NORTH CAROLINA STATE HEALTH IMPROVEMENT PLAN

A companion report to Healthy North Carolina 2030: A Path Toward Health (NCIOM) and the 2019 North Carolina State Health Assessment

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Public Health

DECEMBER
2020

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Public Health

This plan was prepared by the North Carolina Department of Health and Human Services, Division of Public Health by the State Center for Health Statistics (NC DHHS/DPH). The Division of Public Health was assisted in this work by the North Carolina Institute of Medicine (NCIOM).

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The full text of the *2020 NC State Health Improvement Plan* can be found at: https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm

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January 6, 2021

A JOINT LETTER OF INTRODUCTION FOR THE 2020 NC STATE HEALTH IMPROVEMENT PLAN

We are pleased to present North Carolina's first comprehensive state health improvement plan incorporating the principles of results-based accountability and the technology of Clear Impact Scorecard. The *2020 North Carolina State Health Improvement Plan* operationalizes the priorities identified in the *2019 State Health Assessment* and *Healthy North Carolina 2030: A Path Toward Health*.

The plan identifies best practices that can help communities act now to improve health. All of the practices promoted in the *NC SHIP* demonstrate active, local community support with a focus on health equity/health disparity. Many programs have North Carolina roots and most use multilevel interventions. All report successful results in the scope of their work with communities and policy makers.

We are joined in the work to improve population health by many partners, but we take this opportunity to acknowledge a few that have been a part of the strategic planning. We extend appreciation to

- The North Carolina Institute of Medicine (NCIOM) for its logistical and technical assistance in bringing the work groups together to identify "What is Working" and "What We Could Do Better."
- The Foundation for Health Leadership and Innovation (FHLI) for its financial support of Clear Impact Scorecard statewide with funds from The Duke Endowment. This web-based technology visualizes accountability with local community health improvement plans and policy initiatives at the state level.

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- The North Carolina Area Health Education Centers (NCAHEC) for its commitment to provide training for public health and its partners in Results-Based Accountability. Their focus will be "Turn the Curve Thinking" that empowers communities to move from talk to action, quickly.

Finally, we are excited to convene the *NC SHIP* Community Council to provide oversight for the state health improvement plan. Council members, comprised of half community members and half agency/government/institutional members, will meet annually to assess progress and make recommendations to the Division of Public Health.

Thank you for taking time to review this plan and offer your thoughts about opportunities to achieve the results we want for North Carolina.

Sincerely,

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From HNC 2030:

"One of the goals of NC DHHS is to ensure that all North Carolinians have the opportunity for health. Health equity is the opportunity for all people to attain the highest level of personal health regardless of demographic characteristics (CDC, 2018). Health begins in families and communities, and is largely determined by the social and economic contexts (responsible for 40% of the variation in health outcomes) in which we grow up, live, work, and age; the healthy behaviors (30%) that those contexts make easier or harder (Glanz, Rimer, & Viswanath, 2015); and our physical environments (10%). Factors related to clinical care (20%) are also responsible for quality of life and life expectancy. These factors are called drivers of health (also known as social determinants of health) and they directly affect health outcomes like development of disease and life expectancy."

HNC 2030 and the *2019 North Carolina State Health Assessment (NC SHA)* focus on health equity and the overall drivers of health outcomes in the *2020 North Carolina State Health Improvement Plan (NC SHIP)*. This report describes the process, structure, and the implementation and monitoring components of the plan and gives a snapshot of each indicator using the common language of Results-Based Accountability™.

- Results - What are the quality of life conditions we want for the children, adults and families who live in North Carolina?
- Indicators – How can we measure these conditions?
- How are we doing on the most important measures?
- Who are the partners that have a role to play in doing better?
- What can be done better?
- What do we propose to do? (Friedman, 2015)

The *2020 NC SHIP* uses Clear Impact Scorecard to capture the *HNC 2030* population indicators in a web-based reporting tool. The tool tells the story of how state and local health departments and their partners move from talk to action and implement the programs that work while monitoring performance. *NC SHIP* strives to "Do the Right Things and Do Them Well".

NC DHHS/DPH and NCIOM partnered to produce the *2020 NC SHIP.* A diverse group of participants attended one or more of 19 virtual meetings in May-June 2020. Participants reviewed the proceedings and offered edits to the final document. Community Council members were recruited from the initial group of participants. This Council will monitor progress on the plan annually.

December 5, 2020

The North Carolina Department of Health and Human Services released a statement on December 5, 2020 from Dr. Mandy K. Cohen, M.D.

> "In less than a week, we went from exceeding 5,000 new cases reported in one day to exceeding 6,000. This is very worrisome. We are seeing our highest rates of tests that come back positive despite the fact we are doing a lot of testing. This indicates we have even more viral spread across our state right now. We have record numbers of hospitalizations and people in the ICU. I am asking each North Carolinian to take personal responsibility for their actions and slowing the spread of this virus. Always wear a mask when with people you do not live with, keep your distance from other people and wash your hands often. We are looking at what further actions we can take as a state to protect North Carolinians and save lives."

The COVID-19 pandemic continues to be the number one public health priority in North Carolina public health and the *HNC 2030* indicators are an integral part of the pandemic response – not just to the infection, but rather to the fabric of our culture. Covid-19 magnifies inequities and disparities that have too long been a part of our social and institutional biases.

As the primary author of this report, I acknowledge deep appreciation for the cooperation and response of our partners and work group participants in creating this plan. All of the work was conducted virtually amidst competing priorities in a compressed time period with limited resources. Necessity led us to the logical choice of using results-based accountability and Clear Impact Scorecard as we monitor progress on *HNC 2030* population indicators.

I am especially grateful to the Foundation for Health Leadership and Innovation and the North Carolina Area Health Education Centers for their partnership in assuring that staff are trained and have access to the web-based tools for "Turn the Curve" thinking.

Finally, I am most grateful for the networking skills and resourcefulness of the NCIOM staff who conceptualized and conducted the 19 virtual meetings and provided detailed summaries to the Division of Public Health. Thank you.

With sincere appreciation,
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STATE HEALTH IMPROVEMENT PLAN

PROCESS

OVERVIEW

The *2020 State Health Improvement Plan (NC SHIP)* extends the work of the *2019 State Health Assessment (NC SHA)* and *Healthy North Carolina 2030: A Path Toward Health (HNC 2030).* The plan represents the collaborative effort of the North Carolina Department of Health and Human Services (NC DHHS) Division of Public Health (DPH) and the North Carolina Institute of Medicine (NCIOM) to develop a decennial plan to improve population health. In partnership with NCIOM, DPH solicited stakeholder input from community organizers, civic and faith-based organizations, hospitals and health care systems, health care providers, health consumers, businesses, public and private insurers, public health professionals, education, law enforcement, and social service agencies.

The *2020 NC SHIP* is based upon the population health framework and uses results-based accountability to identify measurable population level results for twenty-one priorities identified in the *2019 NC SHA/HNC 2030 report.* Recommended strategies for policy and program changes are identified. Responsibility for implementing the strategies lies with both the state and local health departments and their partners. North Carolina uses an established model for linking local initiatives to the state health improvement plan. During the decade 2020-2030, progress toward meeting the *HNC 2030* targets will be continuously monitored using a web-based data platform (Clear Impact Scorecard). Maximum transparency will be achieved by giving the public full access to the Scorecard as it is continuously updated on results by looking at both population indicator data and program performance measures by the state and local health departments and their community partners. The *NC SHIP* consists of three phases **(Figure 1)**.

Figure 1. The State Health Improvement Process

The State Health Improvement Process has Three Phases:

Development Phase: January 2020 –November 2020

Implementation Phase: December 2020 – July 2021

Monitoring Progress/Community Council Meetings: Annually in July, 2021-2030

TIMELINE

Development Phase

The 2020 NC SHIP is informed by the 2019 NC SHA/HNC 2030 report. HNC 2030 summarizes how the population level indicators were selected as priorities for the *2020 NC SHIP.* The twenty-one population indicators represent four categories of factors that affect health, plus two health outcomes **(Figure 2)**.

Figure 2. *HNC 2030* indicators categorized according to a population health framework (Health Factors/Health Outcomes)

HEALTH FACTORS (19)

- Social and Economic Factors (6)
  - Poverty
  - Unemployment
  - Short-term Suspension
  - Incarceration Rate
  - Adverse Childhood Experiences
  - Third Grade Reading Proficiency
- Physical Environment Factors (3)
  - Access to Exercise Opportunities
  - Limited Access to Healthy Food
  - Severe Housing Problems
- Health Behaviors (6)
  - Drug Overdose Deaths
  - Tobacco Use
  - Excessive Drinking
  - Sugar Sweetened Beverage Consumption
  - HIV Diagnosis Rate
  - Teen Birth Rate
- Clinical Care Factors (4)
  - Uninsured
  - Primary Care Workforce
  - Early Prenatal Care
  - Suicide Rate

HEALTH OUTCOMES (2)

- Infant Mortality
- Life Expectancy

Step 1. In January 2020, NC DHHS/DPH and NCIOM formed a *NC SHIP* Steering Committee to ensure that the planning process was informed by a diverse group of participants. The steering committee representatives included NC DPH staff, NCIOM project director and executive director, and several members of the *HNC 2030* workgroup.

Step 2. The *NC SHIP* Steering Committee recommended work group members with a focus on diversity of race, gender, geographical location, and affiliations.

Step 3. The original planning process included face-to-face work group meetings in March/April 2020. However, the COVID-19 pandemic forced all meetings to be virtual during May/June 2020.

- NC DPH and NCIOM scheduled 19 virtual meetings with 135 participants

Step 4. The NC SHIP work group participants identified evidence-based, evidence-informed, and best practices that are working or could work to improve the 21 population indicators in *HNC 2030*.

- During the work group meetings, participants were asked to share their knowledge of "what's working?" and "what could work?" from their diverse perspectives.
- Work group participants were advised to identify best practices while considering "Turn the Curve" thinking – a principle associated with results-based accountability (RBA) **(Figure 3)**.

Figure 3. Characteristics of best practices selected for the *NC SHIP*

WHAT PRACTICES WILL HELP "TURN THE CURVE" ON THE *HNC 2030* INDICATORS?

The types of best practices that we are looking for can be directed at multiple levels:

- Individuals
- Organizations
- Agencies
- Institutions
- Policies

We seek to identify successful practices as evidenced by:

- Lived experience stories from one or more communities/ community members that use the practice
- Studies about the best practices that tell "How much did we do?", "How well did we do it?", and "Is anybody better off?"
- Published research from communities outside/including NC about use of the practice

The best of the successful practices will appear in the *HNC 2030* Scorecard and have these characteristics:

- active, local community engagement
- focus on health equity/health disparity
- assessed impact of structural racism
- North Carolina roots
- successful outcomes over several years
- widespread community support, and include
- multilevel interventions

Step 5. All work group participants received a summary of recommendations in October/November 2020 and were invited to edit the content to reflect the dialogue of the group. The changes were incorporated into the final *2020 NC SHIP* group. Looking forward to implementation and monitoring of the plan, each participant was invited to serve on the *NC SHIP* Community Council.

- The *NC SHIP* Community Council meets annually to review progress on the *NC SHIP* and provides ongoing recommendations to achieve results that improve population health.

Implementation Phase

For the last three decades, communities have come together to work on health priorities outlined in the decennial *Healthy North Carolina reports (Healthy North Carolina 2000, 2010, and 2020).* The *2020 NC SHIP* continues this work through state and local health department partnerships working with a network of community partners. The *2020 NC SHIP i*s different – in the best possible way!

In response to the *2019 SHA* and *HNC 2030*, the *NC SHIP* embraces results-based accountability (RBA). Results-based accountability is a disciplined way of thinking that is data driven and uses transparent decision-making. The approach is common sense, uses plain language to attract community participants and helps partners move from talk to action, quickly. RBA starts with the results that you want to achieve (the end) and works backwards to do the right things (the means) to achieve the result!

The implementation phase occurs from December 2020 – July 2021. All local health departments and health care systems have been offered training in the web-based software Clear Impact Scorecard. A state *HNC 2030* Scorecard has been created **(Figure 4)** and local community health improvement plans will link their implementation initiatives/programs to the state *HNC 2030* Scorecard. All work is transparent and can be viewed on the web https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm.

Step 1. Provide low cost training in Results-Based Accountability™ through the North Carolina Area Health Education Centers.

Step 2. Work with the Foundation for Health Leadership and Innovation (FHLI) and the North Carolina Health Care Association (NCHA) to introduce health care systems to RBA and Clear Impact Scorecard.

Step 3. Assist local health departments with the transition from paper-based community health improvement plans to the web-based Clear Impact Scorecard.

Step 4. Convene learning collaboratives for stakeholders addressing the *HNC 2030* indicators.

Monitoring Progress

Step 1. Establish and convene the Community Council

- The *NC SHIP* Community Council meets annually to review progress on the *NC SHIP* and provides ongoing recommendations to the NC Division of Public Health to achieve results that improve population health.
- The first meeting will occur in July 2021.

Figure 4. Snapshot of a HNC 2030 Scorecard: Social and Economic Factors

Social and Economic Factors	Time Period	Current Actual Value	Next Period Forecast Value	Current Trend	Baseline % Change
R NC2030 People in North Carolina are economically self-sufficient.					
! NC2030 Percent of Individuals below 200% federal poverty level	2017	36.8%	–	→ 0	0% →
R NC2030 All adults in North Carolina have equitable access to good jobs.					
! NC2030 Percent of population in North Carolina aged 16+ unemployed but seeking work	2018	6.3%	–	↘ 5	-28% ↘
R NC2030 North Carolina's educational system values diversity and assures equitable opportunities for its students, faculty, staff and communities.					
! NC2030 Short term suspension rate per every 10 students	2018	1.39	–	↗ 1	-17% ↘
R NC2030 North Carolina has a fair and equitable criminal justice system in every jurisdiction.					
! Incarceration in North Carolina prisons per 100,000 population	2018	324	–	↘ 1	-24% ↘
R NC2030 All children in North Carolina thrive in safe, stable, and nurturing environments.					
! NC2030 Percent of children who have experienced 2 or more adverse experiences	2019	15.3%	–	↘ 2	-35% ↘
R NC2030 All children in North Carolina have early reading proficiency skills.					
! NC2030 Percent of children reading at a proficient level or above based on third grade End of Grade exams	2019	56.8%	–	↗ 1	-6% ↘

Step 2. Intentionally recruit community representatives (organizers/leaders/activists) to achieve a 1:1 ratio of agency/institutional affiliation members to community representatives on the Community Council.

- Each agency/institutional representative actively recruits a community representative and addresses potential barriers to participation in Community Council meetings.

Step 3. Provide Clear Impact Scorecard training and scorecard access to Community Council members annually.

Step 4. Synthesize findings from the annual Community Council meeting.

- Publish a *State of the State Health Improvement Plan* annually in November.

LEARNING COLLABORATIVES

A learning collaborative brings people with similar interests together to study and apply quality improvement methodology to a focused topic area. NC DPH and the North Carolina Area Health Education Centers (NC AHEC) will convene learning collaboratives around each of the *HNC 2030* indicators beginning in Winter 2021. The learning collaboratives support the adoption of best practices in the community that contribute to improved population health outcomes. The learning collaboratives are anchored in Results-Based Accountability (RBA), a permanent continuing education curriculum available through NC AHEC. Initial learning collaboratives will be organized around the NC AHEC RBA trainings **(Figure 5)**. The concept is that people are trained to "Do the Right Things" in RBA and then draw upon their peers, partners, stakeholders, and community members to learn how to "Do Them Well".

Figure 5. NC AHEC 2021 dates for inaugural results-based accountability training

Results-Based Accountability™: Do the Right Things and Do Them Well

- Feb 9,10,11: Eastern AHEC
- Feb 16,17,18: Charlotte AHEC
- Feb 23,24,25: Greensboro AHEC
- Mar 2,3,4: Northwest AHEC
- Mar 9,10,11: Wake AHEC
- Mar 16,17,18: Southeast AHEC
- Apr 13,14,15: Southern Regional AHEC
- Apr 20,21,22: Area L AHEC
- Apr 27,28,29: Mountain AHEC

PUBLIC COMMENT AND REVIEW

The *2020 NC SHIP* and the *HNC 2030* Clear Impact Scorecard are publicly available on the NC DPH website: https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm. Public comments are welcome and may be submitted by contacting the Director of Community Health Assessment using the posted contact information. All public comments are reviewed and shared with the *NC SHIP* Community Council at the annual meeting. The continuous review process allows NC DPH to consider changes to the *NC SHIP* when indicated.

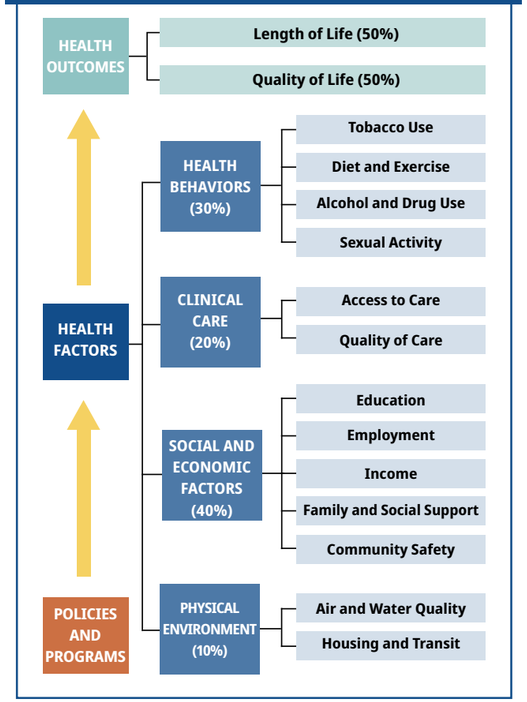
STATE HEALTH IMPROVEMENT PLAN

STRUCTURE

POPULATION HEALTH MODEL

The 2019 SHA, *HNC 2030*, and *2020 NC SHIP* utilize a population health framework to organize the health assessment and health improvement work **(Figure 6)**.

Figure 6. The County Health Rankings Model.
Used with permission of the University of Wisconsin Population Health Institute (2018).



RESULTS–BASED ACCOUNTABILITY FRAMEWORK

Results-Based Accountability™ (RBA) is a disciplined way of thinking and acting to improve entrenched and complex social problems. Communities use RBA to improve the lives of children, youth, families, and adults. It is also used by organizations to improve the effectiveness of their programs and services.

CLEAR IMPACT SCORECARD

Clear Impact Scorecard is a performance management and reporting software for non-profit and government agencies that is used to explain the impact of their work efficiently and effectively, on a web-based platform. The scorecard mirrors RBA and links results with indicators and programs with performance measures.

STATE HEALTH IMPROVEMENT PLAN

PROPOSED POLICY CHANGES

PROPOSED POLICY CHANGES

State and local health departments and their partners contribute to improved population health using multilevel interventions **(Figure 3)**. Policy changes are among the most important measures we have of "Turning the Curve" on the *HNC 2030* indicators. Table 1 provides a summary of policy initiatives that the NC SHIP will monitor.

