North Carolina State Action Plan Table 2026 Application/2024 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Promote comprehensive reproductive health care including postpartum care and support	WMH Objective 1 By 2030, increase the percent of Medicaid deliveries that had a comprehensive postpartum visit on or between seven and 84 days after delivery from 60.7% (2023 Baseline) by 5% to 63.7%. WMH Objective 2 By 2030, the unduplicated number of people in NC receiving patient-centered reproductive health services, including contraception, will increase from 57,414 (2024 Baseline) by 2% annually. WMH Objective 2 By 2030, the unduplicated number of people in NC receiving patient-centered reproductive health services, including contraception, will increase from 57,414 (2024 Baseline) by 2% annually. WMH Objective 3. By 2030, increase the unduplicated number of adolescents in NC receiving adolescent-centered reproductive health education, including contraception, through NC DHHS Teen Pregnancy Prevention Initiatives (TPPI) funded programs	WMH 1.1 Participate in NC Medicaid's Maternal Health Internal Alignment Meetings and the Maternal Health Learning Collaborative, strengthening collaborations and ensuring alignment of activities and resources. WMH 1.2 Leverage home visiting programs (Healthy Beginnings, Healthy Start, Nurse-Family Partnership, Healthy Families America, and local health department (LHD) Women's Health Services Home Visitors, among others) to provide education and support to ensure that participants: (1) receive comprehensive postpartum clinical visits and (2) are informed about Medicaid 12 month extension and Medicaid expansion. WMH 1.3 Improve LHD data reporting and data quality for documenting postpartum visits by: - Providing training and technical assistance to LHD maternal health providers and support/billing staff on appropriate billing and coding for postpartum visit completion - Creating custom data form in each LHD's electronic health record to report out the data; (3) Creating a reporting template to share back EHR services and claims data, inclusive of data related to postpartum care; and (4) Selecting one or two LHDs to implement QI processes to improve the quality of the postpartum visit and the number of completed postpartum visits during FY26 and scaling up promising practices as possible statewide. WMH 1.4 Establish a "community of practice for postpartum care" inclusive of physicians, midwives, nurse practitioners, nurses, home visiting nurses, behavioral health providers, etc., providing care at NC LHDs or federally qualified health centers to share knowledge, best practices, and experiences to provide optimal postpartum care to new mothers. WMH 1.5 Provide postpartum navigation through the Perinatal Nurse Champion program in Perinatal Care Region 3 who will conduct culturally	ESM PPV.1 - Comprehensive postpartum visits in local health departments	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety

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	from 3,844 (FY24 Baseline) by 2% annually.	and linguistically appropriate phone calls to encourage non-English speaking Atrium Health patients to complete their comprehensive postpartum visit. WMH 1.6 Provide postpartum simulation training to OB practices related to postpartum best practices and evidence-based maternal mental health screening in Perinatal Care Region 1. WMH 1.7 Serve on the PRAMS/PAS steering committee established by the NC State Center for Health Statistics. WMH 2.1 Work with LHDs/agencies to increase access to services by offering extended clinic hours; utilizing mobile units or alternate locations; promoting pharmacist-initiated contraception; and educating around over the counter contraception. WMH 2.2. Assist local agencies with offering same-day contraceptive services by providing technical assistance; creating template policies and flowsheets to aid clinic flow; and connecting agencies to share success/barriers. WMH 2.3 Offer webinars and/or office hours to LHDs/agencies on variety of topics to increase patient-centered services (trauma-informed, weight stigma, shared decision making, etc.). WMH 2.4 Provide technical assistance/training to local agencies on reviewing/updating policies to promote patient-centered services. WMH 2.5 Create resources for local agencies to promote patient-centered, accessible reproductive health services, such as social media ads, waiting room slides, advertisements, etc. WMH 2.6 Promote best practices and provide technical assistance for home visiting and care management program staff members to discuss pregnancy intention. WMH 3.1 Create a workgroup comprised of individuals from TPPI funded agencies to discuss applying adolescent-centered reproductive health			

