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 North Carolina Institute of Medicine (NCIOM) assisted with the 2020 NC State Health Improvement Plan (NC SHIP) and continues to partner with the Division of Public Health in the annual review of both Healthy North Carolina 2030: A Path Toward Health (HNC 2030) and the NC SHIP.

NC DHHS/DPH also partners with The Foundation for Health Leadership & Innovation, Inc. and the NC Area Health Education Centers to support Results-Based Accountability™ (RBA).

BlueCross BlueShield of North Carolina Foundation, The Duke Endowment, and the Kate B. Reynolds Charitable Trust funded in part the inaugural 2020 NC SHIP. Any opinions, findings, conclusions, or recommendations expressed in this publication are those of the work group members and do not necessarily reflect the views and policies of the BlueCross BlueShield of North Carolina Foundation, The Duke Endowment, the Kate B. Reynolds Charitable Trust, or NC DHHS.

NC DHHS/DPH LEADERSHIP TEAM

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susan Kansagra, MD, MBA</td>
<td>Assistant Secretary for Public Health/State Health Officer Division of Public Health NC Department of Health and Human Services</td>
</tr>
<tr>
<td>Elizabeth Cuervo Tilson, MD, MPH</td>
<td>State Health Director Chief Medical Officer for the NC Department of Health and Human Services</td>
</tr>
<tr>
<td>Mark T. Benton</td>
<td>Chief Deputy Secretary for Health NC Department of Health and Human Services</td>
</tr>
</tbody>
</table>

NC DHHS/DPH REVIEWER

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elyse Powell, PhD</td>
<td></td>
</tr>
<tr>
<td>Stacie Turpin Saunders, MPH</td>
<td></td>
</tr>
<tr>
<td>Erin Fry Sosne, MPH</td>
<td></td>
</tr>
</tbody>
</table>

DPH TECHNICAL LEADS

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathryn G. Dail, PhD, RN</td>
<td></td>
</tr>
<tr>
<td>Ashley Rink, MPH</td>
<td></td>
</tr>
</tbody>
</table>

DPH DATA ANALYSTS & EPIDEMIOLOGISTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matt Avery, MA</td>
<td></td>
</tr>
<tr>
<td>Mary Beth Cox, MPH</td>
<td></td>
</tr>
<tr>
<td>Samay Bhalodia, BS</td>
<td></td>
</tr>
<tr>
<td>Dianne Enright, GISP</td>
<td></td>
</tr>
<tr>
<td>John Espy, MS</td>
<td></td>
</tr>
<tr>
<td>Courtney Heck, MPH</td>
<td></td>
</tr>
<tr>
<td>Eric Lai, MS</td>
<td></td>
</tr>
<tr>
<td>Robert Lee, MA, MS</td>
<td></td>
</tr>
<tr>
<td>Zachary P. Schafer, MS</td>
<td></td>
</tr>
<tr>
<td>Taylor Swankie, MPH</td>
<td></td>
</tr>
</tbody>
</table>

UNC-CH/CECIL G. SHEPS CENTER DATA ANALYST

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evan Galloway, MPS</td>
<td></td>
</tr>
</tbody>
</table>

DPH PUBLIC HEALTH ACCREDITATION ADVISOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candice DuVernois, BSN, RN, MPH, JD</td>
<td></td>
</tr>
</tbody>
</table>

TECHNICAL REVIEWER

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laura D. Webb, MRP, BSN-RN</td>
<td>HNC 2030 Resource Center</td>
</tr>
</tbody>
</table>

PUBLIC REVIEW AND COMMENT

The 2023 NC State Health Improvement Plan and the Clear Impact Scorecards are 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 and Improvement at the HNC 2030 Resource Center, HNC2030@dhhs.nc.gov.

CREDITS

Report design and layout: Kayleigh Creech, Laser Image Printing & Marketing, Durham, NC.
October 5, 2023

A JOINT LETTER OF INTRODUCTION FOR THE 2023 NC STATE HEALTH IMPROVEMENT PLAN

On behalf of the North Carolina State Health Improvement Plan Community Council, we are pleased to present the annual update to North Carolina’s state health improvement plan. The 2023 North Carolina State Health Improvement Plan (NC SHIP) operationalizes the priorities identified in the 2019 State Health Assessment and Healthy North Carolina 2030: A Path Toward Health (HNC 2030). The plan incorporates the principles of results-based accountability using a population health framework.

The 2023 NC SHIP was driven by the leadership of a Community Council comprised of partners across government, non-profit and faith-based organizations, business, community members, philanthropy, and academia. Launching in July 2022, 18 multisectoral workgroups came together to identify policies and programs that address the wicked problems identified in Healthy North Carolina 2030. Over the course of the year these multisectoral leaders and community members took action together to prioritize policies and programs that would have most impact on the HNC 2030 indicators.

Expanding Medicaid in North Carolina has been a long-standing priority of the Community Council. The recommendations in this plan were developed prior to the official expansion of Medicaid and do not reflect the anticipated impact of covering an additional 600,000 North Carolinians.

If you live, work, or visit North Carolina, this plan is for you. The plan identifies best practices that can help communities act now to improve health. All the practices promoted in the NC SHIP demonstrate active, local community support with a focus on health equity/health disparity. We hope that all actors looking to have impact on the health of North Carolinians will consider aligning strategies, plans, and investments to this document.

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 since the release of HNC 2030. We extend appreciation to

- The Foundation for Health Leadership & Innovation (FHLI),
- The North Carolina Area Health Education Centers (NCAHEC), and
- The North Carolina Institute of Medicine (NCIOM).

We encourage you to follow our progress and become involved in the process. For more information, please contact the HNC 2030 Resource Center HNC2030@dhhs.nc.gov.

Sincerely,

Susan Kansagra
Assistant Secretary for Public Health
Division of Public Health
NCDHHS

Elizabeth Cuervo Tilson
State Health Director
Chief Medical Officer
NCDHHS
Spotlight on Philanthropy .......................................................... 6
Executive Summary .............................................................. 7
NC SHIP Community Council Work Group Members ............ 8-15

SECTION I: Background and Overview of Process .............. 17
Population Health Model .......................................................... 18
Results-Based Accountability Framework/ Clear Impact Scorecard ............................................... 19
RBA vs Smart Goals/Whole vs Client Population ............... 20
Overview/NC SHIP Phases .................................................... 21-22
Roles and Responsibilities .................................................. 23

SECTION II: NC SHIP Community Council ......................... 25
Community Council Structure .................................................. 26
Community Council Function .................................................. 27
Community Council Monitoring ............................................. 28
Policies To Support HNC 2030 ................................................ 29-32
Timeline .................................................................................. 33

SECTION III: HNC 2030 Indicators .................................... 35
Social and Economic Factors ................................................. 36-58
Poverty ................................................................................. 36-39
Unemployment .................................................................... 40-43
Short-Term Suspensions ....................................................... 44-47
Incarceration ......................................................................... 48-51
Adverse Childhood Experiences ....................................... 52-55
Third Grade Reading Proficiency ...................................... 56-58
Physical Environment Factors ............................................. 59-73
Access to Exercise Opportunities ...................................... 60-63
Limited Access to Healthy Foods ...................................... 64-69
Severe Housing Problems .................................................. 70-73

Health Behaviors ................................................................. 75-104
Drug Overdose Deaths ......................................................... 76-79
Tobacco Use .......................................................................... 80-85
Excessive Drinking .............................................................. 86-89
Sugar-Sweetened Beverage Consumption ....................... 90-94
HIV Diagnosis ....................................................................... 96-101
Teen Births ............................................................................ 102-104

Clinical Care Factors ........................................................... 105-122
Uninsured ............................................................................. 106-111
Primary Care Clinicians ...................................................... 112-115
Early Prenatal Care ............................................................. 116-119
Suicide .................................................................................. 120-122

Health Outcomes ................................................................. 123-134
Infant Mortality ................................................................. 124-128
Life Expectancy ................................................................. 130-134

SECTION IV: References & Appendices .............................. 135
WORKS CITED ....................................................................... 136-141
Appendix A: Acronyms ......................................................... 142
Appendix B: List of Tables and Figures ................................. 143-145
Appendix C: HNC 2030 Indicator Table ......................... 146-147
Appendix D: Local Health Department and Tribal Community Priorities ........................................ 148
Appendix E: Photography Sources ........................................ 149
Appendix F: HNC 2030 Artistic Sketch Activity .................. 151-154
Philanthropic partners play an instrumental role in advancing the North Carolina State Health Improvement Plan and Healthy North Carolina 2030. Two of the founding philanthropic partners for HNC2030 share their commitments:

**THE KATE B. REYNOLDS CHARITABLE TRUST**

**Our Commitment:** The Kate B. Reynolds Charitable Trust was pleased to be a founding partner of HNC 2030. As a former state health director, our president, Dr. Laura Gerald, was proud to serve as a co-chair of this effort. We are committed to ensuring that every North Carolinian has the opportunity to thrive, and we believe that the framework established by HNC 2030 lights a pathway toward accomplishing this goal.

