North Carolina State Action Plan Table 2025 Application/2023 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					
Improve access to high quality integrated health care services	WMH 1A. By 2025, increase the percentage of LHDS that offer extended hours for FP services by 10% (from 28.6% in 2023 to 31.5% by 2025). WMH 1B.1 Create the PCH Outreach and Education Toolkit by June 30, 2023. WMH 1B.2. By 2025, increase by 2% the number of individuals who receive preconception health services through LHDs.	WMH 1A.1 Provide guidance and support to LHDs to offer family friendly clinical services in a manner that meets the varying needs of their community. WMH 1A.2. Work with LHDs to increase awareness of their extended hours within their community. WMH 1A.3. Develop a lesson learned document/compendium from existing LHDs that offer extended hours to share with potential new sites. WMH 1B.1 Develop outreach and education toolkit for LHDs and other partners related to preconception health services. WMH 1B.2. Increase awareness of LHDs PCH services and provider type through social media and other outreach efforts.	***Inactive -*** *ESM WWV.1 - Number of LHDs that offer extended hours for FP services.* ESM WWV.2 - Percent of WICWS programs that utilize the PCH Outreach and Education Toolkit ESM WWV.3 - Percent of LHDs who had staff complete training on reproductive justice framework, contraceptive methods, and reproductive life planning (RLP). ESM WWV.4 - Percent of LHDs offering same day insertion of both contraceptive implants and intrauterine devices (IUDs)	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			ESM WWV.5 - Percent of LHDs that offer extended hours for Family Planning services.		NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					Formerly NOM 24) - PPD
Increase pregnancy intendedness within reproductive justice framework	WMH 2A. By 2025, increase by 2.3% from 88% (Baseline May 2020) to 90% the percent of LHDs that provide access to highly effective comprehensive (all methods) contraceptive methods for women. WMH 2B. By 2025, at least 76% of LHDs will have polices to implement same day insertion of contraceptive implants and intrauterine devices (IUDs) (Baseline December 2019 – 74% offer same day insertion). WMH 2C. By 2025, reduce the rate of births to girls aged 15-19 per 1,000 population to 14 (Baseline 2018 N.C. teen birth rate 18.7/1,000).	WMH 2A.1. Provide training for LHDs including the importance of offering all methods of contraceptives, reproductive justice framework, reproductive life planning (RLP). WMH 2A.2. Partner with public health professional societies/organizations to provide information on latest evidence related to all contraceptive methods, i.e., UNC School of Pharmacy, NC Medical Society, NC Office of Rural Health, NC Community Health Center Association, etc. WMH 2A.3 Develop peer mentoring program between LHDs on the importance of offering all methods of contraceptives. WMH 2B.1. Partner with Upstream to promote same-day access to the full range of contraceptive methods at low or no cost. WMH 2B.2. Develop sample policies and clinic flows for LHDs related to same day insertion. WMH 2B.3. Provide consultation and technical support in addressing identified barriers for same day insertion. WMH 2C.1. Provide training for Teen Pregnancy Prevention Initiatives (TPPI) agencies on applying a racial equity/reproductive justice/inclusivity lens to teen pregnancy prevention. WMH 2C.2. Develop at least 4 workgroups across the TPPI network addressing topics including inclusivity, consent, virtual program implementation and reproductive justice/equity. WMH 2C.3.Provide opportunities for youth to raise their voice in reducing teen pregnancy prevention through a statewide youth leadership council.		SPM 1: Percent of PRAMS respondents who reported that their pregnancy was intended	
Improve access to high quality integrated health care services	WMH Objective 3A. By 2025, increase by 10% from 25 (Baseline February 2024) to 28 the number of LHDs who provide home visit for postnatal	WMH 3A.1. Provide training to LHD nurses related to postpartum visits. WMH 3A.2. Provide technical assistance and support for LHDs providing the services.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B)	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	assessment and follow up care		annual report.	Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	report.