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		practices to program implementation. WMH 3.2 Provide webinars/trainings around adolescent-centered reproductive health educational programs to youth-serving agencies. WMH 3.3 Create regional-based youth leadership councils to provide opportunities for young people to voice their opinions and ideas around reproductive health work in NC			
Perinatal/Infant Health					
Prevent infant/fetal deaths	PIH Objective 1 By 2030, increase the percent of NC infants ever breastfed from 81.5% (2023 Baseline) by 2.5% to 83.5%. (Baseline will come from Federally Available Data provided by MCHB and it will be available later this spring). PIH Objective 2 By 2030, increase the percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months from 33.5% (2022-23 Baseline) by 2.5% to 34.3%. PIH Objective 3 By 2030, decrease the infant mortality rate from 6.9 per 1,000 live births (2023 Baseline) by 13% to 6. PIH Objective 4 By 2030, decrease the Black/white infant mortality ratio from 3 (2023 Baseline) by 10% to 2.7. PIH Objective 5 Increase the number of women receiving	PIH 1&2.1 During FY26, establish a 24/7 breastfeeding hotline and text line staffed by International Board Certified Lactation Consultants and Certified Lactation Counselors to provide accessible, consistent breastfeeding promotion and support to lactating people, their partners, and other support people. PIH 1&2.2 Support strategies in the NC Perinatal Health Strategic Plan to improve breastfeeding rates. PIH 1&2.3 Support work of maternity centers to obtain the North Carolina Maternity Center Breastfeeding Friendly Designation from DCFW or full Baby-Friendly Designation from Baby-Friendly, USA. PIH 1&2.4 Support the work of early educators to receive training in Breastfeeding-Friendly Child Care and encourage them to work with Child Care Health Consultants and other Breastfeeding-Friendly trainers to implement and maintain breast feeding best practices PIH 1&2.5 Support the work of LHDs who are working toward or awarded the NC Breastfeeding Coalition's Mother-Baby Award for outpatient healthcare clinics. PIH 1&2.6 Optimize breastfeeding training for, but not limited to, Care Management for At-Risk Children and Care Management for High-Risk Pregnancy care managers, Healthy Beginnings program staff, Community Health Workers, LHD employees, and home visitors, through coordination with the Regional Lactation Training Centers through the State Breastfeeding Coordinator.	ESM BF.1 - First Time Breastfeeding Hotline Callers ***Inactive -*** *ESM BF.2 - Number of eligible WIC participants who receive breastfeeding peer counselor services*	NPM - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality

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	prenatal care in the first trimester as reported on the birth certificate from 72% (2023 Baseline) by 4% to 75%. PIH Objective 6 Each year, 99% of newborn infants in NC will be screened for metabolic and other hereditary and congenital disorders and receive necessary follow-up.	PIH 1&2.7 The Pediatric Nutrition Consultant will provide breastfeeding training to Child Health Program staff at LHDs through virtual, regional, and statewide meetings. PIH 1&2.8 Support dissemination and use of the revised NC Making It Work Tool Kit to help breastfeeding mothers return to work. PIH 1&2.9 Promote the WIC Breastfeeding Peer Counseling Program to all women receiving services in LHD/WIC clinics and increase the number of women who enroll in the program. PIH 1&2.10 Increase the number of NC Breastfeeding Friendly Child Care trainers through a DCFW and NC Child Care Health and Safety Resource Center collaboration. PIH 1&2.11 Increase the number of Breastfeeding Friendly Child Care trainings delivered to child care providers. PIH 1&2.12 Promote Breastfeed NC website through all programs in DCFW and WICWS. PIH 1&2.13 Maintain Title V representation on the DPH/DCFW Breastfeeding Coordination Committee that serves as a collaborative platform for ensuring alignment of breastfeeding services across the divisions. PIH 3&4.1 Support work by the NC Perinatal Health Strategic Plan Collective, NC Child Fatality Task Force, and the NC Office of Child Fatality Prevention to reduce infant mortality and the Black/white infant mortality disparity ratio. PIH 3&4.2 Support implementation of programs intended to reduce infant mortality and prevent premature births including the following: Reducing Infant Mortality in Communities; Healthy Beginnings; Healthy Start Projects (NC Baby Love Plus and Southeastern NC Healthy Start); Improving Community Outcomes for Maternal and Child Health; Nurse Family Partnership; and Healthy Families America.			