**Alignment with Our Work:** Across many areas of work, our goals are aligned with HNC 2030. We think it is critical that HNC 2030 shifted away from traditional health improvement measures such as obesity and blood pressure and refocused on the systems driving disparate outcomes for Black, Native American, immigrant, and rural residents. The Trust also appreciates the focus on social drivers of health such as child poverty and food access. HNC 2030 helps establish common goals, which is a prerequisite to building collective movements.

**Our Support:** The Trust funds statewide but maintains a focus on underserved rural regions and organizations that align with Healthy North Carolina and the NC SHIP. For example:

- We support Cape Fear Collective to provide local data dashboards on HNC 2030 goals for every county.
- Since 2020, we have supported North Carolina Partnership for Children to coordinate and map local coalitions working to address adverse childhood experiences.
- We fund local collaboratives across the state, especially in eastern NC and Forsyth County, to tackle adverse childhood experiences, substance misuse, and equitable food systems and recreation opportunities.
- For more than 10 years the Trust has funded education campaigns to expand Medicaid and enroll residents in Affordable Care Act insurance plans.

To learn more about The Kate B. Reynolds Charitable Trust Visit www.kbr.org

**THE DUKE ENDOWMENT**

**Our Commitment:** The Duke Endowment was pleased to be a founding partner of HNC 2030. We are committed to ensuring that every North Carolinian is healthy and thriving. We believe the framework in HNC 2030 and the subsequent NC SHIP creates a structure to pursue a healthier state.

**Alignment with Our Work:** Our investment in Healthy North Carolina 2030 aligns with the Health Care program area’s strategy to improve community health. We believe communities should identify their most pressing problems, including what is needed to improve the health of their residents. To address complex social conditions, we employ the Collective Impact model. The Results Based Accountability (RBA) framework and corresponding Clear Impact scorecards create the structure for a shared vision and allow diverse sectors to be accountable and transparent on how their programs and services improve lives.

**Our Support:** The Endowment has funded more than $3.4 million in North Carolina to organizations that have advanced and aligned with Healthy North Carolina 2030 and the State Health Improvement Plan. This includes:

- In 2011, we supported the western region in aligning hospitals’ and local health departments’ Community Health Assessments. In 2015, the region adopted RBA and the use of scorecards to meet Community Health Improvement Plan requirements. This work was replicated in 30 eastern N.C. counties beginning in 2018.
- Beginning in 2019, the Endowment began providing funding to support Area Health Education Center (AHEC) training, Clear Impact scorecards, and staff needed to roll out scorecards to all 81 local health departments. The N.C. Division of Public Health and AHEC continue to work with the Endowment to advance the alignment of this work with health systems.
- Several philanthropic partners worked with the Department of Justice to include RBA requirements for the opioid settlement funds.
- Aligning with the State Health Improvement Plan, new Healthy People Healthy Carolinas Coalitions will provide program-level outcome data to the community scorecards in RBA language.

To learn more about The Duke Endowment, visit http://dukeendowment.org/
The 2023 North Carolina State Health Improvement Plan (NC SHIP) describes the process and progress for improving the health of North Carolinians based upon Healthy North Carolina 2030: A Path Toward Health (HNC 2030).

The document is divided into four sections:

**SECTION I** Background & Overview of Process

**SECTION II** NC State Health Improvement Plan Community Council

**SECTION III** HNC 2030 Indicators

**SECTION IV** References & Appendices

**SECTION I** provides an overview of the population health framework that served as a guide for the selection of 21 headline indicators in the HNC 2030 report. The basic characteristics and language of Results-Based Accountability™ (RBA) are also introduced. RBA differentiates between population accountability and performance accountability and shares data to show how people are better off because of our work.

This section provides a description of the roles and responsibilities of NC DHHS and its partners, including local/tribal health departments and the NC SHIP Community Council.

The five developmental phases of the *NC SHIP* are displayed on a timeline:

- Development
- Implementation
- Strategic Planning
- Monitoring
- Evaluation

**SECTION II** describes the structure, function, and monitoring activities of the North Carolina State Health Improvement Plan (*NC SHIP*) Community Council. The Community Council builds partnerships, identifies what works, and develops strategies/action plans for policies to support *HNC 2030*. Community members and partnering organizations can access the web-based tool, Clear Impact Scorecard, for a real-time update on the work of the Community Council.

https://scorecard.clearimpact.com/Scorecard/Embed/82417

Section II includes a table summarizing the priorities identified by the 2022-2023 NC SHIP Community Council. Even though these policies do not constitute an endorsement by NC DHHS/DPH, many of the priorities were originally suggested in *HNC 2030: A Path Toward Health*.

**SECTION III** applies RBA and “Turn the Curve Thinking” to each of the 21 headline indicators.

**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?**

**Partners:** Who are the partners that have a role to play in doing better?

**What Works:** What can be done better?

**Action Plan:** What do we propose to do?

(Adapted from Friedman, 2015)

Consistent with RBA, the *NC SHIP* uses trend data to determine whether we are going in the right direction on each of our most important population indicators. When comparing with data from prior reports, readers should be aware that small variances may be observed due to revised population estimates.

**SECTION IV** provides a list of references supporting both data and narratives presented throughout the report. Moreover, the appendices supplement and summarize *HNC 2030* data.

The *NC SHIP* highlights one of the key characteristics of RBA, “Ends to Means,” by concluding with an artistic rendition which presents a vision for a Healthy North Carolina. The custom artwork, created by Kim Ballentine of Raleigh and Morehead City, is included as part of the RBA course. It provides a visual tool for participants to consider quality-of-life factors that can make it possible for “all people in North Carolina to have equitable opportunities for health, education, and economic stability throughout the lifespan.”

If you are interested in participating/contributing to this work, please contact the Healthy North Carolina 2030 Resource Center at HNC2030@dhhs.nc.gov.
NC SHIP COMMUNITY COUNCIL WORK GROUP MEMBERS

POVERTY AND UNEMPLOYMENT
WORK GROUP CO-LEADERS

Fenaba Addo, PhD
Associate Professor, Public Policy,
Carolina Population Center
University of North Carolina-Chapel Hill

Marianna Poke-Stewart, MPA, MBA
Director, Office of Economic Opportunity
NC Department of Health and Human Services

WORK GROUP MEMBERS

Laura Gerald, MD, MPH
President
Kate B. Reynolds Charitable Trust

Gerri Mattson, MD, MSPH, FAAP
Senior Medical Director
Division of Child and Family Well-Being
NC Department of Health and Human Services

Letha Muhammad
Co-Executive Director
Education Justice Alliance

SHORT-TERM SUSPENSIONS
WORK GROUP CO-LEADERS

Rev. Paul Robeson Ford
Lead Curator (Executive Director)
we are (working to extend anti-racist education)

Karen Fairley
Executive Director, Office of Center for Safer Schools
NC Department of Public Instruction, Division of District and School Support Services

James E. Ford
Executive Director
Center for Racial Equity in Education (CREED)

WORK GROUP MEMBERS

Ronda Taylor Bullock, PhD
Director, Blanchard Community Law Clinic
Campbell University

Jennifer C. Jackson
Chief Executive Officer
Arise Collective

Anita Wilson-Merritt, MD
Medical Consultant, Corrections Team Lead
Division of Public Health, Communicable Disease Branch
NC Department of Health and Human Services

INCARCERATION
WORK GROUP CO-LEADERS

Rick Glazier
Director, Blanchard Community Law Clinic
Campbell University

Jennifer C. Jackson
Chief Executive Officer
Arise Collective

Anita Wilson-Merritt, MD
Medical Consultant, Corrections Team Lead
Division of Public Health, Communicable Disease Branch
NC Department of Health and Human Services

WORK GROUP MEMBERS

Evan Ashkin, MD
Professor of Family Medicine, UNC Chapel Hill
Director, NC Formerly Incarcerated Transition (FIT) Program

Arthur “Les” Campbell, MD
Chief Medical Officer
Division of Comprehensive Health Services
North Carolina Department of Adult Correction

Marie Hartwell Evitt
Government Relations Counsel
North Carolina Sheriffs’ Association, Inc.