Perinatal/Infant Health					
Improve access to high quality integrated health care services	PIH 1A. By June 30, 2023, all birth facilities will have a designation based on the national maternal and infant risk-appropriate level of care standards. PIH 1B. Staff from 75% of LHDs will participate in the LHDs/LMEs annual trainings during FY21 to FY25. PIH 1C. Each year, 99% of newborn infants in NC will be screened for metabolic and other hereditary and congenital disorders and will receive necessary follow-up.	PIH 1A.1. Partner with the Perinatal Health Equity Collective Maternal Health Action Team to prioritize levels of care within the state's Maternal Health Strategic Plan. PIH 1A.2. Partner with Division of Health Services Regulations to update existing neonatal rules and develop maternal health rules. PIH 1A.3. Implement the LOCATe tool within all birthing facilities in collaboration with the MHI Provider Support Network inclusive of the Perinatal Nurse Champions. PIH 1B.1. Provide two maternal mental health and behavioral health trainings for LHDs, LMEs, etc. annually. PIH 1B.2. Conduct orientation on the NC-PAL for all LHDs/LMEs (hold 2-3 webinars). PIH 1B.3. Expand the MATTERS Leadership Team to include local LMEs. PIH 1B.4. WICWS RNC will provide orientation and TA for LHDs inclusive of behavioral health. PIH 1B.5. WICWS RSWC will provide support for the CMHRP Care Managers inclusive of behavioral health. PIH 1C.1. The Newborn Screening Follow-Up Team, EHDI Team and NC Birth Defects Registry 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.	ESM RAC.1 - Percent of birth facilities with level of care documented using the CDC LOCATe tool. ESM RAC.2 - Percent of LHDs who are utilizing the NC Psychiatry Access Line (NC-PAL)	NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC	NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Prevent infant/fetal deaths and premature births	PIH 3A.1. By 2025, increase the percent of NC resident live births who are breastfed at hospital discharge as reported on birth certificate from 80.9% (Baseline 2018) by 2% to 82.5%. PIH 3A.2. By 2025, increase the percent of women participating in WIC who initiate breastfeeding from 72.5% (SFY2019 baseline) by 2% to 74%. PIH 3A.3. By 2025, increase by 14% from 44% (Baseline Fall 2019) to 50% of NC maternity centers that have implemented two or more steps of the World Health Organization's evidenced based Ten Steps to Successful Breastfeeding. PIH 3A.4. By 2025, increase the number of eligible WIC participants who receive breastfeeding peer counselor support by 15% from 27,587 (FY19 baseline) to 31,725. PIH 3A.5. By 2025, increase the number of NC Child Care Centers who are designated as Breastfeeding Friendly Child Care Center by 50% from 28 (Baseline May 2020) to 42. PIH 3A.6. By 2025, increase the number of LHDs who are awarded	PIH 3A.1. Support activities in the following strategic plans/task force to reduce the infant mortality disparity ratio: NC Perinatal Health Strategic Plan; NC Early Childhood Action Plan; and NC Child Fatality Task Force. PIH 3A.2. Support implementation of Healthy Beginnings, Healthy Start Baby Love Plus, Improving Community Outcomes for Maternal and Child Health, and the Infant Mortality Reduction Program/Reducing Infant Mortality in Communities. PIH 3A.3. Support strategies in the following strategic plans to improve breastfeeding rates: NC Perinatal Health Strategic Plan; NC Early Childhood Action Plan; and North Carolina's Plan to Address Overweight and Obesity - Eat Smart, Move More North Carolina. 2020. PIH 3A.4. Support work of maternity centers to obtain the North Carolina Maternity Center Breastfeeding Friendly Designation from the NCDivision of Child & Family Well-Being or full Baby-Friendly Designation from Baby-Friendly, USA. PIH 3A.5. Support the work of child care providers to obtain the NC Breastfeeding Friendly Child Care Designation through application revisions, promotion, and training for external partners. PIH 3A.6. Support the work of LHDs who are working toward or awarded the NC Breastfeeding Coalition's Mother-Baby Award for outpatient healthcare clinics. PIH 3A.7. Optimize breastfeeding training for, but not limited to, Maternal and Child Health care managers, LHD employees, and home visitors through coordination with the Regional Lactation Training Centers through the State Breastfeeding Coordinator. PIH 3A.8. NC Title V Program will work with the Office of Rural Health to ensure that breastfeeding information is included as part of the Knowledge Base Core Competency for NC Community Health Workers. PIH 3A.9. The Pediatric Nutrition Consultant will provide breastfeeding training to Child Health Program staff at local health departments through	ESM BF.1 - Number of eligible WIC participants who receive breastfeeding peer counselor services	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	the NC Breastfeeding Coalition's Mother-Baby Award for outpatient healthcare clinics by 100% from 5 (Baseline May 2019) to 10. PIH 3A.7 By 2025, increase the percent of women participating in WIC, Healthy Beginnings and/or MIECHV who report any breastfeeding through 6 months by 1% (FY19 Baseline: WIC 26.6%; Healthy Beginnings 13.7%; and MIECHV 23%/Non-MIECHV funded 38.6%)	virtual, regional, and statewide meetings. PIH 3A.10. Support dissemination and use of the revised NC Making It Work Tool Kit to help breastfeeding mothers return to work. PIH 3A.11. Promote the WIC Breastfeeding Peer Counseling Program to all women receiving services in LHD/WIC clinics and increase the number of women who sign the Breastfeeding Peer Counseling Program Letter of Agreement to begin services.			