Table 1. Proposed policy changes in the 2020 NC State Health Improvement Plan

INDICATOR	POLICY INITIATIVE
POVERTY	• Expand Medicaid eligibility • Advocate for paid medical leave among employers • Expand subsidized childcare • Increase the state earned income tax credit • Raise the minimum wage to $15.00 per hour
UNEMPLOYMENT	• Increase access to broadband internet • Expand transit options in rural and low-income communities • Increase percentage of jobs that pay a living wage • Increase access to affordable childcare • Seek a national health insurance/service program: An Economic Bill of Rights for the 21st Century
SHORT-TERM SUSPENSIONS	• Develop statewide system of restorative justice programs
INCARCERATION RATE	• Implement Medication Assisted Treatment (MAT) programs in correctional settings • Revise current criminal justice policies to reduce the rates of incarceration
ADVERSE CHILDHOOD EXPERIENCES	• Increase access to behavioral health treatment • Increase access to evidence-based parenting, early intervention, and home visiting programs • Increase minimum wage and employment opportunities
THIRD GRADE READING PROFICIENCY	• Expand access to NC Pre-K, 4-, and 5-star early learning programs and other high-quality early childhood programs • Increase access to home visiting programs for young children • Increase funding to public schools and early learning programs that serve children with the highest barriers to success, including children from low-income families and people of color • Raise wages to attract, recruit, and retain highly qualified teachers, birth - third grade
ACCESS TO EXERCISE OPPORTUNITIES	• Adopt "Complete Streets" policies • Expand transit services to provide access to places for physical activity • Increase number of biking trails and lanes, walking trails, and greenways • Increase number of and access to community parks, particularly in rural areas • Increase the number of joint use/open use policy agreements for school playground facilities • Maintain safe and well-lit sidewalks • Provide public access to municipal recreation facilities
LIMITED ACCESS TO HEALTHY FOOD	• Continue, expand and institutionalize the SNAP online purchasing pilot • Establish a public-private financing fund to stimulate the development/renovation/expansion of new and existing community-supported venues • Expand transit options in rural and low-income communities • Provide additional funding and support to School Nutrition Programs to expand healthy, locally-sourced food options and reduce financial barriers for students. • Provide financial incentives like "double bucks" for SNAP/FNS recipients for the purchase of fruits and vegetables in grocery stores and farmers markets
SEVERE HOUSING PROBLEMS	• Consider regulatory change allowing trailers to be registered as homes, not vehicles. • Enforce fair housing laws • Implement "right to counsel" policies for times tenants need to take their landlord to court • Increase living wage employment opportunities • Support programs designed to increase home ownership for people of color • Update housing standards (H2A housing) required by OSHA • Update the NC Migrant Housing Act
DRUG OVERDOSE DEATHS	• Increase the use of agonist therapies (methadone and buprenorphine) • Encourage insurance companies to expand access to treatment and recovery supports by piloting alternative pain management models • Expand peer support specialist programs • Implement broader use of NC Controlled Substance Reporting System by health care providers and pharmacies • Implement Medication Assisted Treatment (MAT) programs in correctional settings • Implement needle exchange programs • Improve access to drug treatment programs, including medication-assisted treatment • Increase distribution of naloxone • Increase training for health care providers on buprenorphine prescribing • Increase training for health care providers on safe prescribing practices • Support policies that decriminalize and promote treatment of substance use disorder
TOBACCO USE	• Fund comprehensive state tobacco control programs to levels recommended by the CDC • Implement state and local tobacco-free and smoke-free air policies that include e-cigarettes • Implement strategies to curb tobacco product advertising and marketing that are appealing to young people • Increase access to standard-of-care tobacco use treatment • License tobacco retailers to enforce youth access to tobacco laws • Raise the age of tobacco product sales to 21 to comply with Federal law • Raise the price of tobacco products through a tobacco tax • Remove state preemption of local government regulations on the sale, promotion, distribution, and display of tobacco products • Restrict the sales of flavored tobacco products
EXCESSIVE DRINKING	• Consider laws around beer and wine couponing • Expand access to treatment through Medicaid eligibility • Hold alcohol retailers liable for intoxicated or underage customers who cause injury to others • Increase alcohol excise taxes • Increase funding for compliance checks • Increase number and access to programs like Fellowship Hall • Integrate Screening, Brief Intervention, and Referral to Treatment (SBIRT) into medical settings • Reduce density of alcohol retailers • Reduce the days and hours of alcohol sales • Support and maintain state-controlled alcohol sales
SUGAR-SWEETENED BEVERAGE (SSB) CONSUMPTION	• Limit sugary drinks through government and private sector procurement policies • Limit the default beverages served with kids meals to milk, 100% fruit juice, or water • Use SSB taxes and generated revenues to address equity issues • Work with clinicians, medical practices, and insurance providers to add SSB screening questions to the electronic health record
HIV DIAGNOSIS	• Allow pharmacists to provide post-exposure prophylaxis • Increase harm reduction, such as needle exchange programs, housing programs • Implement interventions that improve access to HIV treatment • Increase access to PrEP for individuals at high risk for HIV transmission • Increase education and access for formerly incarcerated populations. • Increase Medicaid eligibility
TEEN BIRTH RATE	• Examine school sex education policies to ensure they include information on how to avoid teen pregnancy and sexually transmitted infections • Increase access to educational programs for youth in juvenile justice and foster care systems on pregnancy and STIs • Make contraceptives available on-site in schools • Require medically accurate sex education
UNINSURED	• Expand Medicaid eligibility criteria • Increase publicity and navigator funding for open enrollment • Support bans or limitations on short-term health plans
PRIMARY CARE CLINICIANS	• Ensure high speed internet access because it impacts telehealth, electronic health records and access to the controlled substance reporting system • Increase access and payment for specialist consults • Increase residency positions in rural areas • Increase rural health clinical rotations for physician assistants (PAs) and Advanced Practice Nurses (DNPs) • Increase telehealth primary care initiatives in rural areas • Invest in rural economies • Support increased funding for provider loan repayment programs that incentivize primary care providers to practice in medically underserved areas • Support pipeline programs in rural areas to encourage high school and college students to pursue careers in medicine/primary care

Table Continued ⟶

PROPOSED POLICY CHANGES

STATE HEALTH IMPROVEMENT PLAN

ROLES AND RESPONSIBILITIES

ROLE OF STATE HEALTH DEPARTMENT AND PARTNERS

- The NC DPH is responsible for conducting a state health assessment every five years. At the beginning of each decade, DPH partners with a larger group of stakeholders to set decennial objectives. In 2019-20, DPH partnered with the NC Institute of Medicine to produce its *2019 SHA/HNC 2030* report. NC DPH also produces a state health improvement plan based upon the state health assessment (*2020 NC SHIP*).
- NC DPH is responsible for creating and maintaining the state level *HNC 2030* Scorecard. This includes training and technical assistance to local health departments and their partners in linking local scorecards to the state scorecard.
- NC DPH is responsible for convening annual meetings of the *NC SHIP* Community Council. DPH ensures that all Council members receive training in the use of Scorecard to monitor progress on the *HNC 2030* indicators.
- NC DPH and partners are responsible for promoting and supporting levers for change. Levers for change and partners are captured for each *HNC 2030* indicator. They are found under "What Works" and "Partners Who Can Help Us" in the Indicator Section of this plan.

ROLE OF LOCAL HEALTH DEPARTMENTS AND PARTNERS

- Local health departments and their partners contribute to the state plan by implementing best practice programs, timely interventions, and promising new activities to address complex social, economic, educational, environmental, and health needs. Performance accountability is transparent and captured in local scorecards that can be linked in local community health improvement plans and to the state level *HNC 2030* Scorecard.
- Local health departments are responsible for ensuring that staff are trained in Results-Based Accountability (RBA).

NC SHIP COMMUNITY COUNCIL

- The NC SHIP Community Council provides oversight on "turning the curve" for the 21 *HNC 2030* indicators **(Figure 7)**. Community Council members were recruited initially from the pool of over 150 work group participants that created the initial plan. Each agency/institutional representative then actively recruits a community representative and addresses potential barriers to participation in Community Council meetings.
- The *NC SHIP* Community Council meets annually to review progress on the *NC SHIP* and provides ongoing recommendations to achieve results that improve population health.
- NC DPH convenes the *NC SHIP* Community Council meeting and provides staff support for their annual report.

Figure 7. NC State Health Improvement Plan: IMPLEMENTATION AND MONITORING

MONITORING EFFORT AND EFFECT USING CLEAR IMPACT SCORECARD

After careful consideration about what works and what has not been working over the last twenty years, NC DPH and its partners identified six strategies to achieve the result of a transparent, data driven reporting system for community health improvement. These strategies are consistent with the values of NC DHHS/DPH, the Foundation for Health Leadership and Innovation (FHLI), and the North Carolina Area Health Education Centers (NC AHEC).

STRATEGY 1

Use data to improve accountability for community health improvement

STRATEGY 2

Implement RBA/CI Scorecard statewide on a voluntary basis

- Positive experience with 16 counties and hospitals in western NC

STRATEGY 3

Initially fund statewide expansion of RBA/CI Scorecard at no cost to participating counties/hospitals using grant funds from The Duke Endowment (TDE)

- Reduce barriers to adoption of technology/changes to existing processes

STRATEGY 4

Develop a collaborative infrastructure for communication, monitoring, training, technical assistance, and coaching

- A multisectoral approach brings additional resources when expanding a simple review & approval process to a continuous quality improvement (CQI) process

STRATEGY 5

Continue research identifying factors associated with accountability of community health improvement

- Multiple factors affecting accountability are likely
- RBA and Clear Impact Scorecard address transparency, data-driven, and disciplined thinking

STRATEGY 6

Continue research examining return on investment and cost savings to local health departments and their partners

- Sustainability is key to permanence: If state and community health assessment and health improvement are core governmental public health functions, then the core infrastructure should be publicly funded.
- When businesses benefit directly from the work, they are more likely to contribute to the cost of sustaining the work.

Table 2. Measurable results reported for LHD NC Community Health Improvement Plans (2011- 2017) n=471

Not Reported	**59%**
Unable to Interpret	**24%**
Not Achieved	**12%**
Partially Achieved	**4%**
Achieved	**~2%**

Source: Dail, KG. (2019). [Dissertation] The Affordable Care Act: Public Health Accreditation and the Community Health Assessment Process in North Carolina (2011-2017).

STATE HEALTH IMPROVEMENT PLAN

INDICATORS

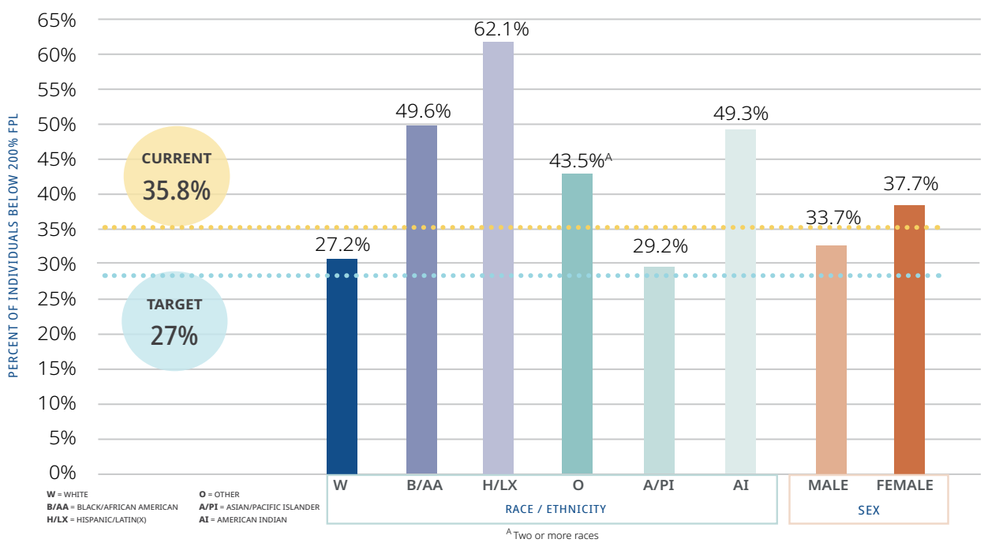
SOCIAL AND ECONOMIC FACTORS

PERCENT OF INDIVIDUALS WITH INCOMES AT OR BELOW 200% OF THE FPL

"People do not need charity and they are tired of grants – they want real change!"

-NC SHIP Work Session May 2020

Figure 8. Percent of individuals below 200% Federal Poverty Level across populations in North Carolina and distance to 2030 target (2014-2018)



WHAT OTHER DATA DO WE NEED?

- Economic Mobility: Job market (income); Savings rate; Ownership (home, business, investment)
- Study the Road to Zero Wealth - https://ips-dc.org/report-the-road-to-zero-wealth/
- Study Economic Mobility - https://scholar.harvard.edu/files/hendren/files/mobility_geo.pdf
- DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of Social Determinants of Health (SDOH) screening questions.
  - Food insecurity
  - Housing instability
  - Lack of transportation
  - Interpersonal violence

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

Information about the data source can be found in **Appendix C:** American Community Survey

WHAT RESULT DO WE WANT?

All people in North Carolina are economically self-sufficient.

WHY IS THIS IMPORTANT?

Low income is a strong predictor of health disparities and instances of disease. Poverty is linked to restricted access to resources and opportunities for healthy living conditions. *HNC 2030, p. 36*

HOW ARE WE DOING?

North Carolina ranks 39th in the nation for percentage of individuals below 200% Federal Poverty Level (FPL). The 5-year average percent of individuals below 200% FPL was 37% from 2013-2017 compared to 33% nationally. The 2019 200% FPL for individuals was $24,980. Ethnic and racial minorities are disproportionately affected by poverty with 52% of American Indians, 51% of African Americans, and 64% of Hispanic North Carolinians living below 200% of the FPL, compared to 31% of the white population. Over the past decade the percent of individuals below 200% FPL has been slowly decreasing across North Carolina. Current goals align with statewide 10-year targets to decrease the percent of individuals living below 200% FPL to 27% or to increase the rate of decline. *HNC 2030 pp. 36-37*

WHAT WORKS?

- Advocate for universal basic income
- Advocate for universal health insurance/Expand Medicaid eligibility
- Bring back the infrastructure to support community & economic development at the state and federal level
- Focus economic development on well-paying jobs
- Improve third grade reading proficiency and high school graduation rates
- Increase paid medical leave
- Increase subsidized childcare
- Increase the state earned income tax credit
- Launch funds for minority businesses
- Raise the minimum wage to $15 per hour
- Reduce incarceration
- Strengthen initiatives to prevent teen pregnancy
- Support and strengthen the community college system

NC PARTNERS WHO CAN HELP US:

- **Communities in Partnership -** https://communitiesinpartnership.org/
- **NCCARE360** Statewide coordinated care network to better connect individuals to local services and resources - https://nccare360.org/
- Primary care providers/Health care systems to screen and refer for social determinant of health questions - https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions
- **Z. Smith Reynolds Foundation** making racial equity a priority - https://www.zsr.org/

PERCENT OF POPULATION AGED 16 AND OLDER WHO ARE UNEMPLOYED BUT SEEKING WORK

UNEMPLOYMENT DISPARITY RATIO BETWEEN WHITE AND OTHER POPULATIONS

"Unemployment is a racial disparity first and foremost, then gender and class."

-SHIP Work Session May 2020

Figure 9. Percent unemployed across populations in North Carolina and distance to target (2014-2018)

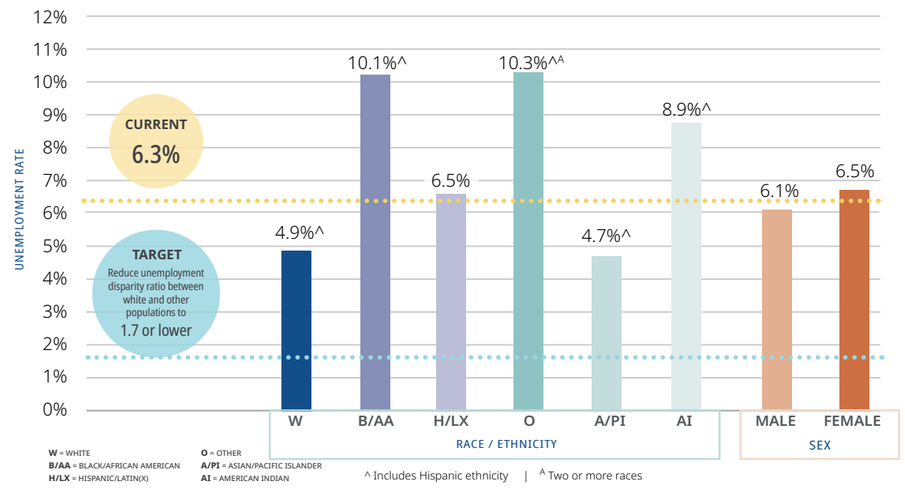
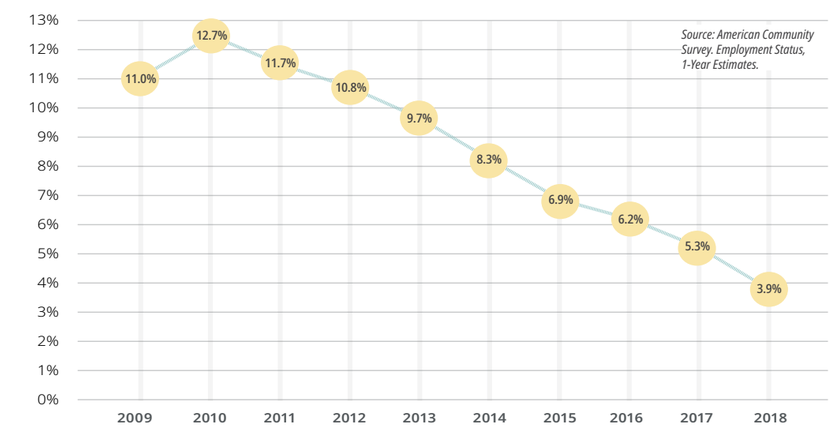


Figure 10. Percent of population in North Carolina aged 16+ unemployed but seeking work, not seasonally adjusted, one-year average



WHAT OTHER DATA DO WE NEED?

- Availability Job Training Programs
- Minority Owned Businesses
- Financial Counseling/Wealth Building for Minorities
- Child Care Subsidy Assistance
- Post-secondary Education Support
- Distribution of Broad-band Internet

Information about the data source can be found in **Appendix C:** American Community Survey

WHAT RESULT DO WE WANT?

All adults in North Carolina have equitable access to good jobs.

WHY IS THIS IMPORTANT?

Loss of income is linked to increased vulnerability to disease, unhealthy behaviors, and adverse health outcomes associated with poverty. Unemployment leads to disparities in health insurance coverage limiting access to medical attention and medication. *HNC 2030, p. 38*

HOW ARE WE DOING?

The 5-year average for the unemployment rate for 2013-2017 is at 7.2% for the state of North Carolina. Current unemployment rates among racial and ethnic groups are 11.7% for African Americans, 10.3% for American Indians, and 7.1% for the Hispanic population, compared to 5.7% for the white population. Unemployment is twice as prevalent in rural areas than in metropolitan areas (disproportionately affecting African Americans), and people who have been incarcerated have reduced access to employment opportunities that provide sufficient income. Unemployment and loss of income leads to loss of health insurance for 56% of the population. The 10-year goal is to decrease the unemployment disparity ratio found between the white population and other racial and ethnic groups. Current efforts are focused on initiating meaningful change at the state and county levels.

HNC 2030 pp. 38-39

WHAT WORKS?

- Access to broadband internet
- Address collective impact of structural racism
- Expand transit options in rural and low-income communities
- Focus on investing in businesses owned by women and people of color
- Improve educational outcomes/increase participation in post-secondary education
- Improve personal finance credit scores and access to financial capital
- Increase access to affordable personal vehicles
- Increase access to affordable childcare
- Increase percentage of jobs that pay a living wage: look at health careers
- Increase workforce development efforts - target those who need it most
- Invest in the entrepreneurial population
- Recognize that opioid epidemic contributes to people not passing employer drug screens
- Seek a national health insurance/service program: An Economic Bill of Rights for the 21st Century
- Shift funding from industrial recruitment to support of small businesses and social enterprises
- Support "fair-chance" hiring policies
- Support economic opportunities that provide full-time employment and grow local businesses

NC PARTNERS WHO CAN HELP US:

- **Care4Carolina** Working to increase access to affordable, quality healthcare for all North Carolinians - https://care4carolina.com/
- **Green Opportunities** - https://www.greenopportunities.org/
- **Hinton Rural Life Center -** https://www.hintoncenter.org/
- **NCCARE360** Statewide coordinated care network that connects individuals to resources including health, housing, employment, and transportation - https://nccare360.org/
- **NC Rural Center** - https://www.ncruralcenter.org/
- **North Carolina Health Care Association -** Helps get people enrolled in health insurance- https://www.ncha.org/
- **OIC, Inc**. - www.oicone.org
- **The Broadband ReConnect Program** Furnishes funding through loans and grants to help cover the costs of construction, facilities and equipment needed to provide broadband service to eligible rural areas - https://www.usda.gov/reconnect

NUMBER OF OUT-OF-SCHOOL SHORT-TERM SUSPENSIONS IN EDUCATIONAL FACILITIES FOR ALL GRADES

"Punishment must be student-centered;

Consequences should be just and appropriate."