Gary Junker, PhD, HSP-P
Deputy Secretary
Division of Comprehensive Health Services
NC Department of Adult Correction

Kenneth Lassiter
Division of Public Health
NC Department of Health and Human Services

Nicole E. Sullivan
Director of Reentry Services
NC Department of Public Safety, Division of Juvenile Justice and Delinquency Prevention

ADVERSE CHILDHOOD EXPERIENCES
WORK GROUP CO-LEADERS

Wanda Boone, PhD
Executive Director
Together for Resilient Youth (TRY)

Mebane Boyd
Resilient Communities Officer
North Carolina Partnership for Children

Gerri Mattson, MD, MSPH, FAAP
Senior Medical Director
Division of Child and Family Well-Being
NC Department of Health and Human Services

WORK GROUP MEMBERS

Na’im Akbar
Community Ambassador, Rural Opportunity Institute
Certified Resiliency Educator, Resources for Resilience

Ingrid Bou-Saada, MA, MPH
Injury Prevention Consultant
Division of Public Health, Injury and Violence Prevention Branch
NC Department of Health and Human Services

Jess Bousquette
Adverse Childhood Experiences and Resilience Coordinator
Durham County Department of Public Health

Ellen Carroll
Director, Program Design
Caro Nova

Elizabeth DeKonty, MSW
Director, NC Center for Resilience & Learning
Public School Forum of North Carolina

Lindsey Guyton, MA, LCMHC
Outpatient Therapist
Thrive Counseling & Consulting, PLLC

Kella Hatcher
Executive Director
North Carolina Child Fatality Task Force

Michael James
President & CEO
Prevent Child Abuse North Carolina

Trishana Jones
Director of Youth Exposure to DV and Special Projects
North Carolina Coalition Against Domestic Violence

Catherine Joyner, MSW
Executive Director, Child Maltreatment Prevention
Division of Public Health, Title V Office
NC Department of Health and Human Services

Stacie Kinlaw
Community Engagement Manager
Robeson County Partnership for Children, Inc.

Graham Palmer, MBA, MA
Policy Lead
Rural Opportunity Institute

Carlton Powell
Attorney
Legal Aid of North Carolina

Peter Rawitsch
Co-Founder
Love Our Children NC

Jerry J. Wilson
Director of Policy and Advocacy
Center for Racial Equity in Education (CREED)

Rachel Zaronne, MSW, LCSW
Behavioral Health Clinical Consultant,
Adolescent Health Coordinator
Division of Child and Family Well-Being,
Whole Child Health Section
NC Department of Health and Human Services

Na’im Akbar
Community Ambassador, Rural Opportunity Institute
Certified Resiliency Educator, Resources for Resilience

Ingrid Bou-Saada, MA, MPH
Injury Prevention Consultant
Division of Public Health, Injury and Violence Prevention Branch
NC Department of Health and Human Services

Jess Bousquette
Adverse Childhood Experiences and Resilience Coordinator
Durham County Department of Public Health

Ellen Carroll
Director, Program Design
Caro Nova

Elizabeth DeKonty, MSW
Director, NC Center for Resilience & Learning
Public School Forum of North Carolina

Lindsey Guyton, MA, LCMHC
Outpatient Therapist
Thrive Counseling & Consulting, PLLC

Kella Hatcher
Executive Director
North Carolina Child Fatality Task Force

Michael James
President & CEO
Prevent Child Abuse North Carolina

Trishana Jones
Director of Youth Exposure to DV and Special Projects
North Carolina Coalition Against Domestic Violence

Catherine Joyner, MSW
Executive Director, Child Maltreatment Prevention
Division of Public Health, Title V Office
NC Department of Health and Human Services

Stacie Kinlaw
Community Engagement Manager
Robeson County Partnership for Children, Inc.
Molly McCambridge  
Prevention Coordinator  
North Carolina Coalition Against Domestic Violence

Melissa W. Radcliff  
Program Director  
Our Children’s Place of Coastal Horizons

Morgan Forrester Ray, MSW  
Director, EarlyWell Initiative  
NC Child

Amber Robinson  
Parent Leader, Guilford Parent Leader Network  
Ready, Ready

Susanne Schmal, MPH  
School Health Partnerships and Policy Consultant  
NC Department of Public Instruction, Office of Academic Standards

Sierra Scott, MPH, CHES  
Project Manager, Outreach Training and Education Core  
Injury Prevention Research Center  
University of North Carolina Chapel Hill

Trina Stephens  
Program Manager, Great Expectations  
MDC

Rebecca Swofford, MSW  
Director of Prevention  
North Carolina Coalition Against Domestic Violence

Crystal E. Taylor  
Co-Founder & Director Agriculture and Farmer Relations, The Black Farmers Market  
Founder & Executive Director, Get Happy

Dan Tetreault  
Project Manager  
NC Department of Public Instruction, Office of Early Learning

Paula Wilkins, PhD  
Executive Director, Strategy/Innovation  
Winston-Salem/Forsyth County Schools

ACCESS TO EXERCISE OPPORTUNITIES  
WORK GROUP CO-LEADERS

Alice S. Ammerman, DrPH  
Director, Center for Health Promotion and Disease Prevention  
University of North Carolina-Chapel Hill

Jayne L. McBurney, M.S.  
Steps to Health Program Coordinator  
North Carolina State University SNAP-Ed  
Department of Agricultural & Human Sciences

Rachel Pohlman, MPH, RD, LDN  
Nutrition Director  
Poe Center for Health Education

Tish Singletary, MA  
Branch Head  
Division of Public Health, Community and Clinical Connections for Prevention and Health Branch  
NC Department of Health and Human Services

WORK GROUP MEMBERS

Brandy Bynum Dawson  
Rural Prosperity and Investment Initiatives  
MDC

Jennifer Delcourt, MPH  
Safe Routes to School Coordinator  
Wake County Health & Human Services/ Public Health Division

Mike Edwards, PhD  
Associate Professor  
NC State University

Katherine (Katie) J. Harmon, PhD  
Research Associate  
UNC Highway Safety Research Center

Kelly Kavanaugh, MPH, CHES  
Built Environment and Early Care and Education Coordinator  
Division of Public Health, Community & Clinical Connections for Prevention & Health Branch  
NC Department of Health and Human Services

Torie Keeton  
Policy & Government Affairs Manager  
NC Rural Center

M. Leah Mayo, MPH, MCHES  
Interim Assistant Dean Community Engagement & Health Equity, College of Health & Human Services  
University of North Carolina Wilmington

Michelle Nance  
Senior Director  
Centralina Regional Council

Alex Rotenberry, AICP  
Multimodal Regional Planner- Western Piedmont, Integrated Mobility Division  
North Carolina Department of Transportation

Laura Sandt  
Interim Co-Director  
UNC Highway Safety Research Center

Jason Urroz  
Director  
Kids in Parks

Kenneth Withrow  
Senior Transportation Planner  
The Capital Area Metropolitan Planning Organization

WORK GROUP CO-LEADERS

Alice S. Ammerman, DrPH  
Director, Center for Health Promotion and Disease Prevention  
University of North Carolina-Chapel Hill

Jayne L. McBurney, M.S.  
Steps to Health Program Coordinator  
North Carolina State University SNAP-Ed  
Department of Agricultural & Human Sciences

