic Acid Council's fiscal agent, the NC March of Dimes, and will be available later in 2004.//2005//

c. Plan for the Coming Year

//2005/Efforts and activities to expand and support campaign and Council infrastructure along with targeted intervention are planned for 2005. Objectives include increasing membership and committee participation; training of new community volunteers; continuing funding for statewide and regional campaign coordinators; distribution of new campaign materials and/or media campaign (this will be based on consumer input); continued use of the "drug rep" model for creating grassroots partnerships with medical offices; and limited distribution of multi-vitamins to women of child bearing age who visit health departments.//2005//

a. Last Year's Accomplishments

/2005/ In FY03, 6 regional school nurse consultants working under the direction of the state school nurse consultant continued to promote the development and expansion of school health services. They collaborated with the School Nurses Association of NC to support the inclusion of 50 new state-funded school nurse positions in the Governor's budget. The General Assembly (GA) provided additional funds to the Department of Public Instruction for Support Services staff, but did not specifically " earmark" the money for school nurse positions. The GA did adopt a "Special Provision" requiring the State Board of Education to study the school nurse to student ratio and make recommendations regarding appropriate ratios by February 2004. Continuing education for approximately 450 school nurses was provided through the 19th Annual School Nurse Conference entitled School Nurses: Partnering with Children, as well as through 2-day orientation workshops for 100 new school nurses. A physical assessment workshop and a school nurse certification review course were also provided. The Annual School Nurse Survey and Program Summary was conducted to determine the nurse to student ratios, the scope and complexity of health services provided to students, the trends in chronic illness prevalence and preventable diseases and the extent of unmet needs. Data were summarized in the NC Annual School Health Services Report for Public Schools. The nurse to student ratios ranged from 1:473 to 1:6324 with the average across the state at 1:1918. Four Local Education Agencies (LEAs) were without school nurse coverage. The percent of school nurses who hold a baccalaureate or higher degree has increased from 74% in FY02 to 77% in FY03. As part of DPH's new School Health Matrix, a two-day conference entitled Broadening Our Horizons was conducted for staff to increase awareness of the components of Coordinated School Health Programs and to expand awareness of partnership opportunities.//2005//

b. Current Activities

/2005/ The 6 regional school nurse consultants continue to work within their regions to promote the development and expansion of school health services. An RFA entitled "Healthy Students Ready to Learn" to fund 40 new school nurse positions and a special Coordinated School Health Program component was developed and distributed to local communities. Eighty-two applications were received, reviewed and ranked for funding to begin in FY05. The State Board of Education, in response to the GAs required study of nurse to student ratios, adopted a recommended 1:750 ratio by 2014. The supporting documents used by the State Board in making their decision were developed and provided by the nurse consultants in the DPH School Health Unit. Continuing education for approximately 450 public health and school nurses was provided at the 20th Annual School Nurse Conference, entitled "School Health Then and Now", two school nurse orientation workshops for 100 new school nurses and their supervisors, a physical assessment course, a school nurse certification review course, the School Mental Health Project consisting of 10 modules on a variety of mental health topics, and the "Nursing Care of Children in Disasters and Public Health Emergencies" course co-sponsored with NC's EMSC attended by more than 250 school nurses. School health services staff have participated in the development of the logic models for the C&Y Branch and for the School Health Matrix. In collaboration with the Best Practice Committee of the School Nurses Association of NC, the Student's Permanent Health Record was revised to include a place to record BMI.//2005//

c. Plan for the Coming Year

/2005/Data from the School Nurse Survey and Program Summary for FY04 will be summarized in the NC Annual School Health Services Report for Public Schools. As in

previous years, these data will be used to identify trends in student needs and services delivery and to support recommendations for policies and increased staff. The Report will be distributed to school nurses, to key decision-makers in state and local government and to advocate for school nursing/health across the state.

