ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

State Profile

A SNAPSHOT OF HOW THE TITLE V MATERNAL AND CHILD HEALTH BLOCK GRANT WORKS IN YOUR STATE

North Carolina

Maternal and Child Health Block Grant 2019

The Maternal and Child Health Services Block Grant, Title V of the Social Security Act, is the only federal program devoted to improving the health of all women, children and families. In FY2017, 86% of all pregnant women, 99% of infants, and 55% of children nationwide benefitted from a Title V-supported service. To learn more about Title V, visit www.amchp.org.

MCH Block Grant Funds to North Carolina

FY 2016	FY 2017	FY 2018
$17,251,965	$17,222,472	$17,424,544

Title V Administrative Agency:

Division of Public Health, NC Department of Health and Human Services

*States must provide a three dollar match for every four Federal dollars allocated.

Protecting and Improving the Health of North Carolina's Families

The most recent strategic plan for Title V children's services in North Carolina identified the following strategies:

1. Support the quality of health services;
2. Support the quality of health providers, both internal and external to the organization;
3. Support access to quality care;
4. Increase and sustain family/community/provider engagement; and
5. Increase and sustain parent/community/provider education and awareness.

Care Coordination for Children – The population care management service called Care Coordination for Children (CC4C) is a collaborative effort at the state level among Division of Public Health (DPH), Division of Medical Assistance (DMA), and Community Care of North Carolina (CCNC). Pediatric care coordination is a patient and family centered, assessment driven, team-based activity designed to meet the needs of children, birth to age five, while enhancing the caregiving capabilities of families. Care coordination is integrated within or strongly linked to a community-based primary care medical home setting. The CC4C priority population is children who: 1) have special health care needs, 2) are exposed to toxic stress, 3) are in foster care and not linked to a Medical Home, 4) are transitioning out of a Neonatal Intensive Care Unit back to the community and a medical home; and 5) who are exposed to substances.

Children and Youth with Special Health Care Needs – The Children & Youth Branch has lead responsibility for CYSHCN from birth to 21 years, including those with special needs, those exposed to adverse childhood experiences and those whose health are negatively affected by social determinants. The Branch works closely with the Early Intervention Branch that provides services to the birth to three-year-old population of children with developmental delays and disabilities. There is a strong Branch/Family Partnership with family linkages to all the programs serving CYSHCN. A staff position that must be a parent of a child with special needs is employed to provide guidance and direction for family/provider interaction, leadership training, program collaboration, and input for services. Specific partnerships and collaborations that occur around CYSCHN include care management, the CYSHCN Help Line, Innovative Approaches grants to improve local systems of care, emergency preparedness, school nurses, the Governor's Commission on CSHCN, the Office on Disability and Health, home visiting, genetic counseling services, and newborn screening programs. The Branch, in partnership with private philanthropic organizations, the federal government, and non-profit organizations fund Nurse-Family Partnership and Healthy Families America home visiting programs in the state. Additional funds focus on Triple P (Positive Parenting Program), an evidence-based population health initiative reaching large numbers of children with mild to severe behavioral health difficulties. Triple P is provided at multiple levels of intervention intensity using a variety of delivery formats. The goals are to 1) improve parenting in broad segments of the community; 2) alter prevalence rates of child emotional and behavioral problems and child maltreatment; and 3) increase school readiness. The roll out of Triple P began in SFY12 in seven counties which has since grown statewide to serve all 100 counties.

Infant Mortality Reduction – The Healthy Beginnings Program addresses the two-fold disparity between white and minority infant mortality in North Carolina by working with communities with significant minority infant mortality. Grants are given to local health departments (LHDs),

community-based organizations, and faith-based entities to support local, community-based minority infant mortality reduction efforts. Funded agencies are expected to provide the following services to minority pregnant and postpartum women, and follow them and their child for two years:

- Care coordination services;
- Health education and support in the following areas: breastfeeding initiation and maintenance up to at least 6 months, eliminating use and exposure to tobacco, infant safe sleep practices, folic acid consumption, reproductive life planning, healthy weight and exercise, and self-sufficiency;
- Ensure compliance with prenatal care, and well child visits and proper immunizations for their babies;
- Community-wide education and outreach; and
- Work with their male partners when applicable.

The Infant Mortality Reduction program distributes funding to LHDs across North Carolina to implement evidence-based strategies that are proven to lower the infant mortality rates in their communities. Funded LHDs must implement or expand upon at least one of the following evidence-based strategies: 17P (alpha hydroxyprogesterone); Centering Pregnancy; reproductive life planning/long acting reversible contraception access; Nurse Family Partnership; infant safe sleep practices; tobacco cessation and prevention; and doula services.