Tish Singletary, MA  
Branch Head  
Division of Public Health, Community and Clinical Connections for Prevention and Health Branch  
NC Department of Health and Human Services

WORK GROUP MEMBERS

Gideon Adams  
Vice President of Community Health & Engagement  
Food Bank of Central & Eastern North Carolina

Jennifer Bailey  
Section Chief, School Nutrition Division  
NC Department of Public Instruction

Tracey Bates, MPH, RDN, LDN, FAND  
School Nutrition Promotion Specialist, Office of School Nutrition  
NC Department of Public Instruction  
Co-Chair, Farm to School Coalition of North Carolina

Jennifer Bedrosian  
Food Systems Coordinator  
Piedmont Triad Regional Council

Diane Beth, MS, RDN, LDN  
Nutrition Program Consultant  
Division of Child and Family Well-Being, Whole Child Health Section  
NC Department of Health and Human Services

Morgan Cooper, MPH, MCRP, RD  
Cape Fear HOP Program Manager  
Cape Fear Collective

Dawn Daly-Mack, BS, RN  
LTSS Care Manager  
Carolina Complete Health

JéWana Grier-McEachin  
Executive Director  
ABIPA (Asheville Buncombe Institute of Parity Achievement)
NC SHIP COMMUNITY COUNCIL WORK GROUP MEMBERS

Amanda S. Hege, MPH, RDN, FAND
Director, Dietetic Internship
Appalachian State University, Nutrition and Health Care Management

Courtney Ramsey-Coleman, MS, RDN, LDN
Healthy Eating and Nutrition Security Coordinator
Division of Public Health, Community and Clinical Connections for Prevention and Health Branch
NC Department of Health and Human Services

Karen Stanley, RDN, LDN
Healthy Communities Program Manager
Division of Public Health, Chronic Disease and Injury Section
NC Department of Health and Human Services

Stefanie Ledwell, BA
Housing Resource Navigator
Center for Housing and Community Studies

Louis Pasteur Alimbuko Mashengo
Community Member

Brian O’Donnell
Policy & Research Analyst
NC Housing Finance Agency

Brad Owen
LME-MCO System Performance Liaison
NC Department of Health and Human Services

Bill Rowe
Community Member

Bettye Teasley
Policy and Research
NC Housing Finance Agency

WORK GROUP CO-LEADERS

SEVERE HOUSING PROBLEMS

Sam Hedrick, JD
Senior Advisor ADA, Transitions to Community Living
NC Department of Health and Human Services

Patricia Macfoy
Executive Director
New Hope Community Development Group, Inc.

Stephen Sills, PhD
Chief Impact Officer
United Way of Forsyth County

NORTH CAROLINA OPIOID AND PRESCRIPTION DRUG ABUSE ADVISORY COMMITTEE (OPDAAC) CO-LEADERS

Mary Beth Cox, MPH
Substance Use Epidemiologist
Division of Public Health, Injury and Violence Prevention Branch
NC Department of Health and Human Services

Amy Patel, MPH
Opioid Prevention Program Manager
Division of Public Health, Injury and Violence Prevention Branch
NC Department of Health and Human Services

WORK GROUP

The Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC) is a legislatively mandated statewide coalition tasked to increase coordination, communication, surveillance, and policy efforts surrounding the overdose epidemic in NC. Since 2010, NCDHHS has convened a wide network of partners quarterly to address prevention of overdoses. OPDAAC has evolved from its initial role of implementing the state’s opioid strategic plan to a community of practice to share emerging trends and impactful intervention programs. Anyone working to address the overdose epidemic is welcome to attend, such as those from harm reduction, treatment, recovery, community groups, families who have lost loved ones to overdose, first responders, healthcare partners, and academics. Meetings are designed to focus on priorities of the NC Opioid and Substance Use Action Plan (OSUAP); expert speakers and panelists present their work; participants have the opportunity to meet and network with content experts and learn diverse perspectives. OPDAAC’s membership has grown from 80 participants to over 1,200 members representing a diverse network of partners working to address the overdose epidemic.

Ronny Bell, PhD, MS
Chair of the Division of Pharmaceutical Outcomes and Policy
UNC Eshelman School of Pharmacy

Sally Herndon, MPH
Head, Tobacco Prevention and Control Branch
Division of Public Health
NC Department of Health and Human Services

Delton Russell
Recovery Specialist
Partners Health Management

WORK GROUP MEMBERS

Sarah Arthur, MBA
Comprehensive Cancer Control Program Coordinator
Division of Public Health, Cancer Prevention and Control Branch
NC Department of Health and Human Services

Joshua Batten
Alcohol Law Enforcement
NC Department of Public Safety

Kim Bayha, CTTS
Tobacco Prevention & Control Supervisor
Mecklenburg County Public Health, Office of Chronic Disease Policy & Prevention

Teressa Beardsley
Tobacco Prevention Manager – Region 9
Albemarle Regional Health Services

Terri Bell
Manager, Clinical Program Implementation
WellCare of NC

Stella Blankenship, BSN, RN
Public Health Nurse
EBCI Public Health & Human Services, Tsalagi Public Health

Anna Bess Brown
Executive Director
Justus-Warren Heart Disease and Stroke Prevention Task Force

Carrie Brown, MD, MPH, DFAPA
Chief Psychiatrist and Deputy Chief Medical Officer
NC Department of Health and Human Services

Heather Burkhardt, MSW
Executive Director
NC Coalition on Aging

Kim Canady
Nurse Consultant
NC Department of Health and Human Services

Megan Canady, MSW, MSPH
Research Associate
UNC Collaborative for Maternal and Infant Health, You Quit, Two Quit

Georgia Childs, MAEd
Healthy Communities Program Consultant
Division of Public Health, Chronic Disease and Injury Section
NC Department of Health and Human Services
NC SHIP COMMUNITY COUNCIL WORK GROUP MEMBERS

Dana Painter  
Contracts Manager - Monitoring  
Trillium Health Resources

Sherri Parish, RN, BSN, CCM  
Program Manager, Population Health and Care Management  
AmeriHealth Caritas North Carolina

Amy Perry  
Senior Director, Population Health  
Alliance Health

Richard Peters  
Director of Pharmacy Services  
Sandhills Center

Sarah Plentl  
Health Promotions Supervisor  
Wake County

Leah M. Ranney, PhD  
Associate Professor, Director, Tobacco Prevention and Evaluation Program  
University of North Carolina at Chapel Hill

Vera Reinstein  
Clinical Pharmacist  
Alliance Health

Ray Riordan  
Director of Local Policy and Programs  
Division of Public Health, Tobacco Prevention and Control Branch  
NC Department of Health and Human Services

Ann Rollins  
Executive Director  
Poe Center for Health Education

Faith L. Samples, PhD  
Director, Community Partnerships/ DSS Liaison  
Carolina Complete Health

Charlene Sampson  
Pharmacist  
Division of Health Benefits  
NC Department of Health and Human Services

Susanne Schmal, MPH  
School Health Partnerships and Policy Consultant  
NC Department of Public Instruction, Office of Academic Standards

Jasmine Simmons  
Tobacco Control Coordinator  
Mecklenburg County Public Health, Office of Chronic Disease Policy and Prevention

Lou Ann Simmons, BSN, RN  
Population Health Manager  
Eastpointe Human Services

Kyle Smith  
Program Manager  
Insight Human Services

Les Spell  
Data & Policy Consultant  
NC Department of Public Instruction, Office of Academic Standards

Ann Staples  
Senior Media Consultant  
Division of Public Health, Tobacco Prevention and Control Branch  
NC Department of Health and Human Services

Gregg M. Stave, MD, JD, MPH  
Consulting Professor  
Duke University School of Medicine

Ashley Stoop, MPH  
Health Director  
Albemarle Regional Health Services

Carolyn Sullivan  
CFAC Secretary, Tillium  
CPSS, Le'Chris Health Systems

Deidre Sully  
Region 7 Manager/Coordinator Tobacco Prevention and Control  
Wake County Health and Human Services

Erin Sutfin, PhD  
Professor, Social Sciences and Health Policy  
Wake Forest University School of Medicine