-NC SHIP Work Session May 2020

Figure 11. Short-term suspension rates across populations in North Carolina and distance to 2030 target (2018-19)

Source: North Carolina Department of Public Instruction; Consolidated Data Reports

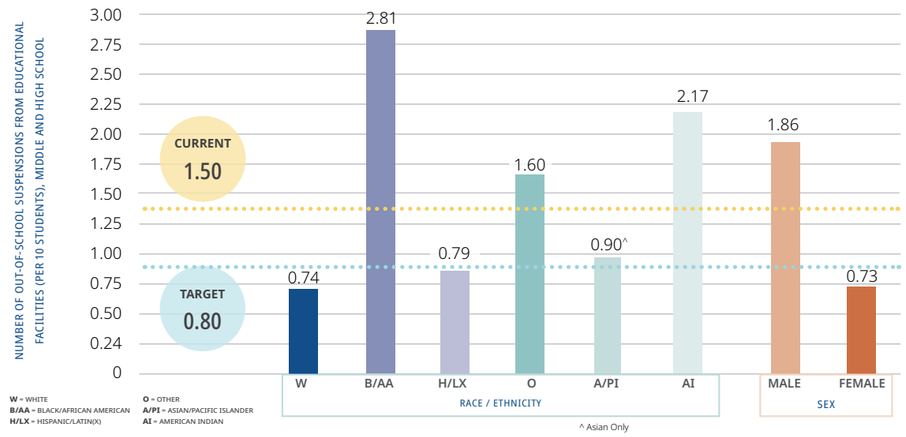


Figure 12. North Carolina Student Population and Short-term Suspensions by Race

Source: Youth Justice Project. The State of Discipline in NC Schools. April 2018. http://youthjusticenc.org/2018/04/11/state-of-discipline/

WHAT OTHER DATA DO WE NEED?

- Economic Mobility: Job market (income); Savings rate; Ownership (home, business, investment)
- Study the Road to Zero Wealth - https://ips-dc.org/report-the-road-to-zero-wealth/
- Study Economic Mobility https://scholar.harvard.edu/files/hendren/files/mobility_geo.pdf
- DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of SDOH screening questions.
  - Food insecurity
  - Housing instability
  - Lack of transportation
  - Interpersonal violence

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

Information about the data source can be found in **Appendix C:** NC Department of Public Instruction

WHAT RESULT DO WE WANT?

North Carolina's educational system values diversity and ensures equitable opportunities for its students, faculty, staff and communities.

WHY IS THIS IMPORTANT?

School disciplinary action is a strong predictor of student academic performance and high school completion. Less education can lead to fewer opportunities for high-paying employment that provides health insurance and access to other social support. *HNC 2030, p. 42*

HOW ARE WE DOING?

Across North Carolina exclusionary discipline (suspension and expulsion) is disproportionately higher for students belonging to racial and ethnic minorities than for white students. Although nearly half of the NC student population is white, it was found that for every 10 African American students there were on average 3 short-term suspensions compared to less than 1 short-term suspension for every 10 white and Hispanic students. African American and American Indian girls were more likely to be suspended than their white counterparts. Clear racial disparity exists for targets of exclusionary discipline despite studies showing that no inherent difference in student behavior can be attributed to race or ethnicity. Students in special education programs account for 24% and boys represent nearly 66% of all suspensions. Current 2030 goals are to reach a rate of 0.80 suspensions for every 10 students (the approximate rate for white and Hispanic students). Meeting this goal is largely dependent on eliminating the targeting of minority students. *HNC 2030 pp. 42-43*

WHAT WORKS?

- Develop collaborative learning groups for schools to share best practices
- Develop statewide system of restorative justice programs
- Enhance recruitment and retention efforts for black and brown educators
- Include suspension rate in measures of school quality
- Promote non-exclusionary approaches to discipline
- Provide informational resources for schools on how to reduce disciplinary actions
- Train teachers, administrators, school resource officers, and others working with students on implicit bias

NC PARTNERS WHO CAN HELP US:

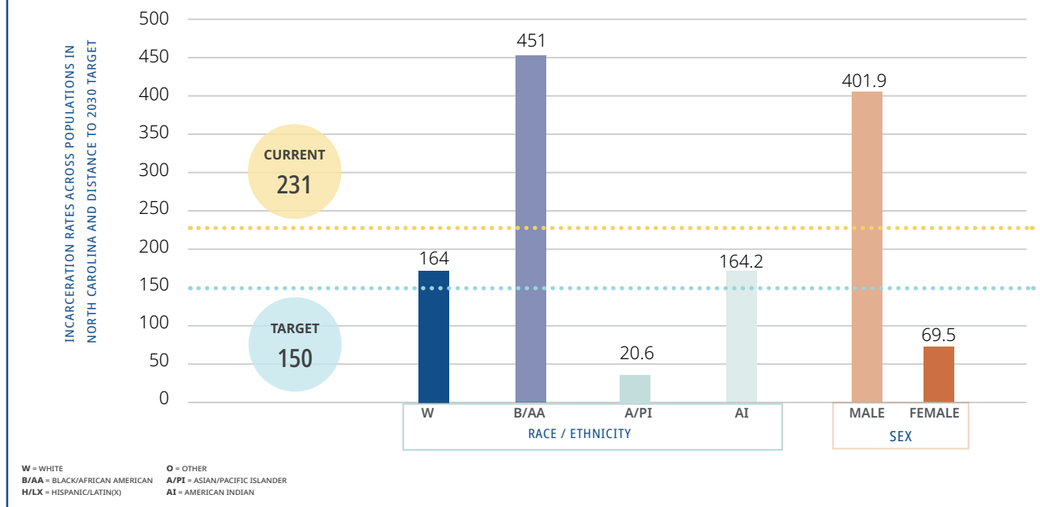
- **Center for Racial Equity in Education (CREED)** - https://www.ednc.org/wp-content/uploads/2019/08/EducationNC_Eraceing-Inequities.pdf
- **Color of Education** - https://colorofeducation.org/about/
- **Duke Center for Research to Advance Healthcare Equity** - https://sites.duke.edu/reachequity/
- **Made in Durham** A community partnership of engaged educators, business, government, nonprofits, youth and young adults aligning their resources and initiatives to create an education-to-career system that better equips Durham's youth for career and life success and builds a stronger local workforce - https://madeindurham.org/
- **Public School Forum of North Carolina** - https://www.ncforum.org/accelerating-the-pace-the-future-of-education-in-the-american-south/#
- **Racial Equity Institute** - https://www.racialequityinstitute.com/
- **Southern Coalition for Social Justice** A project of the (SCSJ) that works to ensure equity, fairness, and justice for youth in high-quality education, juvenile, and criminal systems - https://southerncoalition.org/
- **University of North Carolina at Greensboro Center for Youth Family and Community Partnership** - https://cyfcp.uncg.edu/
- **Village of Wisdom** - https://www.villageofwisdom.org/
- **we are** - https://www.weare-nc.org/
- **Youth Justice Project** - https://www.njjn.org/our-members/north-carolina

INCARCERATION RATE IN NORTH CAROLINA PRISONS PER 100,000 POPULATION

"While we need to reduce the rate of incarceration, we also need to improve conditions and programs in jails and prisons."

-NC SHIP Work Session May 2020

Figure 13. Incarceration rates across populations in North Carolina and distance to 2030 target (2018-2019)



Source: NC Department of Public Safety and the SCHS- https://webapps.doc.state.nc.us/apps/asqExt/ASQ

WHAT OTHER DATA DO WE NEED?

- Racial equity training for court system personnel
- Racial data in Administrative Office of the Courts reporting
- Policies of law enforcement agencies regarding
  - use of force
  - duty to report excessive use of force
- School-based offenses
- Mental health and substance use disorder screening and care in jail health

Information about the data source can be found in **Appendix C:** US Bureau of Justice Statistics and NC Department of Public Safety

WHAT RESULT DO WE WANT?

North Carolina has a fair and equitable criminal justice system.

WHY IS THIS IMPORTANT?

Communities with high rates of incarceration experience damaged social networks and family ties, reduced life expectancy, have greater instances of adverse health outcomes. *HNC 2030, p. 44*

HOW ARE WE DOING?

North Carolina has the 21st lowest incarceration rate among US states with a rate of 341 people incarcerated in prison per 100,00 people in the population. Mental illness affects 17% of inmates in North Carolina. African Americans account for only 22% of the state population, yet make up 52% of the total incarcerated population. African Americans are 6.5 times more likely to be incarcerated for drug-related offenses although drug use among African Americans is lower than other racial and ethnic groups. Rates of trafficking are similar. Explicit targeting of people of color by law enforcement and harsher sentencing leads to jail and prison time. The 2030 state goal is to decrease the incarceration rate to 150 people incarcerated per 100,000 in the population or increase the rate of decline. Reducing the disproportionate incarceration of African Americans and American Indians will largely affect the success in meeting this goal. *HNC 2030 pp. 44-45*

WHAT WORKS?

- Implement Medication Assisted Treatment (MAT) programs in correctional settings
- Implement standardized, evidence-based programs to reduce recidivism
- Improve access to treatment for substance use disorders, physical illnesses, and mental illnesses
- Improve conditions and programs in jails and prisons to reduce harmful impact and foster successful reintegration into community
- Improve educational outcomes, particularly for boys of color
- Increase employment opportunities and job training programs in disadvantaged communities
- Reduce intergenerational and neighborhood poverty
- Revise current criminal justice policies

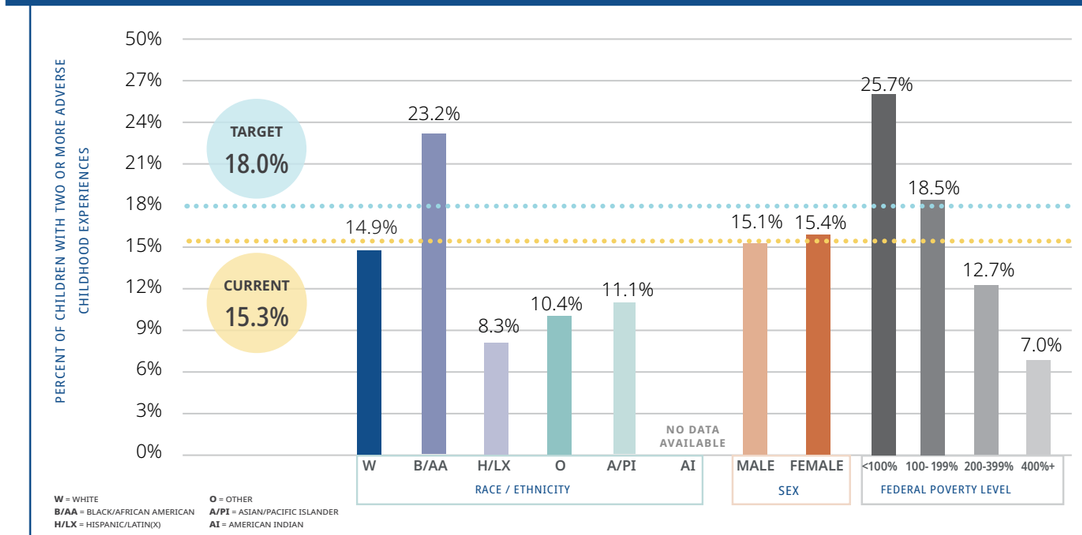
NC PARTNERS WHO CAN HELP US:

- **Durham County Criminal Justice Resource Center -** https://www.ncmedicaljournal.com/content/80/6/369
- **Growing Change, Inc. -** http://www.growingchange.org/
- **Leading Into New Communities, Inc. -** https://lincnc.org/
- **North Carolina Department of Public Instruction -** https://www.dpi.nc.gov/data-reports/discipline-alp-and-dropout-data
- **North Carolina Justice Academy -** https://ncdoj.gov/ncja/
- **North Carolina Task Force for Racial Equity in Criminal Justice -** https://ncdoj.gov/trec/
- **School Justice Partnership -** https://www.nccourts.gov/programs/school-justice-partnership
- **Wash Away Unemployment, Inc. -** https://www.facebook.com/WashAwayUnemployment

PERCENT OF CHILDREN WITH TWO OR MORE ADVERSE CHILDHOOD EXPERIENCES

Racism is a "system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race') that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources." *-Trent, Dooley, & Doug, 2019*

Figure 14. Percent children with two or more Adverse Childhood Experiences across populations in North Carolina and distance to 2030 target (2019)



The target goal for this indicator was set based upon 2016-2017 data. New data in 2019 show that we are doing better across all categories.

WHAT OTHER DATA DO WE NEED?

DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of SDOH screening questions to address and acquire data on the following:

- Food insecurity
- Housing instability
- Lack of transportation
- Interpersonal violence

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

Information about the data source can be found in **Appendix C:** Children's National Health Survey

WHAT RESULT DO WE WANT?

All children in North Carolina thrive in safe, stable, and nurturing environments.

WHY IS THIS IMPORTANT?

Children's experiences of adversity and trauma can have lifelong impact by increasing the risk of poor physical and mental health during growth and increasing their health-related challenges in adulthood. *HNC 2030, p. 46*

HOW ARE WE DOING?

North Carolina is ranked 32nd among US states for the number of children with two or more Adverse Childhood Experiences (ACEs) and is ranked 1st for the lowest percent of children with 2+ ACEs at 23.6% of children ages 0-17 (2016-17). In NC 18% of children ages 0-5 have experienced 2+ ACEs. A child's living arrangements, household income level, care needs, and race and ethnicity can all effect the risk of ACEs. The statewide goal is to decrease the percentage of children with 2+ ACEs to 18.0% by 2030. Current work involves increasing trauma-informed practices and programs that support families and children to decrease their exposure to trauma and overcome the impact of ACEs. *HNC 2030 pp. 46-47*

WHAT WORKS?

- Expand community and domestic violence prevention initiatives
- Increase access to behavioral health treatment
- Increase access to evidence-based parenting, early intervention, and home visiting programs
- Increase minimum wage and employment opportunities
- Increase opportunities for trauma-informed parenting support

NC PARTNERS WHO CAN HELP US:

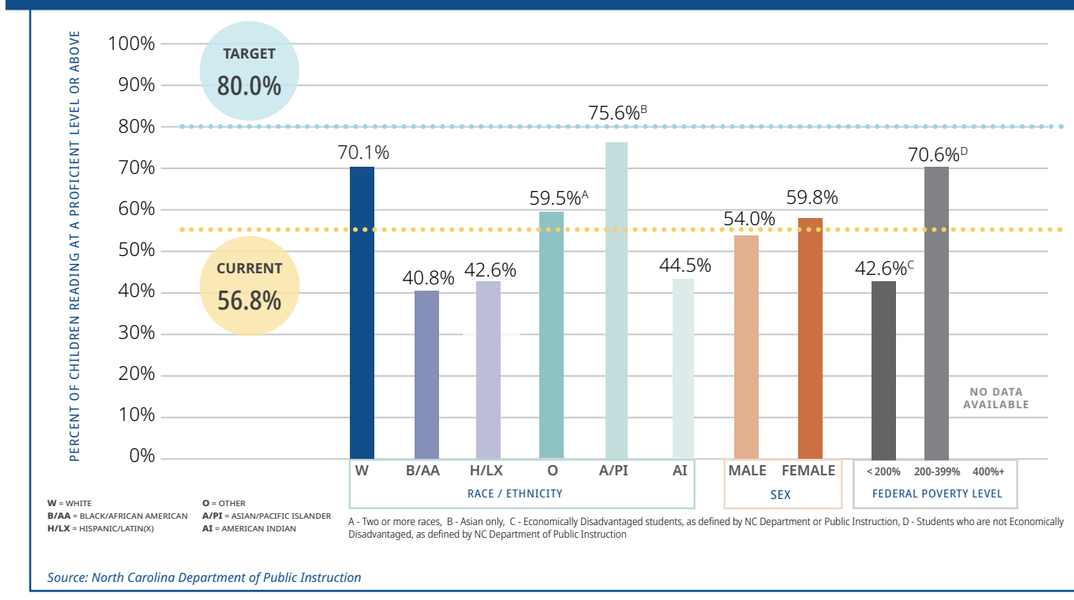
- **Center for Child & Family Health -** https://www.ccfhnc.org/about-ccfh/ Working to define, practice, and teach the highest standards of care in treating and preventing childhood trauma
- **North Carolina Child Treatment Program -** https://www.ncchildtreatmentprogram.org/ - Offers training to mental health providers in evidence-based treatment models addressing childhood trauma, behavior, and attachment
- **North Carolina Homeless Education Program -** https://hepnc.uncg.edu/
- **North Carolina Infant and Young Child Mental Health Association -** http://www.ncimha.org/ - Offers a professional network and community of early childhood mental health professionals to promote, educate, and advocate for the reduction of ACEs.
- **Our Children's Place of Coastal Horizons Center -** https://www.ourchildrensplace.com/- Committed to the well-being of children experiencing parental incarceration, through advocacy, education, and outreach
- **Parenting Inside Out-** http://www.parentinginsideout.org/- Evidence-based parenting skills training program for criminal justice involved parents
- **The Impact of Racism on Child and Adolescent Health -** https://pediatrics.aappublications.org/content/144/2/e20191765
- **The National Child Traumatic Stress Network -** Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)- https://www.nctsn.org/resources/sparcs-structured-psychotherapy-adolescents-responding-chronic-stress-guide-trauma-focused- Utilizes developmental considerations in treating traumatized adolescents and offers suggestions to meet training and implementation challenges
- **Together for Resilient Youth -** http://www.durhamtry.org/- Working to prevent substance use among youth by reducing community risk factors through education, mobilization and collaborative action.
- **Wellness Action Recovery Plan (WARP) -** https://mentalhealthrecovery.com/- Addresses physical, mental health, and life issues to help people get well and stay well

PERCENT OF CHILDREN WHO ARE PROFICIENT IN READING AT THE END OF THIRD GRADE

"We must help migrant students and youth meet high academic challenges by overcoming the obstacles created by frequent moves, educational disruption, cultural and language differences, and health-related problems."

-NC SHIP Work Session May 2020

Figure 15. Percent children who are proficient in reading at the end of third grade across populations in North Carolina and distance to 2030 target (2018-2019)



Source: North Carolina Department of Public Instruction

WHAT OTHER DATA DO WE NEED?

DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of SDOH screening questions to address and acquire data on the following:

- Food insecurity
- Housing instability
- Lack of transportation
- Interpersonal violence

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

Information about the data source can be found in **Appendix C:** NC Department of Public Instruction

WHAT RESULT DO WE WANT?

All children in North Carolina have early reading proficiency skills.

WHY IS THIS IMPORTANT?

Children with low reading proficiency are more likely to drop out of high school, acquire low paying jobs that limit access to health care, and have increased risks for numerous adverse health outcomes. *HNC 2030, p. 48*

HOW ARE WE DOING?

The third grade reading proficiency rate in North Carolina for the 2018-19 school year was 56.8%. This amounts to 53,000 students not meeting third grade reading requirements each year. Performance by school district varied greatly. Twenty-three percent of children with disabilities, 27.7% of English learners, 32.8% of students experiencing homelessness, and 40% of economically disadvantaged students and children in foster care were proficient in reading. From 2018-2019, only 40% of African American, American Indian, and Hispanic third graders were meeting proficiency requirements compared to 70% of white students and 76% of Asian students. The current goal is to accomplish 80% third grade reading proficiency by 2030. Achieving this goal is largely dependent upon eliminating disparities in proficiency rates for African American, Hispanic, and American Indian students.

HNC 2030 pp. 48-49

WHAT WORKS?