Prevent infant/fetal deaths and premature births	PIH 3B. By June 30, 2025, reduce the percent of women who smoke during pregnancy by 10.7% from 8.4% (Baseline 2019) to 7.5%.	PIH 3B.1. Revitalize the work of the Women and Tobacco Coalition for Health as a leader in women's health and tobacco use. PIH 3B.2. Partner with WATCH to update the "Guide for Helping to Eliminate Tobacco Use and Exposure for Women." PIH 3B.3. Smoking cessation counseling will be provided in all WICWS and DCFW/WCHS direct service programs. PIH 3B.4. Provide annual training for at least two WICWS programs on women's health and tobacco use, inclusive of QuitlineNC and e-cigarettes.		SPM 2: Percent of women who smoke during pregnancy	
Child Health					
Promote safe, stable, and nurturing relationships	CH 4A. By 2025, increase the percentage of children that are screened for developmental, psychosocial, and behavioral health concerns by 5% by year.	CH 4A.1. Carry out the activities in the NC Essentials for Childhood Initiative, including those that overlap with the NC Early Childhood Action plan and Pathways for Grade Level Reading. CH 4A.2 DCFW/WCHS staff members will provide statewide trainings on developmental, psychosocial, and behavioral health screening, identification, management, and referral and other EPSDT services that impact children, youth, and their families to LHD child health clinical staff, child care providers (through CCHCs), CMARC providers, Innovative Approaches staff, Triple P trained providers, and private providers.	ESM DS.1 - Percent of LHDs whose child health staff receive training on appropriate use of valid and reliable developmental, psychosocial, social determinants of health, and behavioral	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			health screening tools for children during state fiscal year		Status, Formerly NOM 19) - CHS
Promote safe, stable, and nurturing relationships	CH 4B. By 2025, reduce the percentage of children with two or more Adverse Childhood Experiences to 14%.	CH 4B.1. Continue to support the Learn the Signs Act Early and Reach Out and Read campaign and resources among child care providers (through CCHCs), CMARC and MIECHV home visitors, Innovative Approaches, Triple P, and LHD child health clinical staff and private providers. CH 4B.2. Administer Title V funding to be used to offer a variety of evidence-based and informed strategies for low-income families as part of the Child Health 351 Agreement Addenda – Attachment C, including but not limited to non-medical drivers of health such as language and literacy skills, firearm safety, and access to nutritious and physical activity opportunities. CH 4B.3. 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 4B.4. Support and participate in several initiatives to align efforts, including, but not limited to, the following: Early Well; 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 4.B.5. Continue to collaborate with various external partners (including families) to improve safe, stable and nurturing environments for children, birth to 21 years including but not limited to Exceptional Children's Assistance Center; NC Partnership for Children; Positive Childhood Alliance NC; NC Child; NC Pediatric Society; NC Academy of Family Physicians; NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; NC Division of Social Services; NC Division of Child Development and Early Education; NC Department of Public Instructions; Child Fatality Task Force; NC Early Childhood Foundation, Prevent Blindness NC; and Commission on CSHCN.		SPM 3: Percent of children with two or more Adverse Childhood Experiences (ACEs)	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Improve immunization rates to prevent vaccine-preventable diseases	CH 5A.1. By 2025, 90% of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4). (Baseline for 2018 NIS is 75.2%.) CH 5A.2a. By 2025, 80% of adolescents aged 13-15 years will have received one or more doses of Tdap vaccine (2018 Baseline – 88.9%) CH 5A.2b. By 2025, 80% of adolescents aged 13-15 years will have received one or more doses of MenACWY vaccine (2018 Baseline – 87.4%) CH 5A.2c. By 2025, 80% of female adolescents aged 13-15 years will have received 2 or 3 doses of HPV vaccine as recommended (2018 Baseline – 45.9%) CH 5A.2d. By 2025, 80% of male adolescents aged 13-15 years will have received 2 or 3 doses of HPV vaccine as recommended (2018 Baseline – 47%)	CH 5A.1. NC Immunization Program (NCIP) will recruit and maintain a network of public and private