Joyce Sweetlick, MPH  
Director of Tobacco Cessation  
Division of Public Health, Tobacco Prevention and Control Branch  
NC Department of Health and Human Services

Stacy Thiedeman  
Physician Assistant, Manager, Quit With WakeMed  
WakeMed, Tobacco Cessation Program

Tiffany Thigpen  
Region 10 Tobacco Prevention and Control Coordinator  
Pitt County Health Department

Natalie Thompson  
Regional Tobacco Prevention Manager, Region 5  
Durham County Department of Public Health

Samantha Tillman  
Health Education Intern  
Cumberland County Department of Public Health

Steph Trilling  
Tobacco Control Project Director  
UNC Lineberger Comprehensive Cancer Center

Tenika Walker  
Population Health Director  
Sandhills Center

Mary Ward, MBA  
President, retired  
McLeod Centers for Wellbeing

Raynard Washington, PhD, MPH  
Health Director  
Mecklenburg County

Ernest Watts  
Region 8 Tobacco Lead  
Robeson County Health Department

Cathy Weedman  
Manager, Integrated Care Management  
AmeriHealth Caritas

Tori Whitley, BSN, RN  
Director of Population Health  
Trillium Health Resources

David Willard  
Northwest Tobacco Prevention Coordinator, Region 3  
Appalachian District Health Department

Larissa Williams  
Program Coordinator, Comprehensive Cancer Program  
Division of Public Health, Chronic Disease and Injury Section, Cancer Prevention and Control Branch  
NC Department of Health and Human Services

Megan S. Williams, MSPH, MSW  
Research Associate  
UNC Collaborative for Maternal and Infant Health

Juliana Wilson, MSW  
Sexual and Gender Minority Tobacco Treatment Coordinator  
Division of Public Health, Tobacco Prevention & Control Branch  
NC Department of Health and Human Services

Rachel Yip  
Research Associate  
Collaborative for Maternal and Infant Health at UNC

Christine Zazzaro, M.Ed, LCMHC  
President  
McLeod Centers for Wellbeing

NORTH CAROLINA STATE EXCESSIVE ALCOHOL ADVISORY COMMITTEE (NCSEAAC)  
NC SEAAC LEADERSHIP

Fisher Charlton, MPH  
Alcohol Epidemiologist  
Division of Public Health, Injury and Violence Prevention Branch  
NC Department of Health and Human Services

Mina J. Cook, CPS  
NCPUDI Project Coordinator  
North Carolina Preventing Underage Drinking Initiative  
University of North Carolina Greensboro

Mary Beth Cox, MPH  
Substance Use Epidemiologist  
Division of Public Health, Injury and Violence Prevention Branch  
NC Department of Health and Human Services

Jennifer C. Matthews, PhD, MSPH  
Professor, Department of Health Education and Promotion  
East Carolina University

WORK GROUP MEMBERS

The North Carolina State Excessive Alcohol Advisory Committee (NC SEAAC) is composed of North Carolina partners that work in the prevention, treatment and recovery, policy and advocacy, and research of excessive alcohol use and its related harms.
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

**SUGAR-SWEETENED BEVERAGE CONSUMPTION WORK GROUP CO-LEADERS**

**Alice S. Ammerman, DrPH**  
Director, Center for Health Promotion and Disease Prevention  
University of North Carolina-Chapel Hill

**Fiorella Horna**  
Grants Officer  
El Centro Hispano, Inc.

**Jayne L. McBurney, M.S.**  
Steps to Health Program Coordinator  
North Carolina State University SNAP-Ed Department of Agricultural & Human Sciences

**Tish Singletary, MA**  
Branch Head  
Division of Public Health, Community and Clinical Connections for Prevention and Health Branch  
NC Department of Health and Human Services

**WORK GROUP MEMBERS**

**Crystal Adams, MA, CDA, RDH**  
Director, North Carolina Oral Health Collaborative Foundation for Health Leadership & Innovation

**Jennifer Bailey**  
Section Chief, School Nutrition Division  
NC Department of Public Instruction

**Tracey Bates, MPH, RDN, LDN, FAND**  
School Nutrition Promotion Specialist, Office of School Nutrition  
NC Department of Public Instruction  
Co-Chair, Farm to School Coalition of North Carolina

**Sarah Blanton**  
Healthy Schools Consultant  
NC Department of Public Instruction, Office of Academic Standards

**Mary Anne Burghardt**  
Head, Nutrition Services Branch  
Division of Public Health  
NC Department of Health and Human Services

**Areli Perez-Nava**  
Program Monitoring and Support Division  
NC Department of Public Instruction

**Courtney Ramsey-Coleman, MS, RDN, LDN**  
Healthy Eating and Nutrition Security Coordinator  
Division of Public Health, Community and Clinical Connections for Prevention and Health Branch  
NC Department of Health and Human Services

**Susanne Schmal, MPH**  
School Health Partnerships and Policy Consultant  
NC Department of Public Instruction, Office of Academic Standards

**Yasmine (Yas) Shepard, MA, MPH, DrPH(c)**  
Program Manager & HMP Team Lead  
Office of Diversity, Equity, and Inclusion  
Office of the Secretary  
NC Department of Health and Human Services

**Lisa Shock, DrPH, MHS, PA-C**  
Chief Population Health Officer, North Carolina Health Plan  
UnitedHealthcare Community & State

**Les Spell**  
Data & Policy Consultant  
NC Department of Public Instruction, Office of Academic Standards

**Rhonda Stephens, DDS, MPH**  
Acting Section Chief, State Dental Director  
Division of Public Health, Oral Health Section  
NC Department of Health and Human Services

**Sarah Tomlinson, DDS, RDH**  
Senior Dental Consultant  
Division of Health Benefits  
NC Department of Health and Human Services

**HIV DIAGNOSIS WORK GROUP CO-LEADERS**

**Chelsea Gulden**  
CEO/President  
RAIN

**Matt Jenkins**  
Director - HIV/STD Division  
Mecklenburg County Public Health

**Veleria Levy**  
Interim Executive Director  
North Carolina AIDS Action Network

**JeaNelle Plummer**  
HIV Prevention Program Consultant  
Division of Public Health, Communicable Disease Branch  
NC Department of Health and Human Services

**WORK GROUP MEMBERS**

**Alicia Diggs**  
Community Engagement Manager  
UNC Chapel Hill Center for AIDS Research

**Latoya Gardner, JD**  
President & CEO  
House of Mercy

**Matt Martin**  
Associate Director  
North Carolina AIDS Action Network

**Allison Rice, JD**  
Clinical Professor of Law  
Duke University

**Frankie Simmons, MD**  
Family Physician  
Atrium Health

**PERINATAL HEALTH EQUITY COLLECTIVE (PHEC) POLICY WORKGROUP CO-LEADERS**

**Annette Carrington, MS, MCHES**  
Privacy and Contracts Officer  
Durham County Department of Public Health

**Kelly Kimple, MD, MPH**  
Senior Medical Director for Health Promotion, NC Title V Director  
Division of Public Health  
NC Department of Health and Human Services

**Brittany Garner**  
Family Support Program Manager  
Lee County Partnership for Children

**Belinda Pettiford, MPH**  
Section Chief, Women, Infant, and Community Wellness Section  
Division of Public Health  
NC Department of Health and Human Services

**Velma V. Taormina, MD, MSE, FACOG**  
Associate Medical Director Consultant  
NC Medicaid, Division of Health Benefits  
NC Department of Health and Human Services

**WORK GROUP MEMBERS**

The purpose of the Perinatal Health Equity Collective (PHEC) Policy Workgroup is to advocate for and promote policies found in the 2022-2026 North Carolina Perinatal Health Strategic Plan through education and information sharing. The Perinatal Health Equity Collective’s partner organizations include:

- Alamance Achieves
- Alamance County Health Department
- AmeriHealth Caritas
- AppHealthCare
- Atrium HealthCare
- Birth Sisters Doula
- Blue Cross Blue Shield NC
- Carolina Complete Health
- Carolina Global Breastfeeding Institute
- Chatham County Public Health Department
- Cone Health
- Dogwood Health Trust
- The Duke Endowment
- Duke University
- Durham County Public Health
- Durham Children’s Initiative
- East Carolina University
- Elon University
- Equity Before Birth
- Equity for Moms and Babies Realized Across Chatham (EMBRACE)
- Every Baby Guilford
- Family Connects International
- Forsyth County Health Department
- Foundation for Health Leadership and Innovation
- Greensboro Health Disparities Collaborative
- Healthy Start
- Health Resources and Services Administration (HRSA)
- Jacaranda Health
- Jace’s Journey
• Kate B. Reynolds Foundation
• MAAME
• March of Dimes
• Mecklenburg County Public Health
• Meredith College
• MomsRising
• Momma’s Village Fayetteville
• Mountain Area Health Education Center (MAHEC)
• National Service Office for Nurse-Family Partnership
• North Carolina Academy of Family Physicians
• North Carolina Agricultural and Technical State University
• North Carolina Area Health Education Centers
• North Carolina Association of Certified Nurse Midwives
• North Carolina Black Alliance
• NC Child
• North Carolina Child Fatality Taskforce
• NC Counts Coalition
• North Carolina Coalition Against Domestic Violence
• North Carolina Council of Churches
• North Carolina Department of Health and Human Services, Division of Public Health
• North Carolina Department of Health and Human Services, Division of Child and Family WellBeing
• North Carolina Department of Health and Human Services, Office of Rural Health
• North Carolina Healthcare Association
• North Carolina Institute of Medicine
• North Carolina Medical Society
• North Carolina Partnership for Children
• Orange County Health Department
• Partnership for Children and Families
• Perinatal Quality Collaborative of North Carolina (PQNC)
• Piedmont Health Services
• Points True North Consulting
• Racial Equity Institute
• Robeson Health Care Corporation
• Royal Family Ministries
• Sistas Caring 4 Sistas
• Triangle Doulas of Color
• University of North Carolina at Chapel Hill, School of Medicine
• University of North Carolina at Chapel Hill, School of Social Work
• UNC Collaborative for Maternal and Infant Health
• Upstream
• Vidant Health
• Village of Wisdom
• Wake Health
• WellCare
• Winer Family Foundation
• Individuals with lived experience

UNINSURED WORK GROUP CO-LEADERS

Randy Jordan, JD, MPA
Chief Advisor, Impact for Health
Next Stage

Chris Shank
CEO & President
North Carolina Community Health Center Association

Mark Snuggs
Primary Care Office Grant Director and Shortage Designation Specialist
Office of Rural Health
NC Department of Health and Human Services

WORK GROUP MEMBERS

Patrick Brown, PharmD
Executive Director
North Carolina Association of Local Health Directors

Elizabeth Byrum
Senior Policy Analyst, Early Childhood Education
NC Child

Anshita Chaturvedi, MD, MPH
Director - Population Health
North Carolina Community Health Center Association

April Cook, MBA
Chief Executive Officer
North Carolina Association of Free and Charitable Clinics

Brandy Bynum Dawson
Rural Prosperity and Investment Initiatives
MDC

Zenobia Edwards, MAT, EdS, EdD
Executive Director
Old North State Medical Society

Abby Carter Emanuelson
Executive Director
Care4Carolina

Honey Yang Estrada, MPH, CHW
President
North Carolina Community Health Worker Association

Charlene Green, MD
Chief of Anesthesia
Anesthesiology Consultants of North Carolina, PLLC

Kathy Hodges, MSW, NCCM
Community Development Specialist
Office of Rural Health
NC Department of Health and Human Services

Richard Hudspeth, MD
Chief Executive Officer
Blue Ridge Health

Torie Keeton
Policy & Government Affairs Manager
NC Rural Center

William W. Massengill, Jr.
Chief Executive Officer
Benson Health

Moneka Midgette, MPA
Community Health Worker Coordinator
Office of Rural Health
NC Department of Health and Human Services

John Resendes, MA, LPA, HSP-PA, LCAS-A
Analytics and Innovations Manager
Office of Rural Health
NC Department of Health and Human Services

Alice Salthouse, MHA
Chief Executive Officer
High Country Community Health

Kristen Spaduzzi, MS
Director, Value-Based Programs
Carolina Complete Health Network

Hugh Tilson, Jr., JD, MPH
Associate Dean and Executive Director
North Carolina Area Health Education Centers (NC AHEC)

Sally Wilson
Executive Director
Project Access of Durham County

PRIMARY CARE CLINICIANS WORK GROUP CO-LEADERS

Anshita Chaturvedi, MD, MPH
Director - Population Health
North Carolina Community Health Center Association

Randy Jordan, JD, MPA
Chief Advisor, Impact for Health
Next Stage

Mark Snuggs
Primary Care Office Grant Director and Shortage Designation Specialist
Office of Rural Health
NC Department of Health and Human Services

WORK GROUP MEMBERS

Patrick Brown, PharmD
Executive Director
North Carolina Association of Local Health Directors

Charlene Green, MD
Chief of Anesthesia
Anesthesiology Consultants of North Carolina, PLLC

Greg Griggs, MPA, CAE
Executive Vice President
North Carolina Academy of Family Physicians

Becca Hayes, MD, MEHP
VP of Clinical Affairs
North Carolina Community Health Center Association

Elizabeth Hudgins, MPP
Executive Director
North Carolina Pediatric Society

Savannah Junkins, PA-C, MPAS
Physician Assistant and Director of Integrated Behavioral Health
Carolina Family Health Centers, Inc.

Stephanie Nantz
Assistant Director of Operations
Office of Rural Health
NC Department of Health and Human Services

Alice Pollard, MSW, MSPH
Vice President of Operations and Strategy
North Carolina Community Health Center Association
The NC SHIP priorities were integrated into the existing Comprehensive Suicide Prevention Advisory Council (CSPAC). The CSPAC convenes suicide prevention professionals (Division of Mental Health/Developmental Disabilities and Substance Abuse Services [DMH/DD/SAS], Department of Public Instruction [DPI]), loss survivors, attempt survivors, people who have accessed mental health, substance use, and intellectual and developmental disabilities (MH/SU/IDD) services, veterans, and special populations including Black, Latino/Hispanic, those that identify as person of color (POC) and LGBTQ+ youth to guide action plan components and implementation of strategies.
SECTION I
Background and Overview of Process

Population Health Model..................................................18
Results-Based Accountability Framework/
Clear Impact Scorecard..................................................19
RBA vs Smart Goals/Whole vs Client Population..........20
Overview/NC SHIP Phases..............................................21-22
Roles and Responsibilities............................................23
POPULATION HEALTH MODEL

The NC SHIP adopted the Robert Wood Johnson Foundation population health framework that was developed by the University of Wisconsin. The framework is sometimes referred to as the County Health Rankings Model (Figure 1). Healthy People 2030 also uses the same framework for organizing its work at the federal level.

Health begins in families and communities and is largely determined by the social and economic factors (40%) in which we grow up, live, work, and age. Factors such as health behaviors (30%) and our physical environment (10%) are well known to impact health (Glanz, Rimer, & Viswanath, 2015). Factors related to clinical care (20%) are also responsible for quality of life and life expectancy. Together, these factors are called drivers of health and they directly affect health outcomes like development of disease and life expectancy.
RESULTS-BASED ACCOUNTABILITY FRAMEWORK

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

HNC 2030 and the NC SHIP adopted RBA methodology for community dialogue based on plain language that anyone can understand. Governmental agencies are known for their use of jargon, and public health is no exception. By adopting RBA, public health sends the message that we must have a common language for talking about wicked problems – a language that community members can understand.

RBA teaches us to care more about going in the right direction rather than setting unrealistic goals. We embrace “Turn the Curve Thinking” to make decisions about what to do, and then use “turn the curve thinking” to see if what we do is working. RBA teaches that there are two types of accountabilities: population accountability and performance accountability. We reject the suggestion that holding any one agency/organization, or even multiple organizations accountable for solving wicked problems at the population level is helpful. However, being accountable for the performance of programs, policies, and practices is our direct responsibility. Mark Friedman, the originator of RBA (Image 1), says that too many people associate accountability with punishment. When applied correctly, RBA will help us to:

- Know if what we do is working,
- Explore how we can achieve measurable results faster, and
- Communicate why the work we do matters to those we serve and those that fund our work.