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		PIH 3&4.3 Continue the work of the Women and Tobacco Coalition for Health (WATCH) to offer and disseminate information associated with women's health and tobacco use prevention and treatment across the lifespan. PIH 3&4.4 Provide smoking and other tobacco cessation counseling in all WICWS direct service programs and in WCHS's CMARC and home visiting programs inclusive of referrals to QuitlineNC. PIH 3&4.5 Provide annual training for at least two WICWS programs on women's health and tobacco use, inclusive of QuitlineNC and e-cigarettes. PIH 3&4.6 Partner with Division of Health Services Regulations, NC Institute of Medicine, Perinatal Quality Collaborative of NC, and other providers to update existing neonatal rules and develop maternal health rules to ensure that all birth facilities will have a designation based on the national maternal and infant risk-appropriate level of care standards. PIH 3&4.7 Promote awareness about safe infant sleep using consistent messaging from Safe Sleep NC and providing training to providers who work in obstetric, pediatric, or family medicine clinics and, as possible, to first responders. PIH 3&4.8 Provide annual or as needed safe sleep training/SIDS-ITS to child care providers by Child Care Health Consultants (CCHCs). PIH 3&4.9 Increase the number of certified CCHC SIDS/ITS trainers by offering train the trainer courses 2 times per year. PIH 3&4.10 Support the work of the March of Dimes with recruiting and training 50 individuals, i.e., cosmetologists, fraternal organizations and/or CHWs to serve as peer educators/lay health navigators in communities related to reproductive life planning. PIH 5.1 Improve LHD data reporting and data quality for documenting entry into prenatal care by: (1) Providing training and technical assistance to LHD maternal health providers and billing/support staff on appropriate billing and coding for entry into prenatal care; (2) Creating custom data			

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		form in each LHD's electronic health record (EHR) to report out the data; and (3) Creating a reporting template to share back EHR services and claims data, inclusive of data related to entry into prenatal care. PIH 5.2 Increase the number of LHDs offering group prenatal care to prenatal patients by: (1) Encouraging use of current funding (Supporting Women's Health Services and Reducing Infant Mortality in Communities) and (2) Promoting use of Medicaid reimbursement for group prenatal care. PIH 5.3 Participate in NC Medicaid's Maternal Health Internal Alignment Meetings and the Maternal Health Learning Collaborative, strengthening collaborations and ensuring alignment of activities and resources. PIH 5.4 Support recommendations from the NC Perinatal Health Strategic Plan Collective Maternity Care Workforce Action Team to enhance maternal health workforce and care delivery approaches to improve access to maternal care. PIH 6.1 The Newborn Screening Follow-Up Team, EHDI Team, NC Birth Defects Registry, and NC Sickle Cell Program will continue to ensure that all newborns who screen positive for a particular condition receive timely follow up to definitive diagnosis and are referred to clinical management for their condition.			
Child Health					
Promote safe and nurturing relationships for children and adolescents	CH PN3 Objective 1 By 2030, increase the percentage of children that are screened for developmental concerns using a parent completed tool by 5 percentage points from 47% (2022-23 Baseline NSCH) to 52%. CH PN3 Objective 2 By 2030, increase the percentage of children, ages 6 months-5 years, whose parents report that they are flourishing by 5% from 80.5%	CH PN3 1.1 WCHS staff members will provide statewide trainings on developmental, psychosocial and behavioral health which include assessing relational health and promoting Safe Stable Nurturing Relationships (SSNRs) to LHD child health clinical staff, child care providers (through Child Care Health Consultants), CMARC providers, home visiting providers, and private providers. CH PN3 1.2 Enhance early educators' knowledge related to children's development through training and technical assistance provided by Child Care Health Consultants. CH PN3 1.3 Home visiting programs will complete developmental screenings for children at a minimum at ages 9, 18, 24, and 30 months and	ESM DS.1 - Developmental Screening in Local Health Department During Well-Child Visits ESM DS.2 - Medicaid-Enrolled Children Receiving Developmental Screening ***Inactive -*** *ESM DS.3 - Percent of LHDs*	NPM - Developmental Screening	**Linked NOMs:** School Readiness Children's Health Status