providers to administer: 1) VFC vaccines to program-eligible populations and 2) Section 317-and state-funded vaccines to eligible adult and pediatric populations. CH 5A.2. NCIP will be actively engaged with various provider organizations and agencies (including the NC Pediatric Society and NC Medicaid) that potentially serve VFC eligible children through attendance at meetings, phone calls, and emails at least twice a year. CH 5A.3. NC Title V Program will work across branches and throughout NCDHHS to promote childhood immunizations within all its direct service programs. CH 5A.4. Maintain an up-to-date web site containing information regarding the Standards for Child and Adolescent Immunization Practices, Standards for Adult Immunization Practice and ACIP. CH 5A.5. NCIP will actively partner with the NC Immunization Coalition (NCIC), and the North Carolina Immunization Advisory Committee (IAC) on efforts to reduce morbidity and mortality associated with vaccine-preventable diseases. CH 5A.6. NCIP will assess vaccination coverage using NIS, NC IIS data and school-level survey data annually to identify geographic areas with low vaccination coverage. CH 5A.7. NCIP will implement communication strategies to increase coverage for recommended vaccines in priority populations and to address current immunization barriers with healthcare providers and partners. CH 5A.8. NCIP will provide training opportunities and/or resources to assist immunization providers in communicating with patients and/or parents. CH 5A.9. NCIP will initiate the Immunization Quality Improvement for Providers (IQIP) process according to CDC requirements with 25% of		SPM 4: Percent of NC children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4)	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		CDC-defined IQIP candidate providers and follow-up activities with those VFC providers who received IQIP site visit in budget year one according to the IQIP timelines.			
Promote safe, stable, and nurturing relationships	CH 4C. By 2025, increase the percent of children having a medical home by 9% from 50% (NSCH 2017-18 baseline) to 54.5%.	4C.1. Provide education, training, and support to providers on delivering a medical home approach to care: 1) Collaborate with the NC Chapter of American Academy of Pediatrics to promote PCMH and educate and train providers; 2) CMARC care managers and Home Visitors will do outreach to primary care providers. 4C.2. Provide education, training, and support to families on medical home approach to care. Provide information and resources to families through a variety of methods including fact sheets, an enhanced website, CYSHCN Help Line, Family Partnership, and trainings.	ESM MH.1 - Percent of children with special health care needs who received family-centered care ESM MH.2 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Improve access to mental/behavioral health services	AH 6. By 2025, increase the percent of adolescents with a preventive medical visit in the last year by 5% from 81% (Baseline 2016-17 NSCH) to 85%.	AH 6A.1. Encourage development of teen clinics and outreach to teens by LHDs using Title V funding (351 Child Health Agreement Addendum Attachment C). AH 6A.2. Provide education and technical assistance to LHDs 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	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 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		health and risk for suicide and anticipatory guidance on emotional wellness and social connectedness. AH 6A.3. Continue Child Health Enhanced Role Registered Nurses training to include a focus on quality adolescent health services. AH 6A.4. Provide training on adolescent health needs and provision of services at the Annual School Nurse Conference. AH 6A.5. School Health Centers (SHC) 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 when behavioral health services are offered locally. AH 6A.6. Partner with youth statewide through the Youth Public Health Advisor program to promote youth voice within programs and promote positive public health messaging to adolescents across the state. AH 6A.7. Continue to work with the Division of Health Benefits and Prepaid Health Plans to expand outreach to increase both the number of visits and the quality of the care provided during the adolescent preventative visits provided to Medicaid and Health Choice enrollees. AH 6A.8. Convene the NC-PAL Implementation Team in support of grant objectives for Pediatric Mental Health Care Access (PMHCA) and NC MATTERS. AH 6A.9. Partner with NC DPI and other collaborators on statewide mental health initiatives including the School Mental Health Initiative and Social Emotional Learning in schools.	ESM AWV.2 - Percent of adolescents who had a behavioral health screening at time of preventive care visit at a local health department		Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Children with Special Health Care Needs					
Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN	CYSHCN 6A. By 2025, increase the percent of CYSHCN having a medical home by 9% from 41% (NSCH 2017-18 baseline) to 45%.	CYSHCN 7A.1. Provide education, training and support to providers on delivering a medical home approach to care: 1) Collaborate with the NC Chapter of American Academy of Pediatrics to promote PCMH and educate and train providers; 2) CMARC care managers and Home Visitors will do outreach to primary care providers. CYSHCN 7A.2. Provide education, training and support to families on medical home approach to care. Provide information and resources to families through a variety of methods including fact sheets, an enhanced	ESM MH.1 - Percent of children with special health care needs who received family-centered care ESM MH.2 - Number of Medicaid, Managed Care	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		website, CYSHCN Help Line, Family Partnership, and trainings. CYSHCN 7A.3. Engage parents of CYSHCN in DCFW/WCHS program planning, implementation and evaluation, and in training opportunities to be collaborative leaders at the community, state, and national level. CYSHCN 7A.4. DCFW/WCHS outreach staff will continue to provide outreach for insurance enrollment and assistance in navigating children's health insurance programs, with an emphasis on minority and underserved populations as well as CYSHCN. CYSHCN 7A.5. Explore potential modifications to improve the Innovative Approaches (IA) Initiative to meet emerging needs. CYSHCN 7A.6. Continue to train parents, caregivers, and dental providers serving CYSHCN in best oral health practices and the importance of a dental home. CYSHCN 7A.7. Continue to partner with internal and external partners to assure a supportive system of care for CSHCN in child care facilities, receiving genetic counseling services, and for children and youth with hearing loss, including parent choice in communication modes for their child. CYSHCN 7A.8 The NC Office of Disability and Health (NCODH) will continue to provide technical assistance and education to partners to support increased access and inclusion of CYSHCN in public health activities and health care settings.	Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion		through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN	CYSHCN 7B. By 2025, increase the percentage of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care by 30% from 16.5% (NSCH 2018-19 baseline) to 21.5%.	CYSHCN 7B.1 Continue a medical home work group to prioritize recommendations related to medical home and health care transition from the DCFW/WCHS CYSHCN Strategic Plan. CYSHCN 7B.2 Collaborate with DSS to support health care transition for youth in foster care. CYSHCN 7B.3 Explore modifying language in the agreement addenda for LHDs and SHCs to include a requirement to implement a strategy to support health care transition.	ESM MH.1 - Percent of children with special health care needs who received family-centered care ESM MH.2 - Number of Medicaid, Managed Care Organization, or other	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		CYSHCN 7B.4 Explore development of sample language for Transition of Care Policy for youth and young adults.	stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion		mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Improve access to coordinated, comprehensive, ongoing medical care for CYSHCN	CYSHCN 7C. By 2025, increase the percentage of children ages 4 months to 5 years with sickle cell disease who are placed on prophylactic antibiotics by 4% from 73% (2019 baseline) to 76%.	CYSHCN 7C.1. Provide education to parents on the importance of prophylactic antibiotics during Educator Counselors initial contact. CYSHCN 7C.2. Provide webinar for providers on the importance of prophylactic antibiotics.	ESM MH.1 - Percent of children with special health care needs who received family-centered care ESM MH.2 - Number of Medicaid, Managed Care Organization, or other stakeholder meetings attended by WCHS staff members with an agenda item related to medical home promotion	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					past year (Forgone Health Care, Formerly NOM 25) - FHC