- Expand access to NC Pre-K, 4-, and 5-star early learning programs and other high-quality early childhood programs, particularly for children who are homeless, in foster care, are from immigrant families, or who have disabilities or other special healthcare needs
- Expand use of evidence-based literacy programs connected to health care (e.g., Reach Out and Read)
- Improve the rigor and responsiveness of birth through third grade teacher and administrator preparation programs
- Increase access to home visiting programs for young children
- Increase funding to public schools and early learning programs that serve children with the highest barriers to success, including children from low-income families and people of color
- Raise wages to attract, recruit, and retain highly qualified birth through third grade teachers

NC PARTNERS WHO CAN HELP US:

- **Book Harvest NC -** https://bookharvestnc.org
- **Dolly Parton Imagination Library -** https://imaginationlibrary.com/about-us/
- **North Carolina Early Childhood Action Plan -** https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-action-plan
- **North Carolina Early Childhood Foundation -** Pathways to Grade-Level Reading- https://buildthefoundation.org/initiative/pathways-to-grade-level-reading/
- **North Carolina Migrant Education Program -** https://www.dpi.nc.gov/districts-schools/federal-program-monitoring/migrant-education
- **Peletah Academic Center for Excellence (PACE) Ministry -** https://www.peletahministries.com/pace/
- **Reach Out & Read Carolinas -** https://www.rorcarolinas.org/

STATE HEALTH IMPROVEMENT PLAN

INDICATORS

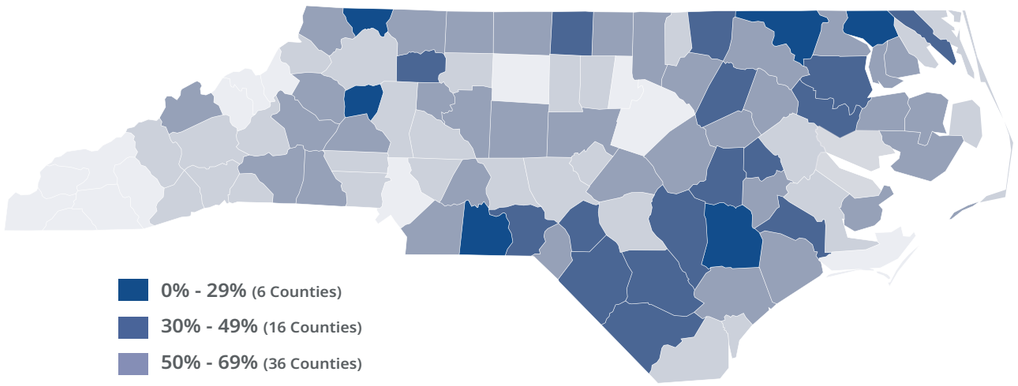
PHYSICAL ENVIRONMENT FACTORS

PERCENT OF PEOPLE WITH ACCESS TO EXERCISE OPPORTUNITIES

"Find a trail near your house!" Let us start by calling it physical activity, not exercise."

-NC SHIP Work Session May 2020

Figure 16. Percent of People with Access to Exercise Opportunities in North Carolina Counties (2018)



Source: County Health Rankings & Roadmaps; https://www.countyhealthrankings.org/app/north-carolina/2019/measure/factors/132/data

WHAT OTHER DATA DO WE NEED?

Work with the city and/or county planning department to identify locations in your community that are used for physical activity and select or create your own measure(s).

- **Walk-ability/Bike-ability of any location -** https://www.walkscore.com/
- **How to assess your community's environment, physical activity -** https://activelivingresearch.org/toolsandresources/toolsandmeasures

Information about the data source can be found in **Appendix C:** County Health Rankings and Roadmaps -Business Analyst, Delorme map data, ESRI, & US Census Tiger line Files

WHAT RESULT DO WE WANT?

All North Carolina residents have equitable access to physical activity opportunities.

WHY IS THIS IMPORTANT?

Communities that provide spaces for physical activity have healthier people with less risk of chronic health conditions, poor cardiovascular health, and premature mortality. *HNC 2030, p. 54*

HOW ARE WE DOING?

In 2019, 74% of the North Carolina population lived within half a mile from a park in any area, one mile from a recreational center in a metropolitan area, or three miles from a recreational center in a rural area. Among counties, the range was 6-100% among US states for percent of population with access to exercise opportunities. Low income communities, people of color, people with physical disabilities, and people living in rural areas have less access to recreational facilities and parks compared to affluent, white, and metropolitan communities. Statewide goals are to increase access to opportunities for physical activity to 92% of the population. *HNC 2030 p. 54*

WHAT WORKS?

- Adopt "Complete Streets" policies
- Expand transit services to provide access to places for physical activity
- Increase access to evidenced-based and informed interventions that support physical activity in childcare, schools, churches, workplaces and other community-based settings
- Increase number of biking trails and lanes, walking trails, and greenways
- Increase number of and access to community parks, particularly in rural areas
- Increase the number of joint use/open use policy agreements for school playground facilities
- Maintain safe and well-lit sidewalks
- Provide public access to municipal recreation facilities
- Support community walking clubs and public fitness classes

NC PARTNERS WHO CAN HELP US:

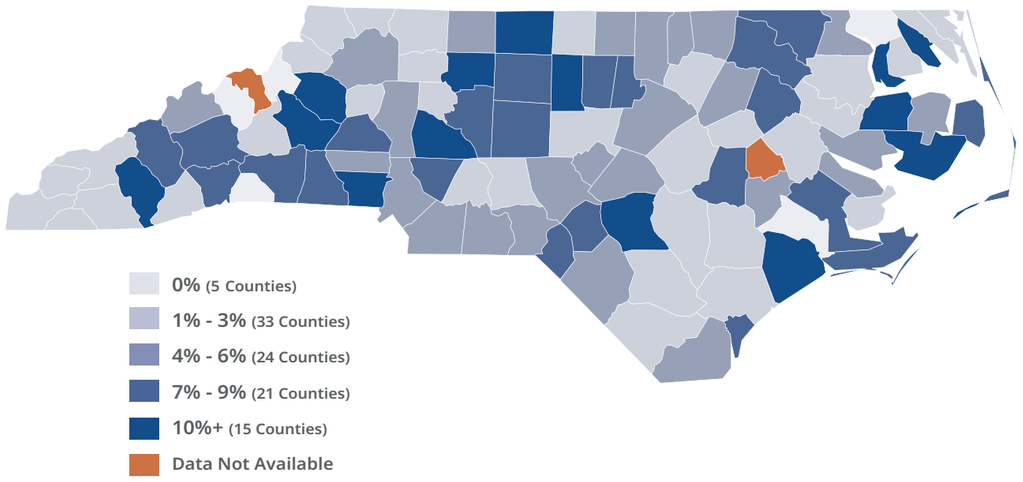
- **Bull City Fit -** https://www.bullcityfit.org/about-us
- **Durham Parks and Recreation -** https://www.dprplaymore.org/27/ABOUT-US
- **National Recreation and Park Association -** 10 Minute Walk- https://10minutewalk.org/
- **NC Department of Transportation: Let's Go NC -** https://www.ncdot.gov/initiatives-policies/safety/lets-go-nc/Pages/default.aspx
- **The Walking Classroom Institute -** https://www.thewalkingclassroom.org/
- **TRACK Trails -** www.kidsinparks.com
- **Vision Zero -** https://visionzeronetwork.org/

PERCENT OF PEOPLE WHO ARE LOW-INCOME THAT ARE NOT NEAR A GROCERY STORE

"We need to tap into local foundations to assist with long-term funding needs."

-NC SHIP Work Session May 2020

Figure 17. Percent of People with Limited Access to Healthy Foods in North Carolina Counties (2015)



County Health Rankings & Roadmaps; https://www.countyhealthrankings.org/app/north-carolina/2019/measure/factors/83/data

WHAT OTHER DATA DO WE NEED?

DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of SDOH screening questions to address and acquire data on the following:

- Food insecurity
- Housing instability
- Lack of transportation
- Interpersonal violence

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

Information about the data source can be found in **Appendix C:** County Health Rankings and Roadmaps - United States Department of Agriculture (USDA)

WHAT RESULT DO WE WANT?

North Carolina residents have equitable access to healthy foods.

WHY IS THIS IMPORTANT?

Good nutrition is essential for mental and physical health. Limited access to healthy food has been linked to obesity, cardiovascular conditions, nutritional deficiencies, and other preventable causes of disease and death. *HNC 2030, p. 56*

HOW ARE WE DOING?

In North Carolina, 7% of people with low-income live more than one mile away from a grocery store in metropolitan areas or more than 10 miles away from a grocery store in rural areas (2015) making North Carolina ranked 26th among US states with limited access to healthy foods. More than 500,000 residents live in one of the 340+ "food deserts" or areas with limited access to healthy foods. Race and income level affect likelihood of living in a food desert and the grocery stores in those communities often have fewer options or higher prices for healthier foods compared to stores in wealthier areas. The current percent of the population with limited access to healthy food has remained steady at 7% for the last five years. The state goal is to reduce this to 5% within the next 10 years.

HNC 2030 pp. 56-57

WHAT WORKS?

- Expand transit options in rural and low-income communities
- Increase access to healthy foods in childcare, schools, churches, workplaces and other community-based settings
- Increase technological support for eWIC payments
- Increase technological support for SNAP EBT payments at food retailers
- Support nonprofit grocery stores working to meet the needs of residents of food deserts
- Support school-based meal programs
- Support tax-incentive programs designed to encourage grocery stores and farmers markets to move into food deserts

NC PARTNERS WHO CAN HELP US:

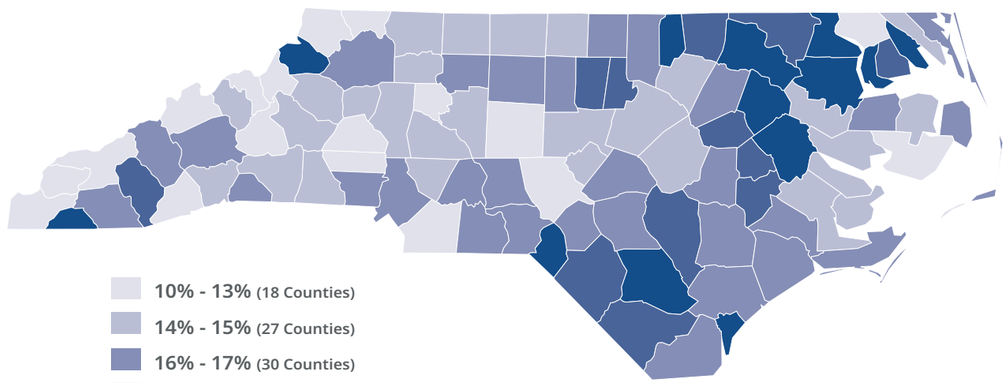
- **BCBS of NC Foundation** https://www.bcbsncfoundation.org/about/how-and-where-we-work/healthy-food/
- **Duke Sanford World Food Policy Center** https://wfpc.sanford.duke.edu/
- **Farmers' Market Nutrition Program (FMNP)** https://www.nutritionnc.com/wic/fmarket.htm
- **Feast Down East** https://www.feastdowneast.org/
- **Feeding the Carolinas** https://feedingthecarolinas.org/
- **Green Rural Redevelopment Organization** https://www.conservationfund.org/projects/green-rural-redevelopment-organization
- **Guilford College Mobile Oasis Farmers' Market** https://guilfordmobileoasis.com/
- **NC Department of Agriculture** http://www.ncagr.gov/smallfarms/
- **North Carolina Alliance for Health** https://www.ncallianceforhealth.org/healthy-food-access/
- **Reinvestment Partners - Healthy Helping** https://reinvestmentpartners.org/what-we-do/produce-prescriptions/
- **The Corner Farmers Market/The Grove Street People's Market Green for Greens Fund** https://www.cornermarketgso.com/greenforgreens/
- **The Food Bank of Central & Eastern North Carolina** https://foodbankcenc.org/

PERCENT OF PEOPLE WITH SEVERE HOUSING PROBLEMS

"Our seasonal and migrant farmworkers often live in substandard housing."

-NC SHIP Work Session May 2020

Figure 18. Percent of People with Severe Housing Problems in North Carolina Counties (2018)



Source: Source: County Health Rankings & Roadmaps; https://www.countyhealthrankings.org/app/north-carolina/2019/measure/factors/136/data

WHAT OTHER DATA DO WE NEED?

DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of SDOH screening questions to address and acquire data on the following:

- Food insecurity
- Housing instability
- Lack of transportation
- Interpersonal violence

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

Information about the data source can be found in **Appendix C:** County Health Rankings and Roadmaps - Comprehensive Housing Affordability Strategy (CHAS) data

WHAT RESULT DO WE WANT?

All low-income families in North Carolina have sufficient, affordable, quality housing.

WHY IS THIS IMPORTANT?

Housing Quality is important for overall well-being affecting physical and mental health. Poor housing can increase risk of respiratory infections, psychological stressors, and other chronic conditions. *HNC 2030, p. 58*

HOW ARE WE DOING?

With 16.1% of the population facing severe housing problems (2011-2016), North Carolina ranks at 28th among US states. One in six households in the state faces severe housing problems.[4] This breaks down to 14,000 overcrowded households, 18,000 households with incomplete plumbing, 24,000 households with insufficient kitchen facilities, and severe cost burden affecting 500,000 households.[4,5] Geographic location, race and ethnicity, education level, and income level are all factors in determining likelihood for facing severe housing problems. People who rent their home face higher costs and lack the ability to improve their housing conditions. Only 43.9% of African American residents and 43% of Hispanic residents live in a home they own compared to 71.2% of white residents. The goal for 2030 is to reduce the percent of the population with severe housing problems to 14%.

HNC 2030 pp. 58-60

WHAT WORKS?

- Consider regulatory change allowing trailers to be registered as homes, not vehicles
- Enforce fair housing laws
- Examine ways to reduce retaliation or rising rents on properties that have been repaired
- Implement "right to counsel" policies for times tenants need to take their landlord to court
- Improve access to social services and resources for affordable housing
- Improve inspection process for migrant farmworkers
- Increase education to community members about housing environmental issues like lead and mold
- Increase involvement of community members in decision-making
- Increase living wage employment opportunities
- Increase understanding of issues for clinical providers and create partnerships to address issues that are uncovered
- Provide education for Latinos on rights and how to file a complaint
- Support programs designed to increase home ownership for people of color
- Update housing standards (H2A housing) required by OSHA
- Update the NC Migrant Housing Act

NC PARTNERS WHO CAN HELP US:

- **Episcopal Farmworker Ministry -** https://episcopalfarmworkerministry.org/
- **Legal Aid of North Carolina -** https://www.legalaidnc.org/about-us/projects/farmworker-unit
- **North Carolina Housing Coalition** Provides advocacy for the housing needs of low - income residents on the federal, state, and local levels https://nchousing.org/
- **Reinvestment Partners -** Neighborhood Improvement- Helping to address problems of poverty and social injustice in the areas of food, housing, community development, health, and financial services - https://reinvestmentpartners.org/
- **UNC Institute for the Environment -** https://ie.unc.edu/
- **UNC-Greensboro Center for Housing and Community Studies -** Working to stabilize housing, reduce cost-burdens, and improve housing quality through social-impact policies, inclusionary practices, and shared-interest collaborations - https://chcs.uncg.edu/

STATE HEALTH IMPROVEMENT PLAN

INDICATORS

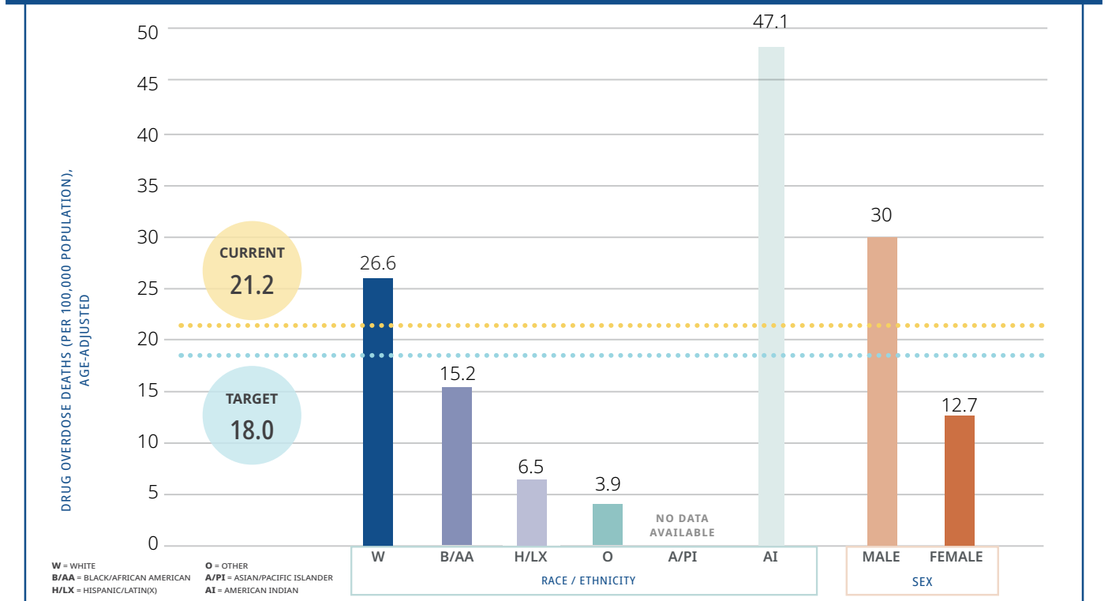
HEALTH BEHAVIORS

NUMBER OF PEOPLE WHO DIE BECAUSE OF DRUG POISONING

"We need better evidence to know the impacts of illicit drug use by youth."

-NC SHIP Work Session May 2020

Figure 19. Drug overdose death rates across populations in North Carolina and distance to 2030 target (2019)



WHAT OTHER DATA DO WE NEED?

DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of SDOH screening questions to address and acquire data on the following:

- Food insecurity
- Housing instability
- Lack of transportation
- Interpersonal violence

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

Information about the data source can be found in **Appendix C:** NC State Center for Health Statistics, Vital Statistics

WHAT RESULT DO WE WANT?

All North Carolina residents live in communities with equitable access to substance use disorder services.

WHY IS THIS IMPORTANT?

Drug overdose is the leading cause of death due to injury in the United States. Drug use affects relationships, employment, physical and mental health, and contributes to the spread of diseases. *HNC 2030, p. 66*

HOW ARE WE DOING?

Substance use disorders (SUDs) are chronic or recurrent conditions that, like other chronic illnesses, require ongoing care and treatment for individuals to regain health and maintain recovery. As with any chronic disease, prevention, identification, treatment, and recovery services and supports are essential to ensuring positive health outcomes. Effective treatments for SUDs and underlying mental and physical health problems exist; however, access to services and supports for SUDs varies greatly across the state. *HNC 2030 pp. 66-67*

WHAT WORKS?

- Access and use the Opioid Action Plan
- Address the needs of justice-involved populations
- Adopt and support payment of evidenced-based interventions that prevent opioid prescribing
- Avert future opioid addiction by supporting youth and families
- Encourage/support mobile crisis units
- Expand Medicaid eligibility
- Expand peer support specialist programs
- Implement broader use of NC Controlled Substance Reporting System by health care providers and pharmacies
- Implement Medication Assisted Treatment (MAT) programs in correctional settings
- Implement needle exchange programs
- Improve access to drug treatment programs, including medication-assisted treatment
- Increase distribution of naloxone
- Increase the use of agonist therapies (methadone and buprenorphine)
- Increase training for health care providers on buprenorphine prescribing
- Increase training for health care providers on safe prescribing practices
- Meet basic needs of individuals like housing and employment
- Promote alternative treatments for pain that are non-pharmaceutical based (e.g., acupuncture)
- Reduce the supply of prescription and illicit opioids
- Support policies that decriminalize and promote treatment of substance use disorder
- Support training for health department staff about naloxone: they are a main access point for people who are uninsured

NC PARTNERS WHO CAN HELP US:

- **Monarch -** https://monarchnc.org/crisis-services/
- **NC Certified Peer Support Specialist Program -** Certifies people living in recovery with mental illness and/or substance use disorder to provide support to other individuals experiencing mental health and addiction challenges- https://pss.unc.edu/
- **NC Opioid and Prescription Drug Abuse Advisory Committee -** https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/nc-opioid-and-prescription-drug-abuse-advisory
- **North Carolina Harm Reduction Coalition (NCHRC) -** A community based overdose prevention project that is working to implement harm reduction interventions, public health strategies, drug policy transformation, and justice reform in North Carolina - http://www.nchrc.org/
- **Recovery Communities of North Carolina -** https://www.rcnc.org/about/
- **Safe Project: Stop the Addiction Fatality Epidemic -** https://www.safeproject.us/

PERCENT OF TOBACCO USE ACROSS THE POPULATION:

Percent of Youth and Adults Reporting Current Use of E-Cigarettes, Cigarettes, Cigars, Smokeless Tobacco, Pipes, and/or Hookah

"Voters are more likely to vote for tobacco price increase when the resources go to affect a health-related outcome."