RBA uses data and disciplined thinking to tell a story in plain language. RBA replaces S.M.A.R.T. goals and objectives with three simple measures:

- How much did you do?
- How well did you do it?
- Is anybody better off?

The North Carolina Department of Health and Human Services, Division of Public Health and our cross-sectoral stakeholders are motivated to do the right things and do them well so that we and our partners can make a difference in the lives of the people we serve. We set targets for the HNC 2030 indicators, but any improvement in the right direction for these indicators defines our success.

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 (Figure 2).

<table>
<thead>
<tr>
<th>CA</th>
<th>COMMUNITY HEALTH ASSESSMENT / COMMUNITY HEALTH NEEDS ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>RESULT</td>
</tr>
<tr>
<td>I</td>
<td>INDICATOR</td>
</tr>
<tr>
<td>P</td>
<td>PROGRAM / POLICY / PRACTICE</td>
</tr>
<tr>
<td>PM</td>
<td>PERFORMANCE MEASURE</td>
</tr>
</tbody>
</table>

The Division of Public Health partners with the Foundation for Health Leadership & Innovation (FHLI) to introduce a web-based tool, Clear Impact Scorecard, to track the direction of HNC 2030 population indicators and program performance measures. In 2021, the tool was introduced statewide. Scorecard tracks the performance measures identified in the community health assessments of local health departments and the Eastern Band of Cherokee Indians (EBCI). These priorities (Appendix D) are aligned with the HNC 2030 population indicators and revised annually when new data become available.

Tracking and reporting data for the 21 HNC 2030 indicators proved to be a challenge in 2021. The global pandemic and its impact on the United States Census delayed reporting for seven of the 21 indicators. The NC State Health Improvement Scorecard can be viewed at https://embed.clearimpact.com/Scorecard/Embed/82417

Image 1. Trying Hard is Not Good Enough: How to Produce Measurable Improvements for Customers and Communities (Mark Friedman).
RESULTS-BASED ACCOUNTABILITY VERSUS S.M.A.R.T. GOALS

The term S.M.A.R.T. goal, often associated with objectives, helps to make sure that objectives are clearly defined and attainable. The goal must be stated in such a way as to be specific, measurable, achievable, relevant, and time-bound. S.M.A.R.T goals are not useful for tracking population level data because of the competing characteristics of being both achievable and time-bound. S.M.A.R.T. goals are better suited for tracking performance measures within a defined program with some control over the resources needed to improve outcomes.

RBA makes a clear distinction between population accountability and performance accountability (Figure 3).

RBA eliminates the jargon and uses plain language to report:
- How much did you do?
- How well did you do it?
- Is anybody better off?

---

Figure 3. Results-Based Accountability

Population Accountability vs Performance Accountability

- **Whole Population**
  - The well-being of **Whole Populations**: Communities, Cities, Counties, States, Nations, World

- **Client Population**
  - The well-being of **Client Populations**: Governments, Agencies, Organizations, Programs, Units

---

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

The NC SHIP extends the work of HNC 2030: A Path Toward Health. The plan represents the collaborative effort of the NC DHHS, DPH and NCIOM to develop a decennial plan to improve the lives of people who live in North Carolina.

The 2020 NC SHIP was developed by DPH in partnership with NCIOM. Together, they 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 2022 NC SHIP grew out of the annual review of the 2020 NC SHIP at the NC SHIP Community Council meeting on July 29, 2021, and the subsequent nine Community and Stakeholder Symposia August – September 2021.

The NC SHIP consists of five phases (Figure 5).

<table>
<thead>
<tr>
<th>Phase 1: Development</th>
<th>Jan 2020 - Nov 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 2: Implementation</td>
<td>Dec 2020 - July 2022</td>
</tr>
<tr>
<td>Phase 3: Strategic Planning</td>
<td>July 2022 - July 2029 (quarterly)</td>
</tr>
<tr>
<td>Phase 4: Monitoring</td>
<td>July 2022 - July 2029 (quarterly)</td>
</tr>
<tr>
<td>Phase 5: Evaluation</td>
<td>July 2029 - Nov 2029 (final)</td>
</tr>
</tbody>
</table>

Specific programs and practices with a high potential for success are listed in the NC SHIP. Responsibility for implementing specific programs and practices lies with the state and local health departments and cross-sectoral partners. North Carolina uses a web-based tool for linking local initiatives to the NC SHIP. During the decade 2020-2030, progress toward meeting the HNC 2030 targets will be continuously monitored using a Clear Impact Scorecard. Maximum transparency is achieved by giving the public full access to the Scorecard as it is continuously updated. (https://app.resultsscorecard.com/Scorecard/Embed/75778)

TIMELINE

Development Phase
January 2020 – November 2020

HNC 2030 summarizes how the population level indicators were selected as priorities for the NC SHIP. The 21 population indicators represent four categories of factors that affect health, plus two health outcomes (Figure 6).

Figure 5. Five phases of the NC SHIP

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 workgroups.

Step 2. The NC SHIP Steering Committee recommended workgroup 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. Nineteen virtual meetings were held 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 health 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. Leaders advised work group participants to identify best practices while applying the RBA principle, “Turn the Curve Thinking” (Figure 7).

**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.

**Implementation Phase**
December 2020 – July 2022

**Step 1.** NC DHHS/DPH published the 2020 NC SHIP December 2020.

**Step 2.** Each participant received a copy of the 2020 NC SHIP and was invited to serve on the NC SHIP Community Council, July 29, 2021. A total of 132 invitations were extended: 29 participated.

**Step 3.** Additional participants were invited to the Community & Stakeholder Symposium August – September 2021. The symposia were well attended and with 323 people participating in one or more of the indicator-specific symposia.

**Step 4.** Partnering with the Foundation for Health Leadership & Innovation (FHLI) and the North Carolina Area Health Education Centers (NC AHEC), NC DHHS/DPH provided low-cost training in Results-Based Accountability™.

**Step 5.** Working with the FHLI and the North Carolina Health Care Association (NCHA), NC DHHS/DPH introduced health care systems to RBA and Clear Impact Scorecard.

**Step 6.** Assisted local health departments with the transition from paper-based community health improvement plans to the web-based Clear Impact Scorecard.

**Step 7.** Partnering with NC AHEC and FHLI, NC DHHS/DPH helped to convene learning collaboratives for stakeholders addressing the HNC 2030 indicators.

**Step 8.** Updated the 2020 NC SHIP and published the 2022 NC SHIP in March 2022.

---

**Strategic Planning**

**July 2022 - July 2029 (quarterly)**

**Step 1.** The 2022-2023 NC SHIP Community Council brought together non-NC DHHS organizational, NC DHHS governmental, and community partners in 18 work groups to identify, develop, and prioritize strategies and policies with the greatest potential for “Turning the Curve” on the HNC 2030 indicators. Work groups across the Community Council aligned with existing plans where applicable. The Community Council will continue to refine and prioritize policies to support HNC 2030 throughout the decade.

**Next steps:**
- Continue to recruit community partners and other actors who offer lived experience, expertise, and influence to join Community Council Workgroups
- Convene the 2024 NC SHIP Community Council Annual Meeting and Indicator Workgroups
- Refresh action plans for advancing priority policy and program improvements
- Document strategies and progress in Clear Impact Scorecard quarterly

**Monitoring Progress**

**July 2022 - July 2029 (quarterly)**

**Next steps:**
- Monitor progress for all HNC 2030 indicators at the population level and performance level and update Clear Impact Scorecard quarterly.
- Review progress annually and publish report.

**Evaluation**

**July 2029 - November 2029 (final)**

The final NC SHIP Community Council (2029-2030) will conduct an evaluation of the decade’s work supporting policy change.

In the interim years leading up to the 2029-2030 Community Council, DPH will monitor performance annually through the Clear Impact Scorecard.