The 6 regional school nurse consultants will continue to work within their regions to promote the development and expansion of school health services and other components of the Coordinated School Health Program. Through the School Health Matrix, they will work closely with regional dental hygienists from the Oral Health Section and with other staff affiliated with the Matrix to assist local school districts in the development of school health advisory councils, implementation of a school health assessment, and the implementation of tobacco free campuses and daily physical activity programs. Considerable attention will be given to the successful implementation of the "Healthy Students Ready to Learn" grants that will provide funding for 40 new school positions and selected components of the Coordinated School Health Program. If the GA funds an additional 100 new school nurse positions as requested by DPI, even greater effort will be displayed in providing appropriate consultation around program expansion.

The 21st Annual School Nurse Conference will be held September 16-17, 2004 in Greensboro, NC for approximately 500 nurses and other school staff. The program will address a number of clinical and environmental issues affecting student health with focus on mental health and cultural sensitivity/diversity. The school nurse consultants will continue to serve on a variety of state committees and task forces in order to promote interdisciplinary and interagency collaboration regarding school health programs. These include: Youth Prevention and Control Committee, NC Asthma Alliance, NC Diabetes Advisory Council, School Mental Health Project, Board of Nursing Medication Aide Project, and the EMSC subcommittee for the NC EMS Advisory Council.//2005//

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 1) Number of substantiated cases of child abuse and neglect (SPM#1) | | | | |
| 1. Continuation of the Intensive Home Visiting Initiative. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Continued implementation of the Adolescent Parenting Program projects. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Training of professionals and promotion of public awareness about the Infant Homicide Prevention Act | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. Assist with implementation of Child Well Being and Domestic Violence Task Force recommendations. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Continued collaboration with NC Parenting Education Network. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Continued support of the NC Fatherhood Development Advisory Council. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|-----|--------------------------|--------------------------|--------------------------|--------------------------|
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|--------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 2) Percent of children less than 6 with elevated blood levels (greater than or equal to 10 micrograms/dL) of lead (SPM#4) | | | | |
| 1. Collaboration between WCHS and DEH/Children's Health Branch. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Ad-Hoc Lead Advisory Committee quarterly meetings. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Full-day clinical workshops for LHD staff and private healthcare providers conducted 3 times/year. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Annual 3-day Lead Investigation and Remediation workshop targeting local EH specialists. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. New local EH specialists receive 1-day training. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Lead-Safe Work Practices workshops provided for housing renovators, housing agencies, and public. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. GIS-based risk prioritization county maps created and revised. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Preventive Maintenance Program and education efforts to owners of older residential rental property. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. State Laboratory of Public Health provides blood lead analysis at no charge. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 10. Funds allocated to LHDs to provide medical and environmental follow-up of lead poisoned children. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|
| | DHC | ES | PBS | IB |
| 3) Percent of women who gained <15 pounds during pregnancy (SPM#5) | | | | |
| 1. Maternal Care Coordination and Maternal Outreach Programs. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Intensive Medical Nutrition Therapy counseling available at LHDs. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Interpreter and bilingual services at LHDs to assure immigrants' access. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. School-based and school-linked clinics educate on disordered eating in youth. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 4) Percent of children 5-18 who are obese (BMI greater than or equal to 95th percentile) (SPM#6) | | | | |
| 1. Continuation and expansion of Nutrition and Physical Activity Self | | | | |