-NC SHIP Work Session May 2020

QuitlineNC

1-800-QUIT-NOW
1-800-784-8669

NORTH CAROLINA TOBACCO TREATMENT STANDARD OF CARE

FDA Approved Pharmacotherapy[1]
12 weeks of varenicline (Chantix®)
or
12 weeks of combination therapy
(nicotine patches and nicotine gum or nicotine lozenges)

Other pharmacotherapy includes bupropion, nicotine nasal spray and nicotine inhaler

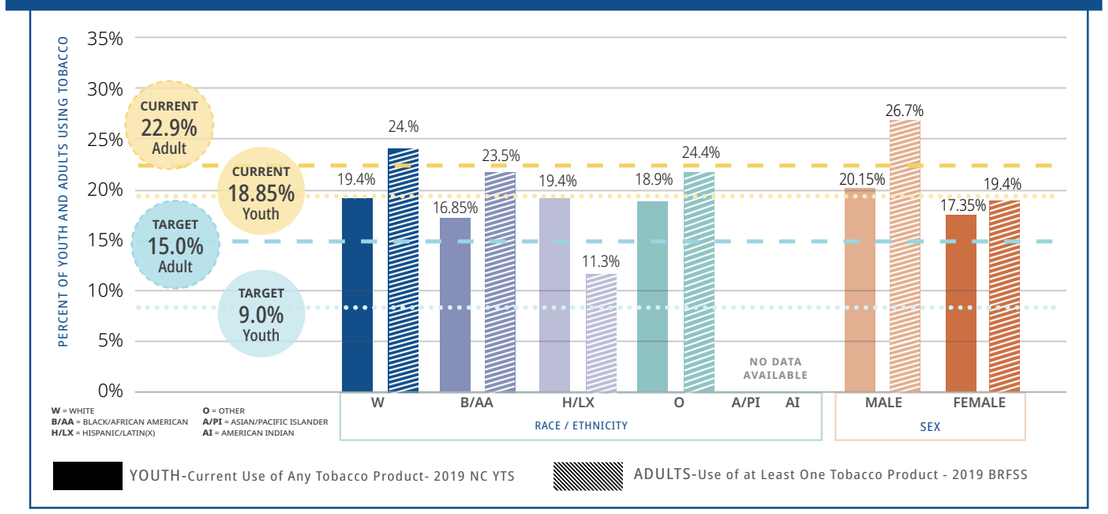
+

Evidenced-Based Counseling

In order of effectiveness:
- Face to face individual counseling
- Group counseling
- QuitlineNC – telephonic, texting, and web-based counseling

100% TOBACCO FREE ENVIRONMENTS HELP PEOPLE QUIT.

Figure 20. Tobacco use across populations in North Carolina and distance to 2030 target (2019)



WHAT OTHER DATA DO WE NEED?

- Data regarding sale and consumption of new and emerging tobacco products
- Data to understand health disparities regarding tobacco use and exposure to hazardous secondhand smoke and e-cigarette emissions.
- Data on the effectiveness of price policies to prevent initiation of e-cigarette use among young people

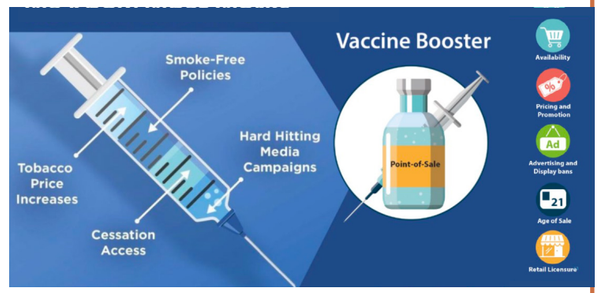
Information about the data source can be found in **Appendix C:** NC BRFSS data, NC Youth Tobacco Survey data, Smoke-free/Tobacco free local regulations maps

WHAT RESULT DO WE WANT?

All North Carolina residents live in communities that support tobacco-free/ e-cigarette-free lifestyles.

WHY IS THIS IMPORTANT?

Far too many of the most vulnerable North Carolinians have suffered for too long from products that have been protected from regulation, yet are designed to addict, are promoted to young people, and are deadly. Until everyone is protected from addiction and exposure, we must keep working toward fairness and value-based services.



Source: King BA, Graffunder C. Tobacco Control 2018;27:123-124. Kong AY, King B. Tobacco Control 2020.

HOW ARE WE DOING?

As of 2019, 27.3% of high school students in North Carolina report tobacco use, and 22.9% of adults report tobacco use. One of every five deaths in North Carolina is associated with cigarette smoking and for each death, 30 more people are sick or live with a disability. Cigarette smoking has declined for both youth and adults while electronic cigarette smoking and use of other tobacco products are increasing. Low income, low educational attainment, mental illness, and unemployment increase likelihood of tobacco use. LGBTQ individuals and people in rural communities are also more likely to smoke. American Indians have a higher prevalence of smoking, while African American tobacco users die from tobacco-related causes at higher rates. Goals for 2030 are to reduce youth tobacco use to 9.0% and adult use to 15.0%.

HNC 2030 pp. 68-69

WHAT WORKS?

- Fund comprehensive state tobacco control programs to levels recommended by the CDC
- Implement high-impact media campaigns that warn about the dangers of tobacco use
- Implement state and local tobacco-free and smoke-free air policies that include e-cigarettes
- Implement strategies to curb tobacco product advertising and marketing that are appealing to young people
- Increase access to standard-of-care tobacco use treatment
- License tobacco retailers to enforce youth access to tobacco laws
- Raise the age of tobacco product sales to 21 to comply with federal law
- Raise the price of tobacco products through a tobacco tax
- Remove state preemption of local government regulations on the sale, promotion, distribution, and display of tobacco products
- Restrict the sales of flavored tobacco products

NC PARTNERS WHO CAN HELP US:

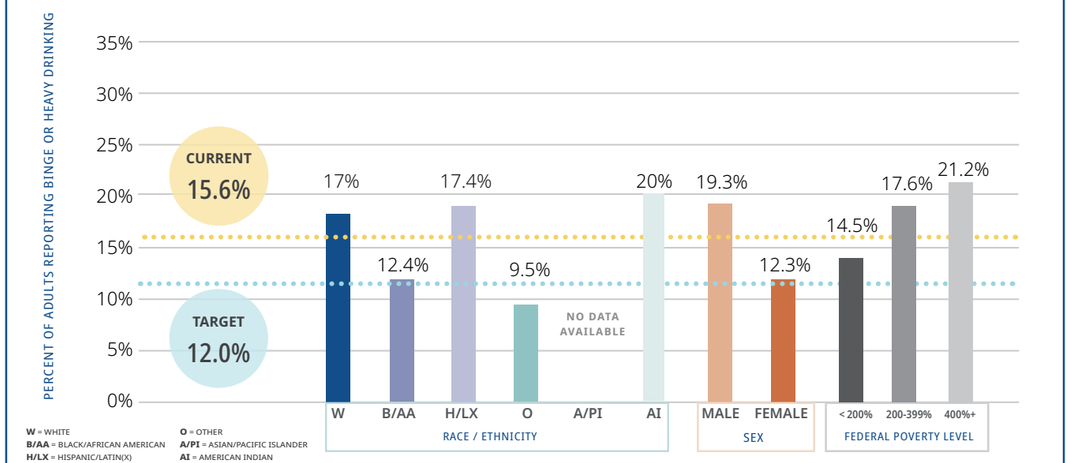
- **Americans for Nonsmokers Rights**
- **ASTHO, NACDD, and National Networks for Health Equity**
- **Campaign for Tobacco Free Kids**
- **Catch My Breath Program**
- **CDC's 6/18 Initiative**
- **Countertobacco.org** and **Counter Tools**
- **Duke - UNC Tobacco Treatment Specialist Training**
- **NC Alliance for Health**
- **NC Association of Local Health Departments and NCPHA**
- **QuitlineNC – 1-800-QuitNow (1-800-784-8669)**
- **The Center for Black Health and Equity -** No Menthol Sunday
- **The TRUTH initiative**

PERCENT OF ADULTS REPORTING BINGE OR HEAVY DRINKING

"By the time you reach treatment, systems have failed...look at the research around adverse childhood events."

-NC SHIP Work Session June 2020

Figure 21. Excessive drinking across populations in North Carolina and distance to 2030 target (2019)



WHAT OTHER DATA DO WE NEED?

- Map of points of liquor sales in community
- Number of criminal offenders under the influence when crime was committed
- Number of emergency room visits for alcohol-related injuries and conditions
- Economic cost of alcohol-related injuries and conditions
- Availability of alcohol from illegal sales and practices
- Availability of inpatient and outpatient treatment and counseling programs
- Alcoholics Anonymous (AA) locations and meeting times
- Expand the NC Alcohol Data Dashboard

Information about the data source can be found in **Appendix C:** NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

WHAT RESULT DO WE WANT?

All North Carolina communities support safe and responsible use of alcohol.

WHY IS THIS IMPORTANT?

Alcohol consumption is the third leading cause of preventable deaths in North Carolina. Excessive alcohol use causes poor health outcomes and has social and economic repercussions. *HNC 2030, p. 70*

HOW ARE WE DOING?

In 2018, 16.9% of adults in North Carolina reported binge or heavy drinking. This placed North Carolina at 14th among US states. Men are twice as likely to report excessive drinking and it is most reported for adults 18-44, whites, Hispanics, and multiracial individuals. Individuals with higher income ($75,000+ annually) reported excessive drinking at 23% compared to 17.7% for lower income individuals ($25,000-$49,999 annually). Although the percentage of excessive drinking has been slowly increasing, the goal is to reduce this indicator to 12.0% over the next 10 years. Prioritizing reducing excessive drinking reported by men will help to reach this goal.

HNC 2030 pp. 70-71

WHAT WORKS?

- Consider laws around beer and wine couponing
- Education for family practitioners about how to talk about alcohol consumption and resources for addressing excessive drinking
- Education for parents about securing alcohol at home
- Expand access to treatment through Medicaid eligibility
- Hold alcohol retailers liable for intoxicated or underage customers who cause injury to others
- Increase alcohol excise taxes
- Increase funding for compliance checks
- Increase number and access to programs like Fellowship Hall
- Integrate Screening, Brief Intervention, and Referral to Treatment (SBIRT) into medical settings
- Reduce density of alcohol retailers
- Reduce the days and hours designated for alcohol sales
- Screen adults for excessive drinking and conduct brief intervention for those that screen positive
- Support and maintain state-controlled alcohol sales

NC PARTNERS WHO CAN HELP US:

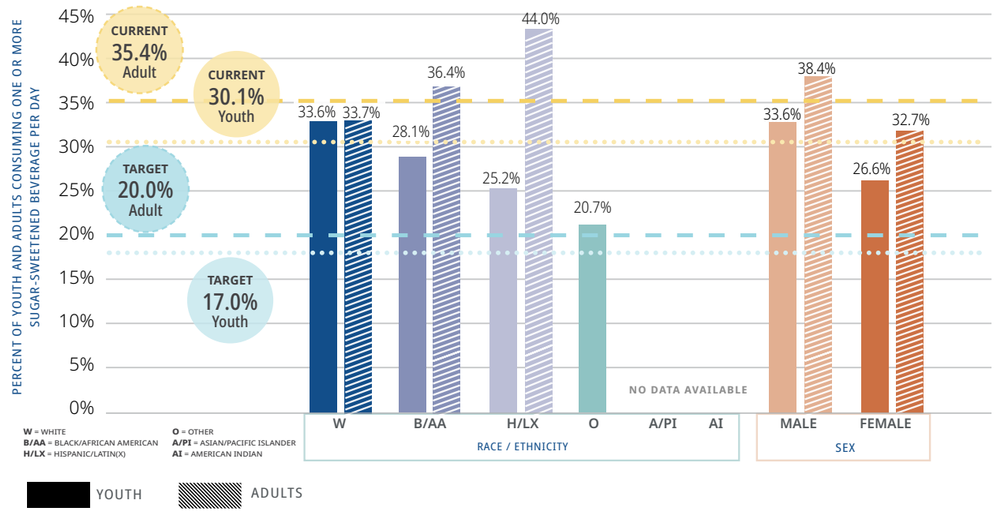
- **Centers for Disease Control's Community Guide on Preventing Excessive Alcohol Consumption -** https://www.thecommunityguide.org/topic/excessive-alcohol-consumption
- **NC-PUDI Collaborative Contacts -** https://www.ncpudi.org/community-collaboratives/collaborative-contacts/
- **North Carolina Alcohol Policy Alliance -** A statewide grassroots network advocating for research-based alcohol policies that foster safe and healthy communities- https://www.centerforalcoholpolicy.org/2019/03/04/north-carolina-alcohol-policy-forum-examines-state-based-alcohol-regulation-public-health-and-safety/
- **North Carolina Preventing Underage Drinking Initiative (NC-PUDi) -** https://www.ncpudi.org/about/
- **Talk It Up. Lock It Up!™ -** http://www.ncpudi.org/resources/talk-it-up-lock-it-up/
- **Too Smart to Start -** http://www.samhsa.gov/underage-drinking

PERCENT OF YOUTH AND ADULTS REPORTING CONSUMPTION OF ONE OR MORE SUGAR-SWEETENED BEVERAGES (SSBs) PER DAY

"The industry targets minority communities."

-NC SHIP Work Session June 2020

Figure 22. Sugar-sweetened beverage consumption across populations in North Carolina and distance to 2030 target (2019)



WHAT OTHER DATA DO WE NEED?

- School and Child Care Policies on SSB sales and consumption
- Early Childhood Programs participating in NAPSACC
- Water quality in community

Information about the data source can be found in **Appendix C:**

- Youth: NC Department of Public Instruction, Youth Risk Behavior Survey (YRBS)
- Adult: NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

WHAT RESULT DO WE WANT?

All North Carolina residents live in communities that support healthy weight initiatives.

WHY IS THIS IMPORTANT?

Sugar-sweetened beverage consumption is the leading source of calories and added sugar in the American diet and is directly linked to greater instances of chronic nutrition-related conditions, heart disease, and dental problems. *HNC 2030, p. 72*

HOW ARE WE DOING?

In 2017, 33.6% of high school students and 34.2% of adults in North Carolina reported consumption of one or more sugar sweetened beverages (SSBs) per day. Men, individuals in low-income households, individuals with low levels of educational attainment, and individuals that have parents with low levels of educational attainment report higher SSB consumption. Perception of tap water and targeted marketing to youth of color and low-income populations contribute to differences in SSB consumption across racial groups. The goal for the next 10 years is to decrease youth consumption of SSBs to from 33.6% to 17% and decrease adult consumption from 34.2 % to 20.0%.

HNC 2030 pp. 72-73

WHAT WORKS?

- Address targeted industry marketing to communities of color
- Consider multidisciplinary approach to reducing SSB consumption that includes oral health
- Create community coalitions to identify additional community strategies to reduce consumption
- Launch public awareness campaigns
- Limit sugary drinks through government and private sector procurement policies
- Limit the default beverages served with kids meals to milk, 100% fruit juice, or water
- Partner with schools and youth-oriented settings to remove or limit SSBs and their marketing
- Promote healthy restaurant meals
- Use SSB taxes and generated revenues to address equity issues
- Work with clinicians, medical practices, and insurance providers to add SSB screening questions to the electronic health record
- Work with retailers to improve offerings and create healthier store environments

NC PARTNERS WHO CAN HELP US:

- **Duke University World Food Policy Center -** https://wfpc.sanford.duke.edu/
- **Durham's Innovative Nutrition Education (DINE) -** https://www.dcopublichealth.org/services/nutrition/dine
- **Eat Smart, Move More NC -** https://www.eatsmartmovemorenc.com/
- **Eat Smart, Move More, Prevent Diabetes -** https://esmmpreventdiabetes.com/how-it-works/
- **Eat Smart, Move More, Weigh Less -** https://esmmweighless.com/how-it-works/
- **Go NAPSACC -** https://gonapsacc.org/
- **Healthy Eating Research** Healthy Drinks Healthy Kids - https://healthydrinkshealthykids.org/
- **I Heart Water-** http://iheartwaternc.com/
- **NC Council of Churches Partners in Health and Wholeness Collaborative -** https://www.ncchurches.org/programs/phw/collaborative/
- **NC State Color Me Healthy -** https://ncstepstohealth.ces.ncsu.edu/color-me-healthy-for-steps-to-health/
- **NC State Take Control -** https://ncstepstohealth.ces.ncsu.edu/steps-to-health-eat-smart-move-more-take-control/
- **North Carolina Expanded Food and Nutrition Education Program -** https://ncefnep.org/
- **Supplemental Nutrition Assistance Program Education -** https://www.fns.usda.gov/snap/SNAP-Ed

HIV RATE: NUMBER OF NEW HIV DIAGNOSES PER 100,000 POPULATION

"We need to move away from the 'You come to Me' mentality and use technology to improve communication."

-NC SHIP Work Session June 2020

Figure 23. HIV rate across populations in North Carolina and distance to 2030 target (2019)

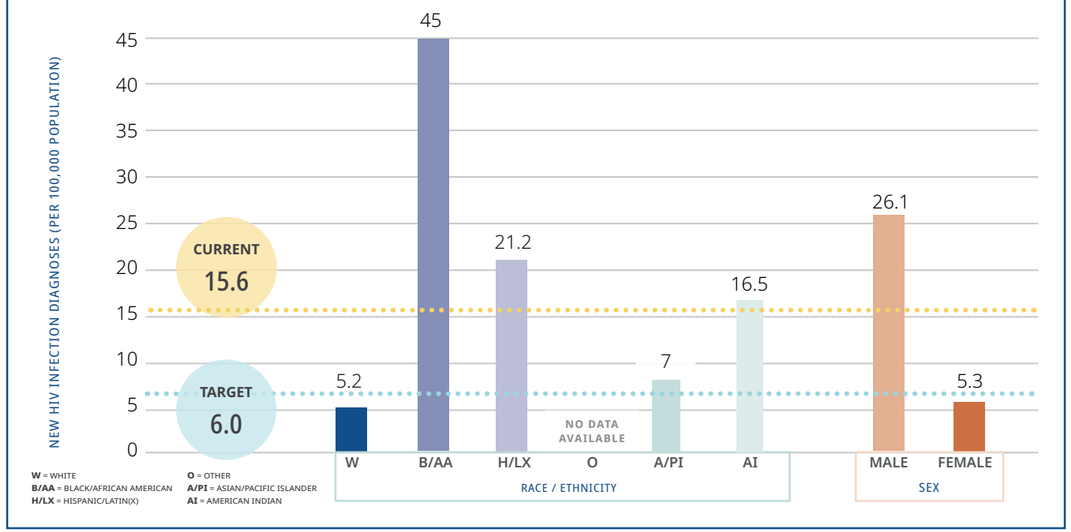
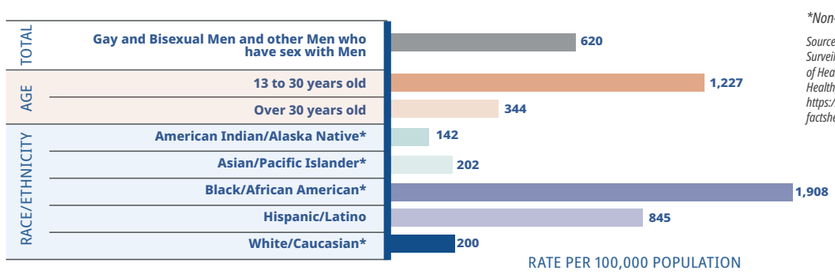


Figure 24. Estimated HIV Infection Rates among Newly Diagnosed Adult and Adolescent (13 years and older) Gay and Bisexual Men and Other Men who have Sex with Men in North Carolina (2018)



WHAT OTHER DATA DO WE NEED?