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	(2022-23 Baseline) to 84.5%. CH PN3 Objective 3 By 2030, increase the percentage of children, ages 6-11 years, whose parents report that they are flourishing by 5% from 61.1% (2022-23 Baseline) to 64.2%.	provide appropriate referrals. CH PN3 1.4 Increase awareness and promotion of evidence-based trauma informed therapeutic services (e.g., Child First) for children age birth to five by Title V programs. CH PN3 2&3.1 Continue to support the Learn the Signs Act Early and early literacy programs and resources for child care facilities, CMARC and MIECHV home visitors, LHD child health clinical staff, and private providers. CH PN3 2&3.2 Continue to participate in the NC Home Visiting Consortium to ensure all families have access to a range of parenting education supports in early childhood to strengthen parent-child relationships and improve family and child well-being. CH PN3 2&3.3 Support and participate in several initiatives to align efforts, including, but not limited to, the following: EarlyWell; NC Advancing Resources for Children (ARCh) Project: Connecting NC's Systems to Strengthen Infant and Early Childhood Mental Health Outcomes (SAMSHA Grant); and NC Psychiatry Access Line (NC-PAL). CH PN3 2&3.4 Continue to collaborate with LHDs and various external partners (including families) to improve services and systems that support safe, stable and nurturing environments for children including but not limited to NC Infant Mental Health Association, NC Partnership for Children, local Smart Start agencies, Child Care Services Association, Exceptional Children's Assistance Center; NC Partnership for Children; Positive Childhood Alliance of NC; NC Child; NC Pediatric Society; NC Academy of Family Physicians; NC Division of Mental Health, Developmental Disabilities, and Substance Use Services; NC Division of Social Services; NC Division of Child Development and Early Education; NC Department of Public Instruction; NC State Office of Child Fatality Prevention, Child Fatality Task Force; NC Early Childhood Foundation, Prevent Blindness NC; Commission on CSHCN; NC Health and Safety Resource Center, and Early Mental Health Policy Action Coalition. CH PN3 2&3.5 Home visiting programs will continue to assess parent-	*whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral health screening tools for children during state fiscal year*		

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		child interactions using valid tools such as DANCE (Dyadic Assessment of Naturalistic Caregiver-Child Experiences) and CHEERS (Cues, Holding, Expression, Empathy, Rhythm, and Reciprocity). CH PN3 2&3.6 Increase awareness of and referrals from/to evidence based infant and early childhood mental health-focused home visiting and other therapeutic services,(e.g., Child First) which provide community-based behavioral health care and family support to children ages birth to five and their families. CH PN3 2&3.7 Triple P LIAs will continue to support practitioners to deliver Triple P to parents and caregivers of children age 0-12 years about promoting their child's development.			
Improve access to quality whole child and adolescent health care	CH PN4 Objective 1 By 2030, increase the percent of children without special health care needs having a medical home by 3% from 54.4% (NSCH 2022-23 baseline) to 56%.	CH PN4 1.1 Provide education, training, and support to providers on delivering a medical home approach to care by collaborating with the NC Chapter of American Academy of Pediatrics to promote patient-centered medical home and educate and train providers and by home visitors providing outreach to primary care providers. CH PN4 1.2 Provide education, training, and support to families on medical home approach to care including: 1) Varied communication strategies (presentations, exhibits, website updates, and targeted email campaigns to parents/caregivers and partner agencies); and 2) Training to equip parents/caregivers with the knowledge and skills to navigate the medical home system effectively. CH PN4 1.3 Regional School Health Nurse Consultants will promote a whole child health approach when identifying speakers and topics to participate in the annual school nurse conference. Through these efforts, school nurses will be equipped with knowledge to provide quality school health services based on best nursing practices. CH PN4 1.4 To promote quality whole child care, DCFW home visiting program staff will educate families about the importance of a medical home for their child and inform them of the practices in their community. CH PN4 1.5 School Health Centers will enhance access to coordinated, preventative healthcare by creating a network of community providers and	ESM MH.1 - Parents who Report That They Understand the Available Tools and Resources Necessary to Access and Maintain Having a Health Care Provider/Team That Uses a Medical Home Approach to Care ***Inactive -*** *ESM MH.2 - Percent of children with special health care needs who received family-centered care* ***Inactive -*** *ESM MH.3 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an*	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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		comprehensive programmatic services that will contribute to the establishment and promotion of a medical home, ensuring students receive consistent, holistic care that supports their overall well-being and academic success. CH PN4 1.6 Provide statewide monthly Child Health provider webinars, Child Health Training Program, other Nursing Continuing Professional Development contact hours, TA, and monitoring. CH PN4 1.7 Increase the number of well child visits under 11 years of age provided by Child Health Enhanced Role Registered Nurses (CH ERRNs).	*agenda item related to medical home promotion*		
Adolescent Health					