| | | | | |
|---|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| Assessment for Child Care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Enhancement of Nutrition and Physical Activity Surveillance System. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Local funding for community-based interventions on healthy eating and physical activity. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Healthy Weight Initiative (CDC grant funded project) activities continue. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|--------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 5) Percent of adolescents in public schools with access to services of a school-based or school-linked health care center (SPM#8) | | | | |
| 1. Regional and Management technical assistance to projects. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Financial Practice Assessment site visits. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Credentialing of SB/SLHCs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Establishing benchmark standards for SB/SLHCs related to productivity, charges, and receipts. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Data collection and analysis. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. RFAs for the planning and development of new SB/SLHCs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Collaboration between the State and local projects. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Strengthen the Continuous Quality Improvement (CQI) component of the credentialing process. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|--------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 6) Percent of women who smoke during pregnancy (SPM#9) | | | | |
| 1. Distribute the revised Guide for Counseling Women Who Smoke and other educational materials. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Develop and implement the Smoking Cessation for Pregnant Teens Project. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Facilitate and manage the Women and Tobacco Coalition for Health activities. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Develop/sustain partnerships with women's health and tobacco use prevention/cessation organizations. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|-----|--------------------------|--------------------------|--------------------------|--------------------------|
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 7) Percent of women giving birth in the state whose pregnancy was unintended (SPM#11) | | | | |
| 1. Full implementation of the 1115(a) demonstration waiver (Medicaid waiver). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Continuation and expansion of the Hispanic/Latino Outreach Initiatives. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Continuation and expansion of special outreach initiatives, particularly to teen patients. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Restoration of sterilization funding and services. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Continuation of TPPI, with greater emphasis on programs for Hispanic/Latino youth. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|--|--------------------------|--------------------------|-------------------------------------|-------------------------------------|
| | DHC | ES | PBS | IB |
| 8) Percent of women of childbearing age taking folic acid regularly (SPM#12) | | | | |
| 1. Education of health care professionals via a variety of strategies. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Education of consumers and reminders to take a multivitamin daily. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Mass media and public awareness activities. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| STATE PERFORMANCE MEASURE | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 9) Ratio of school health nurses to the public school student population (SPM#13) | | | | |
| 1. Development of program agenda for Annual School Nurse Conference | | | | |

| | | | | |
|---|--------------------------|--------------------------|--------------------------|-------------------------------------|
| and other continuing ed offerings. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Participate in the implementation of the School Health Matrix "deliverables." | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Clinical and administrative consultation, training and TA to school districts, LHDs and hospitals. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Collection and analysis of data regarding school health needs, resources, and program services. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Development of standards, guidelines and procedures. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Dissemination of new nursing and school health related information. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

E. OTHER PROGRAM ACTIVITIES

Since 1990, the WCHS has participated in a public/private partnership to conduct an award-winning statewide public education campaign (First Step) and toll-free hotline (1-800-FOR-BABY). In FY99, a partnership of agencies decided to pool resources and create a new service called the NC Family Health Resource Line (NCFHRL) which incorporates the First Step campaign with other state child and family programs. The 1-800-FOR-BABY number and marketing continue. The NCFHRL uses the toll-free number, but advertises it using the numeric format (1-800-367-2229). The First Step campaign uses a multimedia approach to focus public attention on the importance of preconceptional health, prenatal care and appropriate parenting skills. Callers receive information on healthy pregnancies and a variety of other topics such as domestic violence, substance abuse prevention and treatment, parenting, housing, transportation, car seat rentals, public assistance, and other local resources. The hotline employs bilingual staff and a substance abuse specialist and has a TTY line.

In FY99 and FY00, the Minority Infant Mortality Reduction Public Awareness Campaign continued. This multimedia effort, focusing on African-American families, included the distribution of posters, a "family album," television public service announcements, radio advertisements, and a videotape with discussion guide for use in local communities. The theme of the initiative, "Your Family is Bigger Than You Think," emphasized the positive message of the need for and availability of family and community support in achieving a healthy birth outcome. The initiative received an award from the national Healthy Mothers, Healthy Babies Coalition in 1997.

Another educational campaign, the "Marta Campaign," was initiated in FY99. Its goal is to help link the Latino population to existing women's and children's health resources. It is hoped that Marta, the fictional character featured in campaign materials, will be used in future campaigns, thereby creating a trusted advisor that people can look to for answers to health questions. Spanish educational materials describing how to enroll in Medicaid, Health Choice, and day care centers were distributed at community health centers and local tiendas or convenience stores. A database of agencies that serve a high Latino population was developed and these agencies received several targeted mailings of materials.

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.

/2002/The educational campaign targeting the Latino population continued in FY00; however, based on responses from the community and an informal advisory group to NCHSF, the name of the main character was changed from Marta to Ana Marie.