- Availability of PrEP (pre-exposure prophylaxis) within community
- Social media platforms used by the at-risk community
- Community awareness of sexual health
- Access to care for sexual health

Information about the data source can be found in **Appendix C:** NC Division of Public Health, Epidemiology Section

WHAT RESULT DO WE WANT?

All North Carolina residents experience sexual health with equitable access to prevention, treatment, and management of sexually transmitted infections.

WHY IS THIS IMPORTANT?

HIV can cause lifelong physical and psychological consequences. When left untreated, HIV can also be transmitted to sexual partners and unborn children. *HNC 2030, p. 76, revised*

HOW ARE WE DOING?

The North Carolina HIV diagnosis rate was 13.9 per 100,000 people in 2018. Significant racial and gender disparities exist, including higher rates of diagnosis within communities of color. For African American men and women, HIV diagnosis was 68.7 cases per 100,000 and 15.9 cases per 100,000, respectively. Hispanics were diagnosed at a rate of 17.7 cases per 100,000 people. The white population was diagnosed at only 4.9 cases per 100,000 people. HIV diagnosis is significantly higher among men who have sex with men and large disparities exist between African American, Hispanic, and white men within this group as well. Men who have sex with other men are 155 times more likely to contract HIV than men who have sex only with women. People with lower income, who lack health insurance, sex workers, and incarcerated individuals have higher rates of diagnosis and lack resources for prevention and treatment of HIV. The 2030 goals for this indicator are to reduce the rate of diagnosis to 6.0 cases per 100,000 people and reduce racial/ethnic disparities.

HNC 2030 pp. 76-77, revised

WHAT WORKS?

- Address systemic issues of provider discomfort discussing HIV and sexual health especially with young people and LGBTQ populations
- Allow pharmacists to provide post-exposure prophylaxis
- Ensure availability of free condoms at health departments and community-based organizations
- Ensure people who are diagnosed are linked with appropriate care and receive behavioral interventions and other supports to decrease risk of transmission
- Harm reduction, such as needle exchange programs, housing programs
- Implement interventions that improve access to HIV treatment
- Increase access to PrEP (pre-exposure prophylaxis) for individuals at high risk for HIV transmission
- Increase education and access for formerly incarcerated populations
- Increase Medicaid eligibility
- Make testing easy, accessible, and routine

NC PARTNERS WHO CAN HELP US:

- **Duke PrEP Clinic For HIV Prevention** Offers pre-exposure prophylaxis (PrEP) to HIV-negative individuals at risk for HIV infection who are interested in PrEP as a means to prevent HIV https://www.dukehealth.org/locations/duke-prep-clinic-hiv-prevention
- **Getting to Zero Mecklenburg County Goal** is to reduce the number of new HIV infections, in Mecklenburg County, by 75% in 5 years, and 90% in 10 years - https://www.mecknc.gov/HealthDepartment/GettingToZero/Pages/Home.aspx
- **North Carolina Harm Reduction Coalition (NCHRC) Syringe Exchange Program** Allows IV drug users to exchange their used needles for clean needles, helping to prevent transmission of bloodborne diseases like HIV- http://www.nchrc.org/syringe-exchange/syringe-exchange-2/
- **Sexual Health Initiatives For Teens (SHIFT) NC** Working to improve adolescent and young adult sexual health - https://www.shiftnc.org/

TEEN BIRTH RATE: NUMBER OF BIRTHS TO GIRLS AGED 15-19 PER 1,000 POPULATION

"Some women are waiting for their Medicaid card not realizing you can start care before you get the card."

-NC SHIP Work Session June 2020

Figure 25. Teen birth rate across populations in North Carolina and distance to 2030 target (2019)

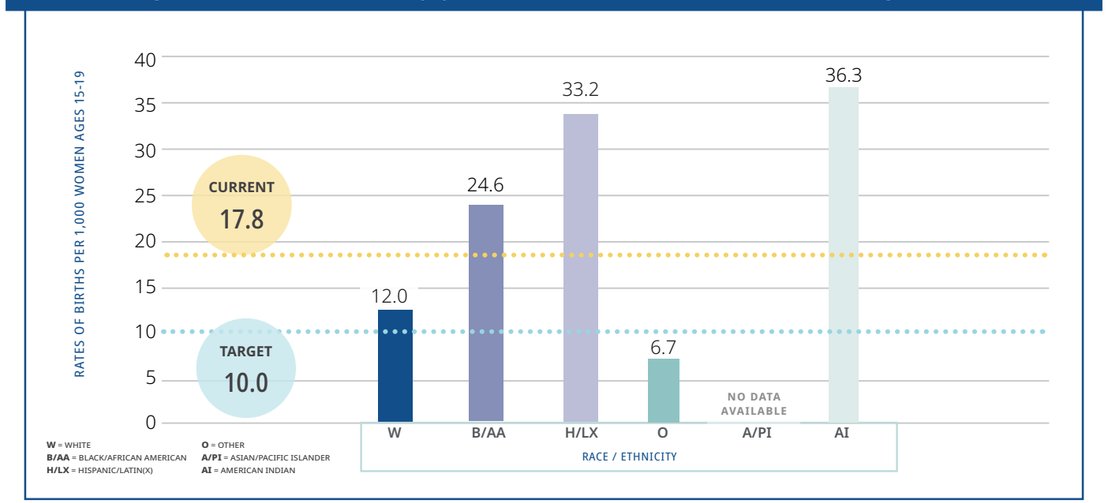
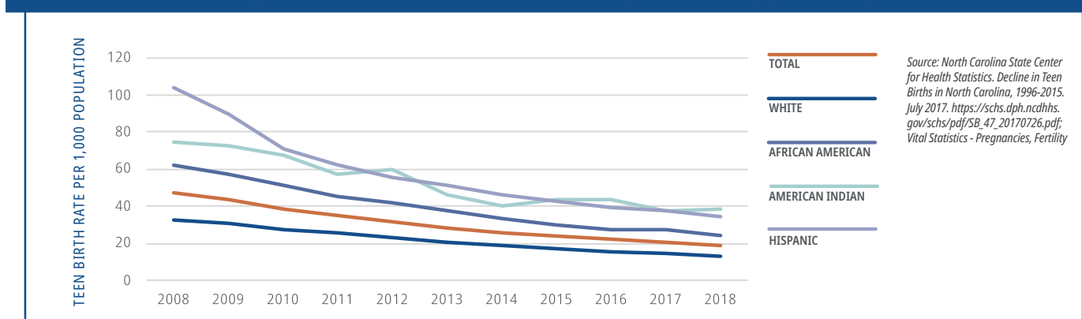


Figure 26. Teen Birth Rate in North Carolina, by Race/Ethnicity (2008-2018)



WHAT OTHER DATA DO WE NEED?

- Number of organizations in community that have similar interest in teens and reproductive health
- Number of teens in community
- Demographic profile of teens in community
- Number of middle and high schools
- Location of contraceptive health services (public and private)
- Number of youth-serving businesses

Information about the data source can be found in **Appendix C:** NC State Center for Health Statistics, Vital Statistics

WHAT RESULT DO WE WANT?

All North Carolina communities support healthy choices for family planning and have equitable access to high quality, affordable reproductive health services.

WHY IS THIS IMPORTANT?

Teenage mothers are more likely to face higher rates of pregnancy-related morbidity, are less likely to receive prenatal care, and experience greater hardships that negatively impact their children's life and their own. *HNC 2030, p. 78*

HOW ARE WE DOING?

In 2018, the North Carolina teen birth rate for girls aged 15-19 was 18.7 per 1,000, ranking 23rd among US states. Teen birth rate is influenced by income level, educational attainment, childhood trauma, racial identity, and geography. Teenage pregnancy and birth are more common among girls from low income families and those with a history of adverse childhood experiences. African American, Hispanic, and American Indian girls give birth at rates 2-3 times higher than white girls and these girls are more likely to reside in under-resourced communities. Over the next 10 years, the goal is to reduce the number of teen births to 10 per 1,000, and to reduce racial disparities for this health indicator. *HNC 2030 pp. 78-79*

WHAT WORKS?

- Engage community. Community input is essential to understanding what issues are impacting unintended pregnancy
- Ensure access to information and services for youth sexual health
- Examine school sex education policies to ensure they include information on how to avoid teen pregnancy and sexually transmitted infections (STIs)
- Increase access to educational programs for youth in juvenile justice and foster care systems on pregnancy and STIs
- Increase access to long-acting reversible contraceptives, such as IUDs and implants, as well as condoms
- Increase education for teen mothers to prevent second pregnancies
- Make contraceptives available on-site in schools
- Require medically accurate sex education

NC PARTNERS WHO CAN HELP US:

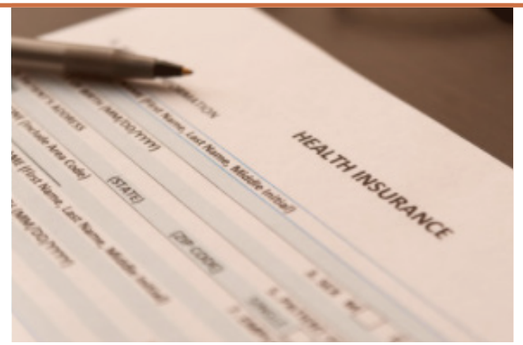
- **Adolescent Pregnancy Prevention Program** Provides essential education, supports academic achievement, encourages parent/teen communication, promotes responsible citizenship, and builds self confidence among their participants - https://www.teenpregnancy.ncdhhs.gov/appp.htm
- **Gaston Youth Connected -** https://www.shiftnc.org/initiatives/gaston-youth-connected
- **H.E.A.R.T.S.** organization in Durham, works with young parents age 13-22 and educates and equips adolescent parents with the tools needed to become independent and self-sufficient. The primary focus is on graduation rate and a second goal is to reduce repeat pregnancies - https://www.heartsnc.org/
- **NC DHHS - PREPare for Success (Personal Responsibility Education Program)** Educates adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections and focuses on healthy relationships, healthy life skills, and parent-child communication - https://www.teenpregnancy.ncdhhs.gov/prep.htm
- **SHIFT NC (Sexual Health Initiatives For Teens)** Partners with communities, youth-serving professionals, organizations, and systems to improve adolescent and young adult sexual health by 1) integrating and scaling-up trauma-informed and LGBTQ+ inclusive, evidence-based prevention programs; 2) providing healthcare quality improvement services to strengthen access to teen-centered and inclusive healthcare services; and 3) advocating for local, statewide, and national policy reform that impacts young people and families - https://www.shiftnc.org/

STATE HEALTH IMPROVEMENT PLAN

INDICATORS

CLINICAL CARE FACTORS

PERCENT OF THE POPULATION UNDER AGE 65 WITHOUT HEALTH INSURANCE



"While we wait for Medicaid expansion and subsidized coverage under the Affordable Care Act, we need to explore alternative ways for NC's uninsured residents to receive care without the overlay of insurance."

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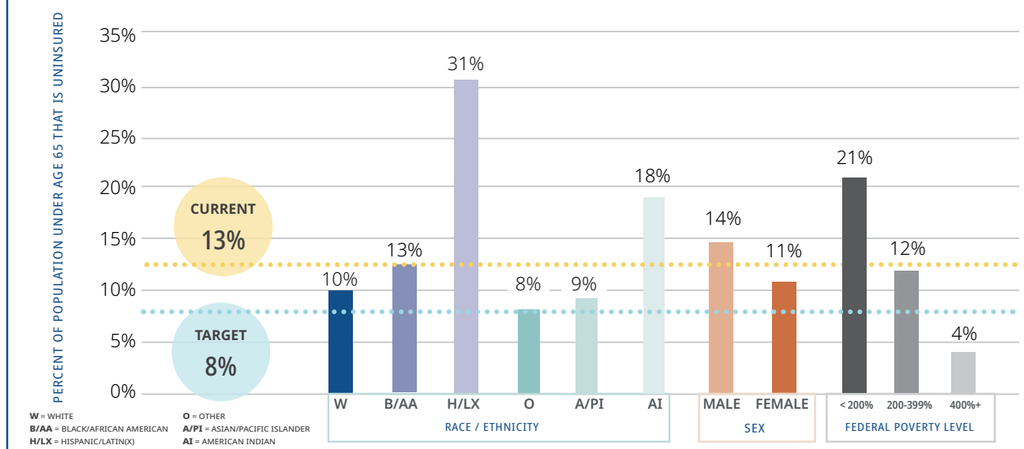
Figure 27. Percent uninsured across populations in North Carolina and distance to 2030 target



WHAT OTHER DATA DO WE NEED?

- Impact of Covid-19 pandemic on employer sponsored insurance
- Estimates of underinsured/uninsured at the county level
- Major employer insurance benefits available in area
- Analysis of support/opposition by elected officials to Medicaid expansion
- Stories from consumers/residents and their experience

Information about the data source can be found in **Appendix C:** US Census Bureau - Small Area Health Insurance Estimates (SAHIE) Program

WHAT RESULT DO WE WANT?

All North Carolinians have access to high quality, affordable health care insurance.

WHY IS THIS IMPORTANT?

Access to quality health care services is critical to achieve and maintain health, prevent and manage disease, and achieve health equity. Lack of health insurance can make health care inaccessible and unaffordable. *HNC 2030, p. 84*

HOW ARE WE DOING?

In 2019, nearly 14% of North Carolina's 8.4 million non-elderly lacked health insurance, ranking North Carolina 46th among US states. Approximately 55 percent of the population held employer-sponsored insurance. Another 8% had individual plans (primarily through the ACA Marketplace). More than one-in-five (21%) had public health insurance (Medicaid, NC Health Choice, or Medicare). Adults with low incomes who do not currently qualify for Medicaid fall into a coverage gap and have high rates of uninsured individuals. When viewed through an explicit race equity lens, conditions are more dire for people of color across the state. Of the nearly 1,845,000 non-elderly African Americans in North Carolina, almost 232,000 or 13% lacked health insurance. Hispanic-Americans are uninsured at higher rates among ethnic groups; about 270,000 (29%) of 937,000 non-elderly are without health insurance. This can likely be attributed to the ethnic group's propensity to be locked into essential work that does not pay a living wage or offer health coverage. Comparatively, 10 percent or 509,000 (out of nearly 5,085,000) non-elderly white North Carolinians are uninsured. People in rural areas are less likely to have health insurance than their urban peers. The 80 rural counties (as defined by the NC Rural Center) make up 38 percent of the state's non-elderly population but account for 42 percent of its uninsured. Expanding Medicaid in North Carolina would support the 2030 goal to decrease the uninsured rate for people under 65 to 8%, reaching more people of color and rural people all over the state.

HNC 2030 pp. 84-85, revised

WHAT WORKS?

- Expand Medicaid eligibility criteria
- Increase publicity and navigator funding for open enrollment
- Increase public education about insurance options
- Support bans or limitations on short-term health plans

NC PARTNERS WHO CAN HELP US:

- **Care4Carolina -** https://care4carolina.com/ - statewide Coalition working to fill the coverage gap for low-income North Carolinians
- **Down Home NC -** https://www.downhomenc.org/about-us/ Building multiracial power for poor and working folks in rural North Carolina.
- **Equality NC -** https://equalitync.org/ - Access to transition-related healthcare services under Medicaid
- **Legal Aid of North Carolina -** https://www.legalaidnc.org/about-us/projects/nc-navigator-consortium - helps people enroll for insurance on the ACA Marketplace
- **NC Child -** https://ncchild.org/uninsured-children2020/
- **NC Community Health Center Association -** https://www.ncchca.org/ - Provides free or reduce cost health care to low income uninsured individuals
- **NC Justice Center -** https://www.ncjustice.org/projects/health-advocacy-project/medicaid-expansion/expanding-medicaid-in-nc/ - advocates for access to health care and insurance coverage for low income North Carolinians
- **NC Rural Center -** https://www.ncruralcenter.org/ - working to build more vibrant rural communities, including filling the coverage gap
- **North Carolina Association of Free & Charitable Clinics -** https://ncafcc.org/our-clinics/ & https://ncafcc.org/

NUMBER OF NC COUNTIES WITH A PRIMARY CARE WORKFORCE TO COUNTY POPULATION RATIO OF 1:1,500

PRIMARY CARE WORKFORCE AS A RATIO OF THE NUMBER OF FULL-TIME EQUIVALENT PRIMARY CARE CLINICIANS

"We need medical students to experience rural health care early in their education. Recruiting practices during COVID has been difficult."

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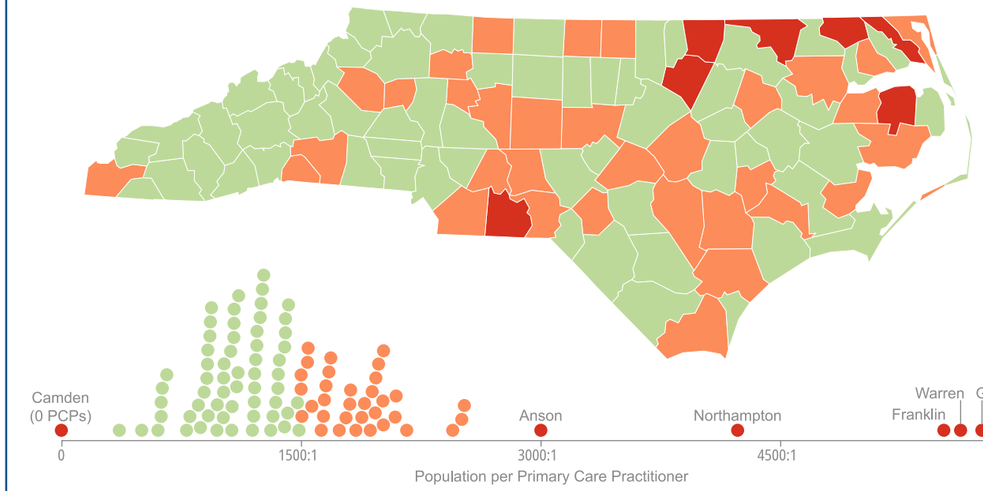
Figure 28. Population per primary care practitioner in North Carolina (2017)



Notes: Updated March 10, 2020 to reflect adjustments to 2017 nurse practitioner data. Primary care physicians, physician assistants, and nurse practitioners are defined as in Spero, J. C., & Galloway, E. M. (2019). Running the Numbers. North Carolina Medical Journal, 80(3), 186-190. Physicians with a primary area of practice of obstetrics/gynecology were weighted as 0.25 of a full-time equivalent (FTE) primary care practitioner. All other primary care physicians were weighted as 1 FTE. Primary care physician assistants, nurse practitioners, and certified nurse midwives were weighted as 0.75 FTE. Physician and physician assistant data are derived from licensure data provided by the North Carolina Medical Board. This analysis only includes physicians who are not residents-in-training and are not employed by the Federal government. Nurse practitioner and certified nurse midwife data is derived from licensure data provided by the North Carolina Board of Nursing. Data include active, licensed practitioners in practice in North Carolina as of October 31, 2017. Practitioners are assigned to counties based on primary practice location. County populations were adjusted for age and gender according to primary care use rates described in data from the Medical Expenditure Panel Survey. The raw (unadjusted) population data was from the NC Office of State Budget and Management (https://www.osbm.nc.gov/demog/county-projections).

SHEPS HEALTH WORKFORCE NC

WHAT OTHER DATA DO WE NEED?

- Stories from consumers/residents and their experiences around access to primary care in their community
- Secondary and post- secondary opportunities to pursue careers in health care
- Telehealth availability
- Contact information for all health care providers serving residents

Information about the data source can be found in **Appendix C:** Cecil G. Sheps Center for Health Services - Research analysis of licensure data from North Carolina Medical Board and North Carolina Board of Nursing

WHAT RESULT DO WE WANT?