Promote safe and nurturing relationships for children and adolescents	AH PN3 Objective 1 By 2030, increase the percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance by 5% from 86.6% (2022-23 Baseline) to 90.9%.	AH PN3 1.1 WCHS staff members will provide statewide trainings and technical assistance on assessing and addressing mental and relational health and promoting safe, stable, nurturing relationships and positive childhood experiences with youth and their families to LHD child health clinical staff, and private health care providers caring for and/or supporting adolescents. AH PN3 1.2 Positive Parenting Program (Triple P) Local Implementing Agencies will promote and connect parents and caregivers to the Triple P Teen parenting support intervention for parents and caregivers of teenagers up to 16 years of age. AH PN3 1.3 School nurse conference and regional meetings will provide training and resources for school nurses about promoting need for adolescents to have positive childhood experiences and safe, stable and nurturing relationships.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Adult Mentor	
Improve access to quality whole child and adolescent health care	AH PN4 Objective 1 By 2030, increase the percent of adolescents with a preventive medical visit in the last year by 5% from 81.5% (Baseline 2022-23 NSCH) to 85.6%.	AH PN4 1.1 Provide education and technical assistance to LHDs and to other statewide partners about the importance of recommended and required components of the annual well adolescent visit. AH PN4 1.2 Subject matter experts in adolescent health, including behavioral health, will provide training on adolescent health needs and provision of services at the Annual School Nurse Conference.	ESM AWV.1 - Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center	NPM - Adolescent Well-Visit	**Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status

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		AH PN4 1.3 School Health Centers (SHCs) will continue to be credentialed to assure they are providing primary and preventive adolescent health services in line with national SHC performance measures including behavioral health screening, and referral for management and/or treatment in collaboration with outside behavioral health providers or internal to the SHC when behavioral health services are offered locally. AH PN4 1.4 Partner with youth statewide through the Youth Health Advisor (YHA) Team to promote youth voice within programs and positive public health messaging to adolescents across the state. AH PN4 1.5 Increase the number of well child visits for adolescents 12 years of age and older provided by Child Health Enhanced Role Registered Nurses (CH ERRNs). AH PN4 1.6 All child health clinical staff (i.e., CH ERRNs, physicians, advanced practice, providers, etc.) will continue to deliver quality adolescent health care to vulnerable populations at LHDs. Regional and state consultants will provide TA and monitoring to all child health clinical staff along with continuing education opportunities. AH PN4 1.7 WCHS will provide technical assistance, consultation, training and/or monitoring on how to develop and implement health care transition strategies to local health department staff to help them meet the requirement from the Health Check Program Guide to address health care transition as part of well visits. AH PN4 1.8 WCHS will explore technical assistance strategies for School Health Centers related to health care transition for adolescents and their families.	ESM AWV.2 - Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department		Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Children with Special Health Care Needs					
Improve access to quality whole child and adolescent health care	CYSHCN PN4 Objective 1 By 2030, increase the percent of CYSHCN having a medical home by 5% from 48.6% (NSCH 2022-23 baseline) to 51%.	CYSHCN PN4 1.1 Provide education, training, and support to providers on delivering a medical home approach to care by collaborating with the NC Chapter of American Academy of Pediatrics to promote patient-centered medical home and educate and train providers and by CMARC care managers and home visitors providing outreach to primary care providers.	ESM MH.1 - Parents who Report That They Understand the Available Tools and Resources Necessary to Access	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN

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		CYSHCN PN4 1.2 Provide education, training, and/or support to families on medical home approach to care including: 1) Varied communication strategies (presentations, exhibits, website updates, CYSHCN Help Line , and targeted email campaigns to parents/caregivers and partner agencies); and 2) Training to equip parents/caregivers with the knowledge and skills to navigate the medical home system effectively. CYSHCN PN4 1.3 Incorporate messages about the importance of choosing a quality medical home, increasing awareness about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and making the most of health insurance benefits in all outreach/enrollment activities. CYSHCN PN4 1.4 Continue to train parents, caregivers, and dental providers serving CYSHCN in best oral health practices and the importance of a dental home. CYSHCN PN4 1.5 The NC Office of Disability and Health (NCODH) will continue to provide technical assistance and education to partners to support increased access and engagement of CYSHCN in public health activities and health care settings. CYSHCN PN4 1.6 Regional School Health Nurse Consultants will provide professional development opportunities to school nurses related to their role in supporting CYSHCN in the school setting through courses provided and the annual School Nurse Conference opportunities. CYSHCN PN4 1.7 Regional School Health Nurse Consultant team will maintain the School Health Program Manual related to CYSHCN as a resource for school nurses emphasizing best practice and promoting advocacy for children/youth and their families.	