Care Management for Pregnant and Postpartum Women – The Women's and Children's Health Section (WCHS) works in partnership with the Division of Medical Assistance (DMA) and Community Care of North Carolina (CCNC) and other community stakeholders, including providers and LHDs to administer an innovative statewide program that creates a system of care through a pregnancy medical home (PMH) model and the provision of pregnancy care management (OBCM) services to pregnant and postpartum Medicaid recipients with risk factors for poor birth outcomes. The majority of the state's public and private prenatal care providers participate as PMHs. In doing so, the providers: ensure that no elective deliveries are performed before 39 weeks of gestation; engage fully in the 17P project; aim to decrease the cesarean section rate among nulliparous women; and complete a risk screening on each pregnant Medicaid recipient in the program to make referrals of patients to the local pregnancy care manager (OBCM). Pregnancy care managers are social workers and nurses employed by the LHD and work as members of the prenatal care team, collaborating closely with prenatal care providers to support the patient in achieving an optimal pregnancy and birth outcome.

Care Coordination for Interconception Women – North Carolina provides care coordination services for interconceptional care to women through its three federally funded Healthy Start sites – NC Baby Love Plus, University of North Carolina at Pembroke Healthy Start Corps and Robeson Health Care Corporation Healthy Start Program. The purpose of these programs is to reduce perinatal health disparities, with a primary focus on African American and American Indian families within seven NC counties. Care coordination services are enhanced through the provision of outreach, health education, and local action networks and community action networks.

Perinatal Health Strategic Plan – The Women's Health Branch and its partners continue work on implementing the Perinatal Health Strategic Plan 2016-2020 which is designed to address infant mortality, maternal health, maternal morbidity, and the health of men and women of childbearing age, with a focus on health equity.

Preconception Health – The NC Preconception Health Campaign, carried out by the March of Dimes-NC Chapter, provides folic acid and preconception health education to women before pregnancy to reduce the likelihood of future poor birth outcomes and infant mortality. Strategies employed include consumer education, provider training, use of electronic/social media, and the distribution of multivitamins to low income women of reproductive age across the state. Training themes focus on preconception health, tobacco cessation, the importance of obtaining a medical home, healthy weight, and reproductive life planning. NC also collaborates with the National Office of Minority Health and Health Disparities in implementing the Preconception Peer Education Program with local colleges and universities in the state.

Perinatal Neonatal/Outreach Coordination (PNOC) Project – Two funded sites, UNC Center for Maternal and Infant Health and Vidant Health Foundation, are administering the CDC Level of Care Assessment Tool (LOCATe) for maternal and neonatal care to birth facilities in two perinatal care regions. The sites also work with birthing facilities to develop and implement policies that support immediate postpartum insertion of highly effective, long-acting reversible contraceptive methods

Perinatal System of Care Task Force – In response to a study bill passed by the NC General Assembly, the NC WCHS is partnering with the NC Institute of Medicine to convene a task force to study the degree to which NC women receive risk appropriate maternal and neonatal care and make actionable recommendations to improve the state's perinatal system of care.

Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality – The NC WCHS is an active participant in both the Social Determinants of Health (SDoH) and Preconception Health (PCH) CoIINs. NC's SDoH CoIIN is working on revising practices and policies using the NC Health Equity Impact Assessment tool and developing a foundational health equity training module for DPH employees. The overall aim of the PCH CoIIN is "to develop, implement, and disseminate a woman-centered, clinician-engaged, community-involved approach to the well woman visit to improve the preconception health status of women of reproductive age, particularly low-income women and women of color." Three sites (Robeson Healthcare Corporation, Forsyth County Department of Public Health, and Mountain Area Health Education Center) are working with a state team in developing different approaches to meeting this aim.

Percentage Served by the North Carolina MCH Program*

90.0%	pregnant women
99.0%	infants under one
14.0%	children and adolescents
17.0%	children with special health care needs
2.0%	others

*2017 State/Jurisdiction Annual Reports Submitted to the Maternal and Child Health Bureau

State Selected National Performance Measures

- Well Woman Visit
- Risk Appropriate Perinatal Care
- Breastfeeding
- Developmental Screening
- Adolescent Well-Visit
- Medical Home
- Adequate Insurance Coverage
- Smoking

Current Special Projects of Regional and National Significance (SPRANS)

Healthy Tomorrows Partnership for Children Program
WAKE FOREST UNIVERSITY HEALTH SCIENCES
Winston Salem, NC

State System Development Initiative (SSDI)
NORTH CAROLINA DEPARTMENT OF HEALTH & HUMAN SERVICES
Raleigh, NC

MCH Research
UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL
Chapel Hill, NC

Epidemiological MCH/SPH Institute
UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL
Chapel Hill, NC

Maternal and Child Health Public Health Training Program
UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL
Chapel Hill, NC

MCH Workforce Development Center
UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL
Chapel Hill, NC

Health Needs in North Carolina

- Improve the health of women of childbearing age with special focus on health equity
- Reduce infant mortality with a special focus on social determinants of health
- Increase the number of newborns screened for genetic and hearing disorders and prevent birth defects
- Prevent child deaths
- Improve the health of children with special needs.
- Provide timely and comprehensive early intervention services for children with special developmental needs and their families
- Promote healthy schools and students who are ready to learn
- Increase developmental screenings for children and adolescents
- Increase access to care for women, children, and families, especially in uninsured populations and where disparities exist
- Improve healthy behaviors in women and children and among families incorporating the life course approach

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