All residents of North Carolina have equitable access to high quality, affordable primary care.

WHY IS THIS IMPORTANT?

Primary care providers help to maintain and improve the overall health and well-being of communities. Access to primary care is associated with fewer health care disparities and better health outcomes across socioeconomic circumstances. *HNC 2030, p. 86*

HOW ARE WE DOING?

In 2017, 62 counties in North Carolina met the recommended ratio of one primary care provider for every 1,500 residents. The growing demand and subsequent shortage of primary care, dental, and behavior health providers is largely due to the aging baby boomer population and overall population growth. The challenges are especially prevalent in rural communities which face difficulties recruiting and retaining health care professionals. Shortages in the primary care workforce in rural areas lead to an increase in unmet health care needs, delays in receiving care, forgoing of preventive care, preventable hospitalizations, and deaths. The 2030 goals are to have all 100 counties in North Carolina meeting the recommended ratio of 1 primary care worker: 1,500 population. *HNC 2030 pp. 86-87*

WHAT WORKS?

- Ensure high speed internet access because it impacts telehealth, electronic health records and access to the controlled substance reporting system
- Identify rural provider champions
- Increase access and payment for specialist consults
- Increase residency positions in rural areas
- Increase rural health clinical rotations for physician assistants (PAs) and Advanced Practice Nurses (DNPs)
- Increase support for all primary care providers
- Increase telehealth primary care initiatives in rural areas
- Invest in rural economies
- Support increased funding for provider loan repayment programs that incentivize primary care providers to practice in medically underserved areas
- Support pipeline programs in rural areas to encourage high school and college students to pursue careers in medicine/primary care

NC PARTNERS WHO CAN HELP US:

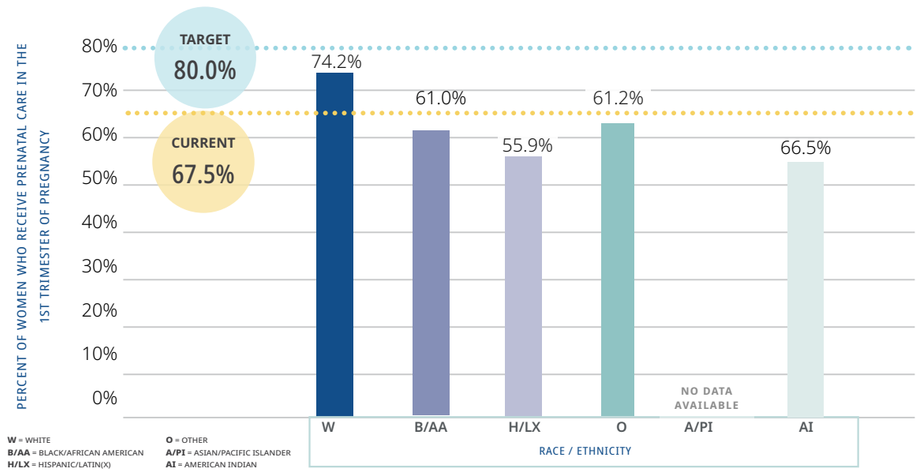
- **Duke Health's Primary Care Preceptor Development Mini-Fellowship Program** Equips primary care preceptors to become effective clinician educators who can develop and implement curricula and facilitate group Quality Improvement (QI) projects that will address the needs of vulnerable populations in North Carolina - https://fmch.duke.edu/education-training/primary-care-preceptor-development-mini-fellowship
- **Mountain Community Health Partnership** Working to improve the quality of life for all residents in our communities, regardless of their ability to pay, by providing excellent primary healthcare services - https://www.mchp.care/
- **The Cecil G. Sheps Center at UNC -** https://www.shepscenter.unc.edu/programs-projects/workforce/health-workforce-data-visualization-tools/

PERCENT OF WOMEN WHO RECEIVE PREGNANCY-RELATED HEALTH CARE SERVICES DURING THE FIRST TRIMESTER OF A PREGNANCY

"Some women are waiting for their Medicaid Card not realizing you can start care before you get the card."

-NC SHIP Work Session June 2020

Figure 29. Early prenatal care use across populations in North Carolina and distance to 2030 target (2019)



WHAT OTHER DATA DO WE NEED?

- Number of pregnancy care providers in the community
- Number of High-risk pregnancy care providers in the community
- Employer policies related to pregnancy care
- Number of community health care workers providing outreach and education
- Availability of public transportation to get to prenatal appointments

Information about the data source can be found in **Appendix C:** NC State Center for Health Statistics, Vital Statistics

WHAT RESULT DO WE WANT?

All mothers have healthy pregnancies and all babies are born healthy.

WHY IS THIS IMPORTANT?

Women who receive early prenatal care have lower rates of negative pregnancy outcomes and have access to social support systems and programs that can help navigate pregnancy safely and healthily. *HNC 2030, p. 88*

HOW ARE WE DOING?

In 2018, 68% of women in North Carolina received pregnancy related healthcare services within the first trimester of pregnancy. Women in lower income groups are less likely to be insured and have less access to appropriate prenatal care. Medicaid in North Carolina provides women with lower income prenatal care, delivery, postpartum care, childbirth classes, and treatment for complications with pregnancy. Teenage mothers and mothers in their early 20s are less likely to seek early prenatal care than older mothers. African American women, Hispanic women, and American Indian women are less likely to receive early prenatal care when compared to white women. The current goal for the next 10 years is to improve the percentage of early prenatal care to 80% of women for the first trimester of pregnancy. *HNC 2030 pp. 88-89*

WHAT WORKS?

- Allow certified nurse midwives to practice under their full authority
- Encourage group prenatal care, childbirth education, and doula services are covered services by Medicaid
- Expand Medicaid eligibility
- Expand safe and reliable public transit options
- Provide education for local health & human services agencies on the importance of prenatal care.
- Public and provider awareness/education about ability to receive prenatal care services before receiving Medicaid card
- Strengthen workforce diversity and cultural humility in the delivery of prenatal care services
- Support quality improvement efforts to address provider bias
- Take advantage of the Children's Health Insurance Program option to provide coverage for comprehensive prenatal care to undocumented immigrant women
- Use community health workers to provide outreach and education to women of childbearing age in underserved communities

NC PARTNERS WHO CAN HELP US:

- **Maternal Support Services/Baby Love Program-** Program available to Medicaid-eligible pregnant women during and after pregnancy (60-day postpartum period) - https://medicaid.ncdhhs.gov/providers/programs-services/family-planning-and-maternity/maternal-support-services
- **North Carolina Perinatal Health Strategic Plan-** Designed to address infant mortality, maternal health, maternal morbidity, and the health of men and women of childbearing age - https://whb.ncpublichealth.com/phsp/
- **Pregnancy Medical Home (PMH) -** Promotes evidence-based, high-quality maternity care in more than 400 practices across the state & enhances access to comprehensive care for pregnant Medicaid beneficiaries and to improve birth outcomes - https://medicaid.ncdhhs.gov/providers/programs-services/family-planning-and-maternity/pregnancy-medical-home

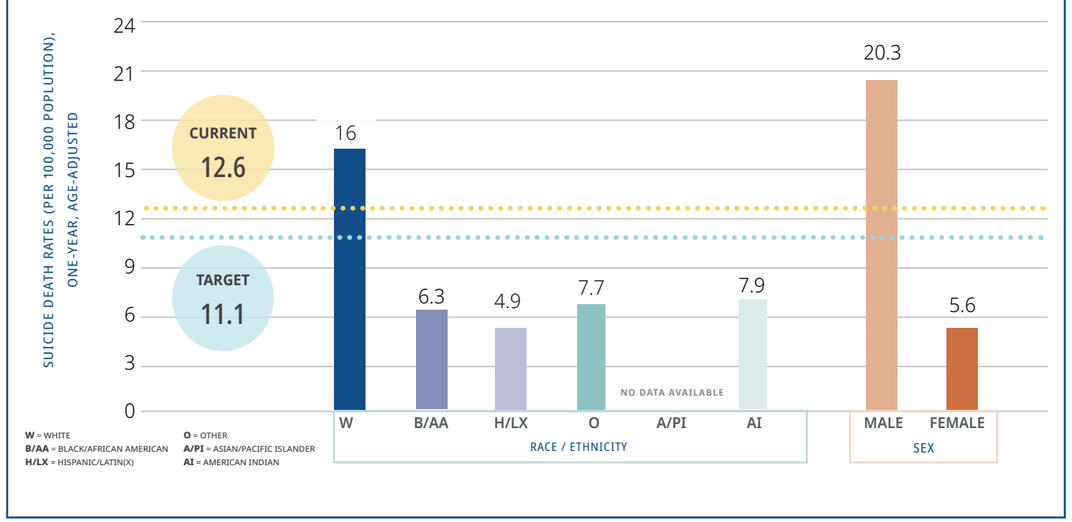
SUICIDE RATE PER 100,000 PEOPLE
(AGE-ADJUSTED NUMBER OF DEATHS ATTRIBUTABLE TO SELF-HARM PER 100,000)

"The justice system overall has issues with untreated mental health and isolation."

-NC SHIP Work Session June 2020

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Figure 30. Suicide rate across populations in North Carolina and distance to 2030 target (2019)



WHAT OTHER DATA DO WE NEED?

- Stories from survivors/families and their experiences with getting help for mental health/substance use disorders
- Enhanced death certificate review
- Inventory of all local/regional services for mental health care/substance use disorder

Information about the data source can be found in **Appendix C:** NC State Center for Health Statistics, Vital Statistics

WHAT RESULT DO WE WANT?

All North Carolina residents live in communities that foster and support positive mental health.

WHY IS THIS IMPORTANT?

Suicide rate is an indicator of access to comprehensive high-quality health care and overall well-being. Suicide has impact on individuals and across communities. *HNC 2030, p. 90*

HOW ARE WE DOING?

The suicide rate, the number of deaths due to self-harm, was 13.8 per 100,000 people in North Carolina in 2018, ranking 16th among US states. Gender, age, racial and ethnic group, and geography were all factors for increased rates of suicide. Men over the age of 45, American Indians, white North Carolinians, rural residents, veterans and members of the LGBTQ population present higher rates of suicide. For children age 10-17, suicide is the second leading cause of death with higher rates among African American students, Hispanic students, and students who report their race as Other. Since the rate of suicide has been slowly rising over the past 10 years, current statewide goals are to reduce the rate to 11.1 per 100,000 within the next decade. *HNC 2030 pp. 72-73*

WHAT WORKS?

- Continue to support the integration of physical and mental health
- Create trauma informed schools with access to mental health providers
- Expand access to tele-mental health services
- Expand Medicaid eligibility criteria to increase access to mental health services
- Implement policies targeted to decrease access to lethal means
- Improve access to social services and other supports
- Increase programs that provide mental health services and support for LGBTQ youth
- Increase programs that provide mental health services and support for veterans
- Increase state funding for mental health services provided through local mental health systems

NC PARTNERS WHO CAN HELP US:

- **American Foundation for Suicide Prevention - North Carolina Chapter** Focuses on firearms, health care systems, emergency departments, and corrections- https://afsp.org/chapter/north-carolina
- **Faith Connections on Mental Illness** Working to stop the stigma of mental illness and to connect across faiths in mental health ministry - https://www.faithconnectionsonmentalillness.org/
- **National Alliance on Mental Illness- North Carolina Chapter** Provides advocacy, education, support, and public awareness to individuals and families affected by mental illness - https://naminc.org/
- **North Carolina Governor's Challenge to Prevent Suicide** Prevention of veteran suicide by identifying service members, veterans and families, screening for suicide risk, improving care transitions, and educating the public about limiting access to lethal means and improving safety planning - https://challenge.ncgwg.org/
- **UCLA/Duke ASAP Center for Trauma-Informed Suicide, Self-Harm & Substance Abuse Prevention & Treatment with the National Child Traumatic Stress Network** Focuses on treating and preventing suicidal behavior, self-harm, depression, and substance abuse in youth - https://www.asapnctsn.org/

STATE HEALTH IMPROVEMENT PLAN

INDICATORS

HEALTH OUTCOMES

RATE OF INFANT DEATHS PER 1,000 LIVE BIRTHS

"We see a disproportionate distribution of providers of color to the general population."

-NC SHIP Work Session June 2020

Figure 31. Infant mortality rates across populations in North Carolina and distance to 2030 target (2019)

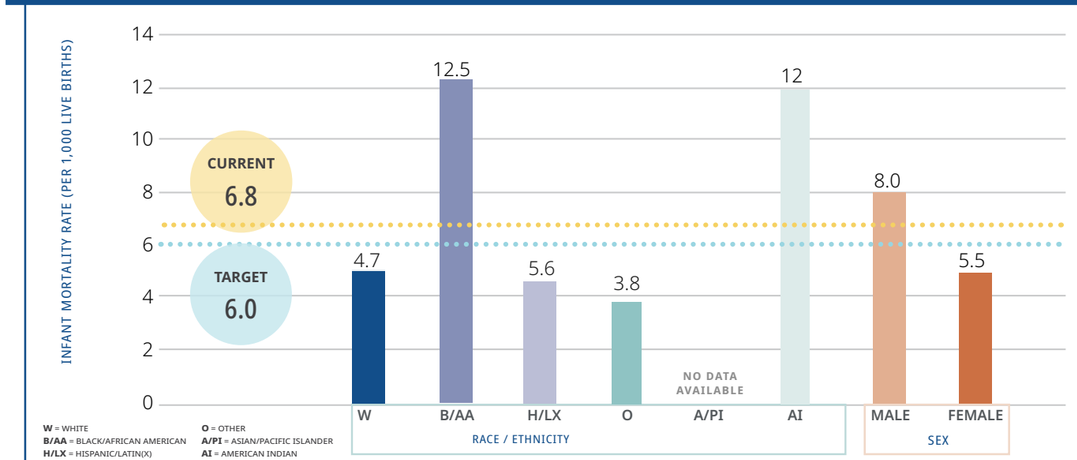
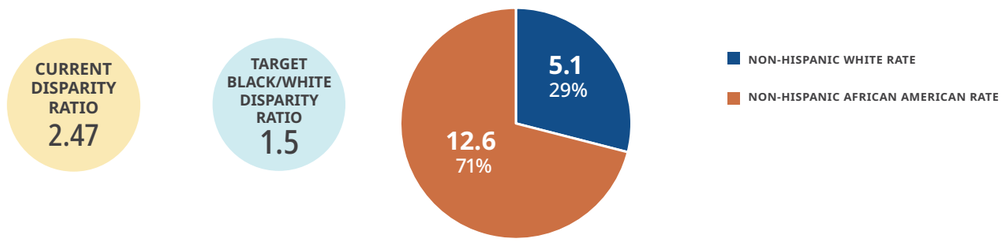


Figure 32. Infant Mortality Racial Disparities Between White Non-Hispanic and African American Non-Hispanics (2015-2019)



WHAT OTHER DATA DO WE NEED?

- Communities that participate in all aspects of the research process
- Research that leads to a better understanding of the drivers of health and well-being with attention to health equity/ health disparity issues

Information about the data source can be found in **Appendix C:** NC State Center for Health Statistics, Vital Statistics

WHAT RESULT DO WE WANT?

All babies are born healthy and thrive in caring and healthy homes.

WHY IS THIS IMPORTANT?

Infant mortality is an indicator of maternal and child health and reflects health equity of a community. *HNC 2030, p. 96*

HOW ARE WE DOING?

The infant mortality rate in North Carolina was 6.8 per 1,000 live births in 2018, with a ranking tied for 40th among US states. Significant disparities exist for African American and American Indian women who have much higher infant mortality rates compared to other racial and ethnic groups. The infant mortality rate for African American and American Indian women in North Carolina was 12.2 and 9.3 deaths per 1,000 live births, respectively, compared to 5.0 infant deaths per 1,000 live births for white women and 4.8 infant deaths per 1,000 live births for Hispanic women. Implicit bias in health care delivery and historic segregation resulting in less access to educational resources in African American communities has contributed greatly to these disparities. Infant mortality occurs more often for babies born to mothers who are experiencing poverty, are uninsured, and who are undocumented immigrants without access to Medicaid. The disparity ratio between the infant mortality rates for white women and black women is 2.4 and has been increasing over the past decade. The 2030 goals are to reduce the infant mortality rate to 6.0 infant deaths per 1,000 live births overall and to reduce the Black/white disparity ratio to 1.5. *HNC 2030 pp. 96-97*

WHAT WORKS?

- Consider recommendations from the Perinatal Health Strategic Plan
- Improve access to, and use of, prenatal care, including group prenatal care and evidence-based home visiting programs
- Improve individual preconception routine medical check-ups and reproductive life planning counseling with a focus on intimate partner violence, substance use, immunizations, depression, body mass index, blood pressure, and diabetes
- Increase access to health insurance
- Reduce maternal obesity
- Reduce maternal tobacco use before, during, and after pregnancy
- Support training on health equity including implicit bias and determinants of health.
- Take advantage of the Children's Health Insurance Program option to provide coverage for comprehensive prenatal care to undocumented immigrant women

NC PARTNERS WHO CAN HELP US:

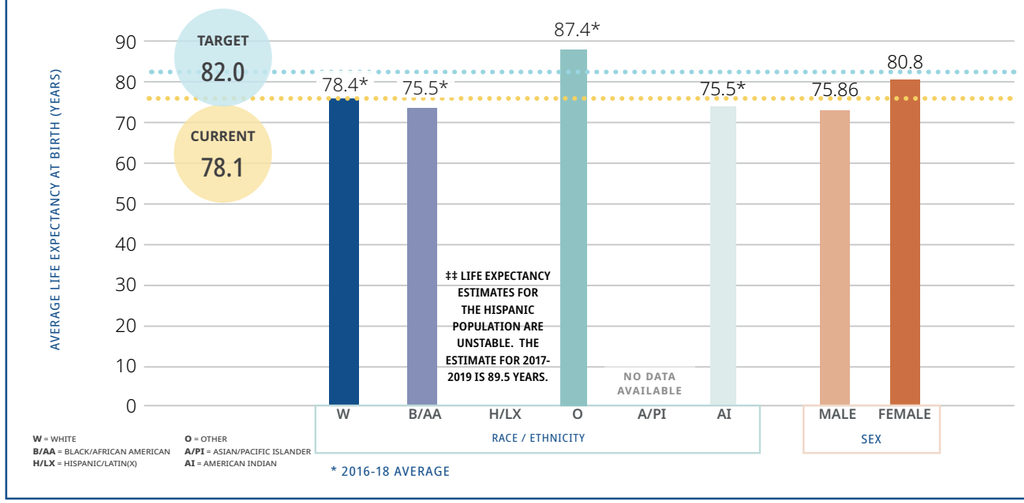
- **March of Dimes, NC Chapter -** Educates medical professionals and the public about best practices; Supports lifesaving research; Provides comfort and support to families in NICUs; Advocates for those moms and babies - https://www.marchofdimes.org/state-advocacy/state-advocacy-priorities-and-wins-NC.aspx
- **NC Child -** Four focus areas: High quality early childhood education; Healthy children; Nurturing homes and communities, Family economic security – https://ncchild.org/
- **NC Child Advocacy Network (CAN) -** Brings together child advocates from across North Carolina to build power that can impact public policies and benefit children and families - https://ncchild.org/what-we-do/
- **The UNC Center of Excellence in Maternal and Child Health Education, Science and Practice -** https://sph.unc.edu/mch/center-of-excellence/
- **UNC Collaborative for Maternal and Infant Health -** Provides leadership in North Carolina to several important public health campaigns, including tobacco use cessation, preterm birth prevention, preconception health, postpartum care and inequities in birth outcomes - https://www.mombaby.org/

AVERAGE NUMBER OF YEARS OF LIFE REMAINING FOR PEOPLE WHO HAVE ATTAINED A GIVEN AGE

"We must do all that we can to protect one another."

-Secretary Mandy Cohen, NC DHHS

Figure 33. Life expectancy across populations in North Carolina and distance to 2030 target (2019)



WHAT OTHER DATA DO WE NEED?