and Maintain Having a Health Care Provider/Team That Uses a Medical Home Approach to Care ***Inactive -*** *ESM MH.2 - Percent of children with special health care needs who received family-centered care* ***Inactive -*** *ESM MH.3 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion*		Flourishing - Child Adolescent - All
Ensure all CYSHCN and families receive care in a well-functioning system	CYSHCN PN5 Objective 1 By 2030, increase percent of CSHCN who receive care in a well-functioning system by 5% from 15.6% (2022-23 Baseline) to 16.4%. CYSHCN PN5 Objective 2 By	CYSHCN PN5 1.1 CMARC program will continue to promote outreach and engagement using communication strategies and processes with NICUs, hospitals, primary care providers, DSS, WIC, Early Intervention, and other local, regional and state programs that serve CSHCN. CYSHCN PN5 1.2 CMARC state program will provide TA and consultation to CMARC staff in LHDs about strategies for how to motivate families of CSHCN to choose to receive services and decrease families choosing to	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: CYSHCN Receiving Care in Well-Functioning System	

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	2030, increase the percentage of children ages 4 months to 5 years with sickle cell disease who are placed on prophylactic antibiotics by 3 percentage points from 86% (2023 baseline) to 89%.	leave the CMARC program before family driven social and health goals and needs are met in the care plan. CYSHCN PN5 1.3 The North Carolina System of Care infrastructure support team will assess and determine strategies to be used across Title V CYSHCN programs to improve the function of systems of care for CYSHCN. CYSHCN PN5 1.4 Innovative Approaches 2.0 grantees will provide increased access to care for CYSHCN and families through system changes in areas of emergency preparedness, health care transition, and community accessibility. CYSHCN PN5 1.5 Engage parents/caregivers of CYSHCN in WCHS program planning, implementation, and evaluation, and in training opportunities to be collaborative leaders at the community, state, and national level. CYSHCN PN5 1.6 Continue to partner with internal and external partners to assure a supportive system of care for CSHCN in child care facilities, receiving genetic testing, counseling and other services, and for children and youth with hearing loss, including parent choice in communication modes for their child. CYSHCN PN5 1.7 Provide staff support to the Commission for Children with Special Health Care Needs, and its related committees by preparing reports, gathering data, and explaining the implications of proposed policies that keep these entities informed and focused on the interests of priority populations. CYSHCN PN5 1.8 Explore how to best update the WCHS Strategic Plan for CYSHCN with meaningful engagement with system partners to include the six core outcomes that serve as indicators of a well-functioning system of services for CYSHCN. CYSHCN PN5 1.9 Continue to implement and improve parent to parent training using curriculum included in the Parent Training Cadre (Parent Leadership, Sexual Health, Dental Home, and Medical Home) by outreach			

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		to prospective host organizations, recruiting trainers based on identified needs (geography, language, etc.), coaching/training current and prospective trainers, and utilizing post-training survey results to make improvements to curriculum. CYSHCN PN5 1.10 The WCHS Community Outreach Coordinator will continue to co-chair the NC Coalition to Promote Health Insurance for Children which provides a forum for statewide collaboration on outreach. CYSHCN PN5 1.11 Increase health care transition efforts for CYSHCN from pediatric to adult health care into at least two WCHS efforts and/or programs for CYSHCN. CYSHCN PN5 1.12 CYSHCN Help Line will continue to provide information and resources to families, caregivers and providers that improve access to health care and related services for CYSHCN. CYSHCN PN5 2.1 Provide education, including a flyer about the provider webinar, to parents on the importance of prophylactic antibiotics during Educator Counselors initial contact. CYSHCN PN5 2.2 Add web link and a flyer in the newborn screening follow-up provider resource packet that provides webinar information for providers on the importance of prophylactic antibiotics. CYSHCN PN5 2.3 Post link to prophylactic antibiotics educational webinar for providers on the NC Sickle Cell Syndrome Program web page.			