Cross-Cutting/Systems Building					
Increase health equity and eliminate disparities and address social determinants of health	CCSB 8A. By 2025, the Title V Program will be working in alignment with the NCDHHS Health Equity Portfolio on health equity and social determinant of health efforts throughout all divisions and sections. CCSB 8B. By 2025, decrease the percent of children living across North Carolina in food insecure homes by 6% from 20.9% to 17.5% according to data provided by Feeding America and cited in the NC Early Childhood Action Plan.	CCSB 8A.1. Provide two trainings for Healthy Beginnings and Reducing Infant Mortality in Communities programs to include a focus on equity and social determinants of health. CCSB 8A.2. NC Title V Program will identify how they are currently incorporating the NCDHHS Health Equity Framework strategies into their work. CCSB 8A.3. NC Title V Program will identify additional ways they can incorporate the NCDHHS Health Equity Framework strategies into their work. CCSB 8A.4. WICWS will continue to require all staff, clinical and non-clinical, from LHDs and other contracted partners, to participate in at least one training annually focused on health equity, health disparities, or social determinants of health to support individual competencies and organizational capacity to promote health equity. This requirement is part of their agreement addenda. LHDs are provided a list of low-cost trainings or continuing education opportunities. CCSB 8A.5.WICWS will continue to require all staff, clinical and non-clinical, from LHDs and other contracted partners, to participate in at least one training annually focused on health equity, health disparities, or social determinants of health to support individual competencies and organizational capacity to promote health equity. This requirement is part of their agreement addenda. LHDs are provided a list of low-cost trainings or continuing education opportunities. CCSB 8A.6 Explore ways to address health equity and health disparities among CYSHCN, increasing recognition of intersectionality of CYSHCN and race/ethnicity. CCSB 8A.7. Promote the use of NCCARE360 within all Title V Programs.		SPM 5: Ratio of black infant deaths to white infant deaths	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		CCSB 8A.8. Explore how Title V Programs can best engage with the Healthy Opportunity Pilots. CCSB 8B.1. NC Title V Program staff will collaborate across Divisions, Departments, and state plans (ECAP, PHSP, NCDHHS State Action Plan for Nutrition Security, NC State Improvement Plan) to enhance, connect and partner on nutrition/physical activity/food insecurity work at the state and local level using multi-level approaches. CCSB 8B.2. Increase training to child health staff around nutrition/physical activity/food insecurity and identify audiences in the NC Title V Program and across NCDHHS that would also benefit from these trainings and materials.			
Increase health equity and eliminate disparities and address social determinants of health	CCSB 8B. By 2025, decrease the percent of children living across North Carolina in food insecure homes by 6% from 20.9% to 17.5% according to data provided by Feeding America and cited in the NC Early Childhood Action Plan.	CCSB 8B.1. NC Title V Program staff will collaborate across Divisions, Departments, and state plans (ECAP, PHSP, NCDHHS State Action Plan for Nutrition Security, NC State Improvement Plan) to enhance, connect and partner on nutrition/food insecurity work at the state and local level using multi-level approaches. CCSB 8B.2. Increase training to child health staff around nutrition/physical activity/food insecurity and identify audiences in the NC Title V Program and across NCDHHS that would also benefit from these trainings and materials.		SPM 5: Ratio of black infant deaths to white infant deaths	
Increase health equity and eliminate disparities and address social determinants of health	CCSB Objective 8C By 2025, the Title V Program will be working in alignment with the NCDHHS Health Equity Portfolio on health equity and social determinant of health efforts throughout all divisions and sections.	CCSB 8C.1. Promote the use of NCCARE360 within all Title V Programs. CCSB 8C.2. Explore how Title V Programs can best engage with the Healthy Opportunity Pilots.		SPM 5: Ratio of black infant deaths to white infant deaths	