- Impact of Covid-19 pandemic on life expectancy
- Continuing impact of opioid epidemic on life expectancy
- Continuing impact of infant mortality on life expectancy

Information about the data source can be found in **Appendix C:** NC State Center for Health Statistics, Vital Statistics

WHAT RESULT DO WE WANT?

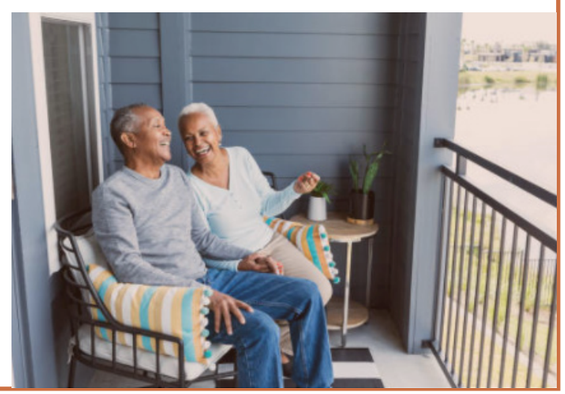
All residents of North Carolina have long and healthy lives.

WHY IS THIS IMPORTANT?

Life expectancy is a proxy measure for the total health of a population. Disparities in life expectancy between populations point to where issues of health equity must be addressed. *HNC 2030, p. 98*

HOW ARE WE DOING?

From 2016 - 2018 the life expectancy for residents of North Carolina was 78.0 years and has been decreasing over the past several years. The top causes of years of life lost during this time period were ischemic heart disease, trachea, bronchus, and lung cancer, and road injuries. Race, geography, gender, and socioeconomic factors contribute largely to disparities for this health measure. Life expectancy varies greatly among North Carolina counties, ranging between 73.1 to 82.1 years. Disparities exist within counties as well. African American men and women have an average life expectancy of 72.2 years and 79.0 years, respectively, much lower than their white counterparts averaging 76.5 years for men and 81.1 years for women. Goals for improvement to be actualized by 2030 would successfully reverse the downward trend to achieve an overall state life expectancy of 82.0 years. *HNC 2030 pp. 98-99*



Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. Health Equity. Accessed September 1, 2019. http://www.cdc.gov/chronicdisease/healthequity/index.htm

Dail, KG. (2019). [Dissertation] The Affordable Care Act: Public Health Accreditation and the Community Health Assessment Process in North Carolina (2011-2017).

Friedman, M. (2015). *Trying hard is not good enough: How to produce measurable improvements for customers and communities.* Santa Fe, New Mexico: Parse Publishing.

Glanz K, Rimer BK, Viswanath K. *Health Behavior: Theory, Research, and Practice.* 5th ed. (Jossey-Bass, ed.). San Francisco, California. 2015.

King BA, Graffunder C. Tobacco Control 2018;27:123-124. Kong AY, King B. *Tobacco Control* 2020.

North Carolina Institute of Medicine. Healthy North Carolina 2030: A Path Toward Health. Morrisville, NC: North Carolina Institute of Medicine; 2020.

University of Wisconsin Population Health Institute (UWPHI). (2018). County health rankings and roadmaps. Retrieved from www.countyhealthrankings.org

REFERENCES BY INDICATOR

INDIVIDUALS BELOW 200% FEDERAL POVERTY LEVEL (FPL)

The Children's Defense Fund. Ending Child Poverty Now. 2019. https://www.childrensdefense.org/wp-content/uploads/2019/04/Ending-Child-Poverty-2019.pdf

- Raise the minimum wage to $15 per hour
- Increase the state earned income tax credit
- Focus economic development on well-paying jobs
- Increase subsidized childcare

UNEMPLOYMENT

Rosenbaum, J. 2020. Educational and Criminal Justice Outcomes 12 Years After School Suspension. *Youth & Society,* 52(4), 515–547. https://doi.org/10.1177/0044118X17752208

SHORT-TERM SUSPENSION RATE

Kostyo, S, Cardlchon, J, Darling-Hammond, L. Reducing Student Suspension Rates. Learning Policy Institute. October 2018. https://learningpolicyinstitute.org/product/essa-equity-promise-suspension-brief

- Train teachers, administrators, school resource officers, and others working with students on implicit bias
- Develop collaborative learning groups for schools to share best practices
- Include suspension rate in measures of school quality
- Develop statewide system of restorative justice programs
- Provide informational resources for schools on how to reduce disciplinary actions
- Promote non-exclusionary approaches to discipline

INCARCERATION RATE

National Research Council. 2014. The Growth of Incarceration in the United States: Exploring Causes and Consequences. Washington, DC: The National Academies Press. https://doi.org/10.17226/18613.

- Revise current criminal justice policies to reduce the rates of incarceration
- Improve conditions and programs in jails and prisons to reduce harmful impact and foster successful reintegration into community
- Improve educational outcomes, particularly for boys of color
- Reduce intergenerational and neighborhood poverty
- Improve access to treatment for substance use disorders, physical illnesses, and mental illnesses
- Increase employment opportunities and job training programs in disadvantaged communities
- Implement standardized, evidence-based programs to reduce recidivism

THIRD GRADE READING PROFICIENCY

North Carolina Department of Health and Human Services. North Carolina Early Childhood Action Plan. February 2019. https://files.nc.gov/ncdhhs/ECAP-Report-FINAL-WEB-f.pdf

- Expand access to NC Pre-K, 4-, and 5-star early learning programs and other high-quality early childhood programs, particularly for children who are homeless, in foster care, are from immigrant families, or who have disabilities or other special healthcare needs
- Increase funding to public schools and early learning programs that serve children with the highest barriers to success, including children from low-income families and people of color
- Improve the rigor and responsiveness of birth through third grade teacher and administrator preparation programs
- Raise wages to attract, recruit, and retain highly qualified birth through third grade teachers
- Increase access to home visiting programs for young children
- Expand use of evidence-based literacy programs connected to health care (e.g., Reach Out and Read)

ACCESS TO EXERCISE OPPORTUNITIES

Access to Exercise Opportunities. County Health Rankings & Roadmaps. (2019). Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/diet-exercise/access-to-exercise-opportunities

- Expand transit options to include places for physical recreation
- Maintain safe and well-lit sidewalks
- Increase number of biking, walking trails, and greenways

Carter WM, Morse WC, Brock RW, Struempler B. Improving Physical Activity and Outdoor Recreation in Rural Alabama Through Community Coalitions. Preventing Chronic Dis 2019;16:190062. DOI: http://dx.doi.org/10.5888/pcd16.190062

- Increase number of community parks, particularly in rural areas

Centers for Disease Control and Prevention. 2015. Step It UP! A Partners Guide to Promote Walking and Walkable Communities. https://www.cdc.gov/physicalactivity/walking/call-to-action/pdf/partnerguide.pdf

- Support community walking clubs and public fitness classes

Centers for Disease Control and Prevention. Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase Physical Activity in the Community. Atlanta: U.S. Department of Health and Human Services; 2011.

- Increase access to evidence-based and informed interventions that support physical activity in childcare, schools, churches, workplaces and other community-based settings

Lafleur M, Gonzalez E, Schwarte L, Banthia R, Kuo T, Verderber J, et al. Increasing Physical Activity in Under-Resourced Communities Through School-Based, Joint-Use Agreements, Los Angeles County, 2010–2012. Preventing Chronic Dis 2013;10:120270. DOI: http://dx.doi.org/10.5888/pcd10.120270

- Increase the number of joint use agreements for school playground facilities

Physical Activity Guidelines for Americans. DHHS. (2018). Retrieved from https://health.gov/paguidelines/second-edition/pdf/Physical_Activity_Guidelines_2nd_edition.pdf

- Provide public access to municipal recreation facilities

SEVERE HOUSING PROBLEMS

Braveman P, Dekker M, Egerter S, Sadegh-Nobari T, Pollack C. How does housing affect health? Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/research/2011/05/housing-and-health.html. Published May 1, 2011. Accessed May 20, 2019.

- Increase living wage employment opportunities
- Enforce fair housing laws
- Improve access to social services and resources for affordable housing
- Increase involvement of community members in decision-making
- Support programs designed to increase home ownership for people of color

DRUG OVERDOSE DEATHS

America's Health Rankings. Drug Deaths. 2018. https://www.americashealthrankings.org/explore/annual/measure/Drugdeaths/state/NC?edition-year=2018.

- Reduce the supply of prescription and illicit opioids
- Implement needle exchange programs
- Improve access to drug treatment programs, including medication-assisted treatment

North Carolina's Opioid Action Plan – Updates and Opportunities. 2019. https://files.nc.gov/ncdhhs/OAP-2.0-8.7.2019_final.pdf.

- Avert future opioid addiction by supporting youth and families
- Address the needs of justice-involved populations
- Increase distribution of naloxone
- Implement broader use of NC Controlled Substance Reporting System by health care providers and pharmacies
- Increase training for health care providers on safe prescribing practices
- Adopt and support payment of evidenced-based interventions that prevent opioid prescribing

TOBACCO USE

Centers for Disease Control and Prevention. Tobacco Control Interventions. https://www.cdc.gov/policy/hst/hi5/tobaccointerventions/index.html.

- Implement high-impact media campaigns that warn people about the dangers of tobacco use
- Raise the price of tobacco products through a tobacco tax
- Implement state and local tobacco-free and smoke-free air policies that include e-cigarettes

Office of the Surgeon General. 2014. *The Health Consequences of Smoking--50 Years of Progress A Report of the Surgeon General.* Washington, DC: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://www.ncbi.nlm.nih.gov/books/NBK179276/pdf/Bookshelf_NBK179276.pdf

- Fund comprehensive state tobacco control programs to the levels recommended by the CDC
- Increase access to standard-of-care tobacco use treatment

EXCESSIVE DRINKING

The Guide to Community Preventive Services. Excessive Alcohol Consumption – https://www.thecommunityguide.org/

- Integrate Screening, Brief Intervention, and Referral to Treatment (SBIRT) into medical settings
- Reduce the days and hours of alcohol sales
- Reduce density of alcohol retailers

America's Health Rankings. Excessive Drinking. 2018. https://www.americashealthrankings.org/explore/annual/measure/ExcessDrink/state/NC

- Increase alcohol excise taxes
- Reduce the days and hours of alcohol sales
- Screen adults for excessive drinking and conduct brief intervention for those that screen positive
- Hold alcohol retailers liable for intoxicated or underage customers who cause injury to others
- Reduce density of alcohol retailers

SUGAR-SWEETENED BEVERAGE CONSUMPTION

ChangeLabSolutions. Sugary Drink Strategy Playbook. 2018. https://www.changelabsolutions.org/sites/default/files/Sugary_Drink_Playbook_FINAL_20180906.pdf

- Tax sugary drinks
- Launch public awareness campaigns
- Work with retailers to improve offerings and create healthier store environments
- Limit sugary drinks through government and private sector procurement policies
- Partner with schools and youth-oriented settings to remove or limit SSBs and their marketing

HIV DIAGNOSIS RATE

Centers for Disease Control and Prevention, HIV Prevention in the United States: New Opportunities, New Expectations. December 2015. https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-prevention-bluebook.pdf

- Increase access to PrEP for individuals at high risk for HIV transmission
- Implement interventions that improve access to HIV treatment
- Make testing easy, accessible, and routine
- Ensure people who are diagnosed are linked with appropriate care and receive behavioral interventions and other supports to decrease risk of transmission
- Ensure availability of condoms at health departments and community-based organizations

TEEN BIRTH RATE

National Conference of State Legislatures. Teen Pregnancy Prevention. http://www.ncsl.org/research/health/teen-pregnancy-prevention.aspx

- Ensure access to information and services for youth sexual health
- Examine school sex education policies to ensure they include information on how to avoid teen pregnancy and sexually transmitted infections

UNINSURED RATE

Collins, SR, Bhupal, HK, & Doty, MM. February 7, 2019. Health Insurance Coverage Eight Years After the ACA. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca

- Expand Medicaid eligibility criteria
- Support bans or limitations on short-term health plans
- Increase publicity and navigator funding for open enrollment
- Increase public education about insurance options

PRIMARY CARE WORKFORCE

Abernathy, A., & Byerley, J. 2019. Developing the Health Care Workforce of the Future for North Carolina. *North Carolina Medical Journal*, 80(3), 150-154. doi:10.18043/ncm.80.3.150

- Support pipeline programs in rural areas to encourage high school and college students to pursue careers in medicine

Fraher E.P., Spero J.C. August 2015. The State of the Physician Workforce in North Carolina: Overall Physician Supply Will Likely Be Sufficient but Is Maldistributed by Specialty and Geography. Program on Health Workforce Research and Policy, The Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. https://www.shepscenter.unc.edu/wp-content/uploads/2015/08/MedicalEducationBrief-ShepsCenter-August20151.pdf

- Identify rural provider champions and increase support for physicians in ongoing practice (Fraher & Spero, 2015)
- Increase residency positions in rural areas (Fraher & Spero, 2015)

Holmes, M. 2018. The Sufficiency of Health Care Professional Supply in Rural North Carolina. *North Carolina Medical Journal,* 79(6), 372-377. doi:10.18043/ncm.79.6.372

- Invest in rural economies (Holmes, 2018)

Lin, C. C., Dievler, A., Robbins, C., Sripipatana, A., Quinn, M., & Nair, S. 2018. Telehealth In Health Centers: Key Adoption Factors, Barriers, And Opportunities. *Health affairs (Project Hope),* 37(12), 1967–1974. https://doi.org/10.1377/hlthaff.2018.05125

- Increase telehealth primary care initiatives in rural areas

EARLY PRENATAL CARE

Reference to PRAMS given for one bullet point, but I cannot locate that reference. List developed internally.

- Increase telehealth primary care initiatives in rural areas

INFANT MORTALITY RATE

America's Health Rankings. Infant Mortality. (2018) https://www.americashealthrankings.org/explore/annual/measure/IMR/state/ALL

- Improve male and female pre-conception routine medical check-ups and family planning counseling with a focus on intimate partner violence, substance use, immunizations, depression, body mass index, blood pressure, and diabetes
- Improve access to, and use of, prenatal care, Centering Pregnancy Programs, and evidence-based home visiting programs
- Reduce maternal obesity
- Reduce maternal tobacco use before, during, and after pregnancy

HEALTHY OPPORTUNITIES SOCIAL DETERMINANTS OF HEALTH SCREENING QUESTIONS

DHHS, in partnership with a diverse set of stakeholders from across the state, developed a standardized set of SDOH screening questions. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

HEALTH SCREENING

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	YES	NO
FOOD		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
HOUSING/ UTILITIES		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent (other than recreational camping), in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
TRANSPORTATION		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
INTERPERSONAL SAFETY		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
OPTIONAL: IMMEDIATE NEED		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

FREQUENTLY USED ACRONYMS

ACE – Adverse Childhood Experience

BRFSS - Behavioral Risk Factor Surveillance System

CDC – Centers for Disease Control and Prevention

CHA – Community Health Assessment

CI Scorecard – Clear Impact Scorecard

DPH – Division of Public Health

FHLI – Foundation for Health Leadership and Innovation

FPL – Federal Poverty Level

HIV – Human Immunodeficiency Virus

HNC – Healthy North Carolina

HPV – Human papillomavirus

IUD – Intrauterine device

LGBTQ – Lesbian, gay, bisexual, transgender, and queer

NC AHEC – North Carolina Area Health Education Centers

NC DHHS – North Carolina Department of Health and Human Services

NC DPI – North Carolina Department of Public Instruction

NC IOM – North Carolina Institute of Medicine

NC SHA – North Carolina State Health Assessment

NC SHIP – North Carolina State Health Improvement Plan

NCHA – North Carolina Healthcare Association

PA – Physician Assistant

PrEP – Pre-exposure prophylaxis

RBA – Results-Based Accountability

SNAP/EBT – Supplemental Nutrition Assistance \ Program/Electronic Benefits Transfer

SSB – Sugar-sweetened beverage

STI – Sexually transmitted infection

SUD – Substance use disorder

TDE – The Duke Endowment

YRBS – Youth Risk Behavior Surveillance

LIST OF TABLES AND FIGURES

DATA SOURCES

HNC 2030/NC SHIP INDICATOR	NOTES ABOUT THE DATA SOURCE/S
1. **Poverty**	American Community Survey (US Census)
2. **Unemployment**	American Community Survey (US Census)
3. **Suspension Rate in Schools**	NC Department of Public Instruction
4. **Incarceration Rate**	US Bureau of Justice Statistics and NC Department of Public Safety
5. **ACEs**	Children's National Health Survey
6. **Third Grade Reading Proficiency**	NC Department of Public Instruction
7. **Exercise/Physical Activity**	County Health Rankings and Roadmaps - Business Analyst, Delorme map data, ESRI, & US Census Tiger line Files **Should not compare ranked data from year to year*
8. **Healthy Foods**	County Health Rankings and Roadmaps - United States Department of Agriculture (USDA) **Should not compare ranked data from year to year*
9. **Severe Housing Problems**	County Health Rankings and Roadmaps - Comprehensive Housing Affordability Strategy (CHAS) **Should not compare ranked data from year to year*
10. **Drug Overdose Deaths**	NC State Center for Health Statistics, Vital Statistics
11. **Tobacco Use**	NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS) NC Youth Tobacco Survey, Smoke-free/Tobacco free local regulations maps
12. **Excessive Drinking**	NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)
13. **Sugar-Sweetened Beverage Consumption**	Youth: NC Department of Public Instruction, Youth Risk Behavior Survey (YRBS) Adult: NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)
14. **HIV Diagnosis Rate**	NC Division of Public Health, Epidemiology Section
15. **Teen Birth Rate**	NC State Center for Health Statistics, Vital Statistics
16. **Uninsured**	US Census Bureau - Small Area Health Insurance Estimates (SAHIE) Program
17. **Primary Care Clinicians**	Cecil G. Sheps Center for Health Services - Research analysis of licensure data from North Carolina Medical Board and North Carolina Board of Nursing
18. **Early Prenatal Care**	NC State Center for Health Statistics, Vital Statistics
19. **Suicide**	NC State Center for Health Statistics, Vital Statistics
20. **Infant Mortality**	NC State Center for Health Statistics, Vital Statistics
21. **Life Expectancy**	NC State Center for Health Statistics, Vital Statistics

POPULATION ACCOUNTABILITY RESULTS

Results Statement: A population + a geographic region + a condition of well being

- All North Carolina communities support healthy choices for family planning and have equitable access to high quality, affordable reproductive health services.
- All babies are born healthy and thrive in caring and healthy homes.
- All residents of North Carolina have long and healthy lives.
- All mothers have healthy pregnancies and all babies are born healthy.
- All North Carolina residents live in communities that foster and support positive mental health.
- All residents of North Carolina have equitable access to high quality, affordable primary care.
- All North Carolinians have access to high quality, affordable health care insurance.
- All North Carolina residents live in communities that support healthy weight initiatives.
- All North Carolina residents live in communities with equitable access to substance use disorder services.
- All North Carolina residents live in communities that support tobacco-free/e-cigarette-free lifestyles.
- All North Carolina communities support safe and responsible use of alcohol.
- All North Carolina residents experience sexual health with equitable access to prevention, treatment, and management of sexually transmitted infections.
- All North Carolina residents have equitable access to healthy foods.
- All low-income families in North Carolina have sufficient, affordable, quality housing.
- All North Carolina residents have equitable access to physical activity opportunities.
- All children in North Carolina have early reading proficiency skills.
- All children in North Carolina thrive in safe, stable, and nurturing environments.
- North Carolina has a fair and equitable criminal justice system in every jurisdiction.
- People in North Carolina are economically self-sufficient.
- All adults in North Carolina have equitable access to good jobs.
- North Carolina's educational system values diversity and ensures equitable opportunities for its students, faculty, staff and communities.

Adapted from: North Carolina Institute of Medicine. *Healthy North Carolina 2030: A Path Toward Health*. Morrisville, NC: North Carolina Institute of Medicine; 2020.

Development guidance: Friedman, M. (2015). *Trying hard is not good enough: How to produce measurable improvements for customers and communities.* Santa Fe, New Mexico: Parse Publishing.