Cross-Cutting/Systems Building					
Engage individuals and families with lived experience, as well as community-based organizations,	CC/SB PN6 Objective 1 By 2030, increase by 20% from baseline (TBD in FY26) the percent of WICWS and WCHS staff who have used any tool or resource in their work to address disparities and improve health outcomes for all individuals.	CC/SB PN6 1.1 Conduct organizational assessment to determine current tools and resources available to staff and opportunities to address current gaps. CC/SB PN6 1.2 Conduct baseline assessment among WICWS, WCHS, and Title V staff regarding their current use of tools in their work. CC/SB PN6 1.3 Develop and publish a resource center with tools on the Title V website for staff to improve health outcomes for all individuals into	No ESMs were created by the State. ESMs are optional for this measure.	SPM 3: Compensated Family Engagement and Leadership Opportunities	

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as partners in the development and implementation of people-centered programs and policies that reduce	CC/SB PN6 Objective 2 By 2030, increase by 10% from baseline (TBD in FY26) the percent of Title V programs that offer compensated family engagement and leadership opportunities CC/SB PN6 Objective 3 By 2030, 75% of Title V contractors will have a plan to identify and address health disparities and/or improve health outcomes for all individuals as part of their contract with NC DHHS.	their work within core elements of public health work including program planning, community engagement, procurement, and data collection and analysis. CC/SB PN6 1.4 Work with DPH and DCFW leadership to embed opportunities for staff to engage in ongoing learning and dialogue, such as workshops, affinity groups, and town hall meetings, to promote common language and shared understanding of improving health outcomes for all individuals along with opportunities for exposure and interaction with individuals with lived experiences and share success stories/barriers, etc. CC/SB PN6 2.1 Understand and better coordinate current efforts across NCDHHS divisions to partner with and engage communities, families, fathers, and youth at the systems and program level. CC/SB PN6 2.2 Build and sustain relationships and trust with families of different backgrounds and life experiences to share voice and power in the design and delivery of services. CC/SB PN6 2.3 Ensure communication tools, such as marketing materials and intake forms for maternal and child health programs, are representative of all family structures and available in multiple languages. CC/SB PN6 2.4 Develop best practices for virtual engagement of families, fathers, and youth that maintain high quality opportunities. CC/SB PN6 2.5 Support the NC Perinatal Health Strategic Plan Collective Village to Village work group in conducting a Community Engagement Community of Practice to include topics such as power sharing, trust building, resource sharing, etc. CC/SB PN6 2.6 Develop and implement best practices for sustainable compensation for people with lived experience who provide direction for Title V activities. CC/SB PN6 3.1 Review current contracts to establish understanding of current practices surrounding health disparities and/or improving health outcomes for all individuals.			

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		CC/SB PN6 3.2 Develop and offer technical assistance sessions/office hours for contracted partners in collaboration with people from the community they are serving to review current activities and determine how to incorporate addressing improving health outcomes for all and community health factors. CC/SB PN6 3.3 Examine current procurement practices and determine if changes need to be made to ensure fair practices are in place and community-based organizations are able to apply for contracts. CC/SB PN6 3.4 WICWS and WCHS will require all staff, clinical and non-clinical, from LHDs and other contracted partners, to participate in at least one training annually focused on health disparities to support individual competencies and organizational capacity. This requirement is part of their agreement addenda. LHDs are provided with a list of low-cost trainings or continuing education opportunities.			