The SIDS Program continued to work closely with NCHSF to expand opportunities for community outreach and awareness. SIDS Counselors were involved in training and material development targeting health care and childcare providers. Counselors were trained to use specific educational tools that were made available through special grant funding. This educational service coincided with the annual billboard and radio campaigns. Expansion of prevention services includes a primary focus on health disparities reported in the African-American and Latino communities. Update training for SIDS Counselors was provided through a 1-day regional teleconferencing event. Initial training for SIDS Counselors was provided during a 3-day conference.

/2003/In FY01, 46,770 calls were answered by the NCFHRL. Of these, 32, 271 were English speaking callers and 14, 449 were Spanish speaking callers. This showed a 350% increase in Spanish speaking callers from FY00. During FY01, the Native American Public Awareness Committee was formed as a collaborative effort between WCHS, the Commission on Indian Affairs, the Office of Minority Health and Health Disparities, and the NCHSF. Plans were underway to develop print materials and a media campaign focused on improving birth outcomes in the American Indian community.

/2004/ Due to problems with the original contractor and funding issues, the NCFHRL was moved in August 2002, requiring the hiring of new staff and co-location of the line with the Child Care Resource and Referral Line at the NC Partnership for Children. UNC-Chapel Hill now administers the line. Orientation/extensive training for new management and staff and creation of new guidance for resource/referral manuals occurred in August and continued after the line opened at its new location. WCHS has continued to promote the NCFHRL as a routine aspect of HC/NCHC outreach. In addition, the hotline staff's listing of free and low cost clinics was updated so that staff are better prepared to respond to uninsured families who do not qualify for state programs or who qualify but end up on a waiting list for enrollment. Problem calls are regularly referred for intervention/resolution. Biannual meetings and daily phone/email communication keep NCFHRL staff updated. There are periodical tests to assure that the National Insure Kids Now rollover is functioning properly.//2004//

/2005/UNC-CH administers the NC Family Health Resource Line (FHRL). The Child Care Health & Safety Resource Center is an integral part of FHRL. Having bilingual Health Communication Specialists helps with the increased number of Hispanic callers. FHRL helps advocate for the Hispanic callers and connects them to appropriate resources in NC. The service level remains high. WCHS promotes the FHRL routinely with HC/NCHC outreach. Periodic tests are conducted to assure that the National Insure Kids Now rollover functions properly. Bimonthly in-services and daily phone/email communication keep FHRL staff updated.//2005//

F. TECHNICAL ASSISTANCE

Technical assistance needs during FY01 will center around assessment of WCHS organization, structure and functioning in the wake of changes in agency structure and personnel changes that resulted from these changes and planned retirement of key management team members.

/2003/ There are no identified technical assistance needs for FY03 at this time.

/2004/ See Form 15 for specific technical assistance requests.//2004//

//2005/ See Form 15 for specific technical assistance requests.//2005//

V. BUDGET NARRATIVE

A. EXPENDITURES

/2004/ Total State partnership expenditures were approximately \$16 million lower in FY02 than in FY01. This reduction (9%) was attributed primarily to decreases in the program income category (Form 3). Significantly fewer expenditures paid by the state Medicaid program for child service coordination activities, along with a general reduction in other Medicaid services, accounted for this lower expenditure. This reduction was reflected in lower expenditures attributed to infants and children (Form 4), and in Enabling Services (Form 5).//2004//

/2005/Specific expenditure variations that appear on Forms 3, 4, and 5 are explained in the appropriate notes for line items in each of those forms. There were multiple reasons for the variations, including changes to the way the MCH Block Grant funds were budgeted, a reduced receipt and expenditure of the WIC infant formula rebate, and differences in Medicaid budgets.//2005//

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 budgeting method that was implemented in FY03 continued in FY04. Attached is a table reflecting the distribution of MCH Block Grant funds anticipated in FY05 according to the targeted programs.

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 FY04 application, is \$13,143,054.//2005//

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.