Improve access to mental and behavioral health services for maternal and child health populations	CC/SB PN7 Objective 1 Increase calls to NC Maternal Mental Health MATTERS (Making Access to Treatment, Evaluation, Resources, and Screening Better) psychiatry access line by 15% annually. CC/SB PN7 Objective 2 Increase calls to the pediatric NC Psychiatry Access Line (NC-PAL) by 20% annually. CC/SB PN7 Objective 3 Increase the percent of mental/behavioral health screenings completed at designated prenatal and/or postpartum appointments at a local health department (Baseline to be determined during FY26 using data from LHD/HSA).	CC/SB PN7 1&2.1 NC MATTERS will continue to train and educate NC professionals (health care, human service, etc.) in a variety of ways including: hosting a cohort-based Maternal Mental Health Fellowship opportunity to improve access and capacity for addressing perinatal behavioral health; sharing toolkits and promotional materials through targeted outreach; conducting a statewide media campaign to promote NC MATTERS and HRSA's National Maternal Mental Health Hotline; and offering online modules covering core components of mental health care, including mood and anxiety disorders, substance use disorders, barriers to care, and more. CC/SB PN7 1&2.2 NC-PAL will continue pediatric practice engagement, inclusive of Lunch and Learn series and developing practice implementation cohort to focus on enhancing screening and supporting social-emotional health. NC-PAL will continue providing training and technical assistance to Part C Early Intervention Children's Developmental Services Agencies (CDSAs) providers on supporting social-emotional and early relational health. CC/SB PN7 1&2.3 Increase attendance for the REsource for Advancing Children's Health (REACH) Institute's Patient-Centered Mental Health in Pediatric Primary Care (PPP) courses.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 4: Counties who Have Utilized NC-PAL or NC MATTERS	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	CC/SB PN7 Objective 4 Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department (LHD/HSA).	CC/SB PN7 1&2.4 WICWS Women's Health Social Work Consultant (WHSWC) will convene a LHD Community of Practice to engage LHD behavioral health providers in learning opportunities, such as case studies, to enhance their practice and ability to identify, treat, or refer issues related to perinatal mental health and substance use disorders. CC/SB PN7 1&2.5 WCHS and WICWS staff members promote NC-PAL/NC MATTERS to all LHDs and CBOs and can provide more detailed education sessions as requested. CC/SB PN7 1&2.6 The Perinatal Care Region I Perinatal Nurse Champion will create educational materials /resources for OB providers related to maternal mental health screening and recruit up to 5 OB/GYN practices to participate in postpartum maternal mental health screenings simulation training. CC/SB PN7 1&2.7 The NC MATTERS Stakeholders Network, which includes Title V representatives, will help identify outreach strategies to clinics and/or providers who care for pregnant and postpartum women. CC/SB PN7 3&4.1 WICWS will provide maternal mental health and behavioral health trainings, orientation, and technical assistance for LHDs and community-based organizations that serve pregnant and/or postpartum women annually. CC/SB PN7 3&4.2 WICWS Regional Social Work Consultant will provide education and support for the CMHRP Care Managers inclusive of the Perinatal Mental Health Pathway. CC/SB PN7 3&4.3 WCHS Regional CMARC Nurse Consultants will provide education and support for the CMARC Care Managers inclusive of behavioral health. CC/SB PN7 3&4.4 Provide education and technical assistance to LHDs and education to other statewide partners about the importance of recommended and required components of the annual well adolescent visit with an emphasis on screening and confidentiality related to mental health			

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		and risk for suicide and anticipatory guidance on emotional wellness and social connectedness. CC/SB PN7 3&4.5 Partner with NC DPI and other collaborators on statewide mental health initiatives including the School Mental Health Initiative and Social Emotional Learning in schools. CC/SB PN7 3&4.6 School Health Centers will continue to provide mental health services (in-person and virtual). CC/SB PN7 3&4.7 Regional School Health Nurse Consultants provide school nurse professional development related to behavioral and mental health by means of courses and school nurse conference topics. CC/SB PN7 3&4.8 Increase use of NCCARE360 for referrals by LHDs. CC/SB PN7 3&4.9 Work collaboratively with the NC Comprehensive Suicide Prevention Team and the Youth Suicide Prevention Coordinator to provide the following trainings: Youth Mental Health First Aid Training (YMHFA); Applied Suicide Intervention Skills Training (ASIST), and Counseling on Access to Lethal Means (CALM). CC/SB PN7 3&4.10 DCFW Early Mental Health Action Team (EMHAT) will continue to develop and implement Action Plan strategies to enhance internal and external alignment of IECMH-related supports across programs. CC/SB PN7 3&4.11 Triple P LIAs will continue to support practitioners to deliver Triple P to parents and caregivers of children age 0-17 years about promoting their child's development. CC/SB PN7 3&4.12 Support work by the NC Perinatal Health Strategic Plan Collective to carry out strategies in the Perinatal Health Strategic Plan to increase access to mental and behavioral health. CC/SB PN7 3&4.13 Home visiting programs will conduct depression and intimate partner violence screenings for primary caregivers.			