---

**Figure 7. 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 you do?, How well did you do it?, and is anybody better off?”
- Published research from communities outside/inside 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**
- **Claim North Carolina roots**
- **Successful outcomes over several years**
- **Widespread community support, and include**
- **Multilevel interventions**
ROLE OF NC DHHS AND PARTNERS

- NC Division of Public Health is responsible for conducting a state health assessment (SHA) every five years. At the beginning of each decade, NC DPH partners with a larger group of stakeholders to set decennial objectives. In 2019-20, NC DPH partnered with NCIOM to produce its 2019 SHA/HNC 2030 report. NC DPH also produces a state health improvement plan based upon the SHA (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. NC DPH ensures that all Council members receive annual orientation in the use of Scorecard to monitor progress on the HNC 2030 indicators (Figure 8).

- 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 NC SHIP.

ROLE OF LOCAL HEALTH DEPARTMENTS AND MULTI-SECTOR PARTNERS

- Local health departments and 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 to the state level HNC 2030 Scorecard.

- Local health departments are responsible for ensuring that staff are trained in RBA.

NC SHIP COMMUNITY COUNCIL

- The NC SHIP Community Council provides oversight on “Turn the Curve Thinking” for the 21 HNC 2030 indicators (Figure 6). Initially, the composition of the NC SHIP Community Council consisted of individuals who participated in the HNC 2030 and/or NC SHIP working groups. Beginning in 2022, NC DHHS designated leads for each indicator and worked with NCIOM to build cross-sectoral agency partners. NC DHHS leads and cross-sectoral agency partners prioritized and pursued those policies with the most support.

- 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 its annual report.

**Figure 8. Roles and responsibilities of state and local health departments and their partners in the NC SHIP**

**Annual Review**
Are we doing the right things?
Are we doing the right things well?

**Web-Based Platform:** Clear Impact Scorecard using Results-Based Accountability

https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm
STATE HEALTH IMPROVEMENT PLAN

SECTION II
NC SHIP Community Council

Community Council Structure...........................................26
Community Council Function.............................................27
Community Council Monitoring.........................................28
Policies To Support HNC 2030...........................................29-32
Timeline.............................................................................33
In July 2022, a new structure for the NC SHIP Community Council was adopted to build cross-sectoral partnerships across the 21 HNC 2030 indicators. Co-leads were identified for each of the indicators and either new work groups were formed, or existing work groups were identified that were willing to align the NC SHIP into their current efforts. The Community Council structure is unique to North Carolina and was designed to build structure for longevity.

Each work group was asked to identify at least three co-leaders, one organizational representative not from NC DHHS, one community representative, and one NC DHHS representative.

There are 18 work groups across the 21 indicators. Meeting structures were established by co-leads and varied across the Community Council.

<table>
<thead>
<tr>
<th>Table 1. 2022-2023 NC SHIP Community Council Working Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty and Unemployment Work Group</td>
</tr>
<tr>
<td>Short-Term Suspensions Work Group</td>
</tr>
<tr>
<td>Incarceration Work Group</td>
</tr>
<tr>
<td>Adverse Childhood Experiences Work Group</td>
</tr>
<tr>
<td>Third Grade Reading Proficiency Work Group</td>
</tr>
<tr>
<td>Access to Exercise Opportunities Work Group</td>
</tr>
<tr>
<td>Limited Access to Healthy Food Work Group</td>
</tr>
<tr>
<td>Severe Housing Problems Work Group</td>
</tr>
<tr>
<td>NC Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC)</td>
</tr>
<tr>
<td>SHIP Tobacco Committee</td>
</tr>
<tr>
<td>North Carolina State Excessive Alcohol Advisory Committee (NCSEAAC)</td>
</tr>
<tr>
<td>Sugar-Sweetened Beverage Consumption Work Group</td>
</tr>
<tr>
<td>HIV Diagnosis Work Group</td>
</tr>
<tr>
<td>Perinatal Health Equity Collaborative (PHEC) Policy Workgroup</td>
</tr>
<tr>
<td>Uninsured Work Group</td>
</tr>
<tr>
<td>Primary Care Clinicians Work Group</td>
</tr>
<tr>
<td>Comprehensive Suicide Prevention Advisory Council</td>
</tr>
<tr>
<td>Life Expectancy Work Group</td>
</tr>
</tbody>
</table>
The purpose of the 2022-2023 NC SHIP Community Council was to prioritize policies/programs and advance actions of HNC 2030 population indicators. Work groups across the Community Council aligned with existing plans where applicable.

From August 2022 to June 2023, the Community Council reviewed proposed policy initiatives, identified priorities, completed asset mapping, reviewed data, began action planning, and engaged partners and communities across the state.

In June 2023, listening sessions were held to gather input on co-leaders’ experiences as part of the 2022-2023 NC SHIP Community Council during its inaugural year, inform the agenda for the Annual Meeting on July 12, 2023, and plan for the next year.

Building on the efforts of the previous Community Council, 2023-2024 will be the Year of Action. The purpose of the 2023-2024 NC SHIP Community Council is to prioritize, act, and connect to advance the HNC 2030 population indicators. As the Community Council moves into the Year of Action, each work group will be reviewing priorities and identifying resources needed to move forward. For example, ensuring that each work group has clear and actionable priorities; identifying and engaging partners in new ways that may be able to accelerate action and/or provide other resources needed to move forward (such as data, facilitation, specific expertise, etc.); and matching resources to needs.

“Having the opportunity to be a co-lead, it is great to be able to say that there are efforts that have been/are being put into place to try to make our state the healthiest that it can be.”

PRIORITIZE    ACT    CONNECT
The 2022 NC SHIP Policy/Program Scorecard monitored the status of the NC SHIP Community Council’s state-level priorities (policies/programs) and its partners to improve the quality of life for North Carolinians (Figure 9). Each policy/program was tracked numerically according to defining criteria for each stage of development.

The 2022 NC SHIP Policy/Program Scorecard is available at https://embed.clearimpact.com/Scorecard/Embed/76966.

**THE FIVE STAGES:**

1. Proposed
2. Designed
3. Adopted
4. Implemented
5. Evaluated

As of July 1, 2023, 83% of the 2022-2023 NC SHIP Community Council’s prioritized policies/programs were in the Designed stage. From August 2022 to June 2023, the work groups recommended lead organizations, began action planning, engaged additional partners, and considered resources needed.

In 2023-2024, the Community Council will continue to move toward policies/programs being fully designed and progressing toward being adopted, implemented, and evaluated. Progress on priorities, including work group meeting notes and action plans, will continue to be publicly available and tracked on the 2023-2024 Community Council Scorecard at https://embed.clearimpact.com/Scorecard/Embed/82417.
Table 2 provides a summary of the policies identified by the 2022-2023 NC SHIP Community Council to support HNC 2030 and does not constitute an endorsement by NC DHHS/DPH. Many of the policies were originally suggested in HNC 2030: A Path Toward Health, and others were added by the NC SHIP Community Council members and community stakeholders July-September 2021 (pp. 8-9). Some of the policies are also those included in the Robert Wood Johnson Foundation County Health Rankings & Roadmaps Evidence Library of “What Works for Health” - https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health. NC DHHS/DPH welcomes the opportunity to work with its partners and the community to prioritize policies and programs that have the greatest potential for “Turning the Curve” on the HNC 2030 indicators.

See indicator pages for additional content.

### Table 2. Priorities identified by the 2022-2023 NC SHIP Community Council

#### INDICATOR 1: POVERTY

The following proposed policy initiatives from the 2022 NC SHIP report remain under consideration.

- Expand Medicaid eligibility
- Create and expand legislation and advocate with employers to provide paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers
- Ease negative impact of “benefits cliffs” caused by reductions in benefits, by lengthening phase-out periods
- Eliminate taxation on sanitary products including menstrual supplies, diapers, and breastfeeding supplies
- Expand the availability and amount of childcare subsidies to reflect the cost of care more adequately
- Raise the minimum wage to $15.00 per hour
- Restore the North Carolina Earned Income Tax Credit
- Support “early college while in high school” programs, such as REaCH and SEarCH

#### INDICATOR 2: UNEMPLOYMENT

The following proposed policy initiatives from the 2022 NC SHIP report remain under consideration.

- Expand Medicaid eligibility
- Create and expand legislation and advocate with employers to provide paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers
- Expand access to higher educational opportunities
- Expand transit options in rural and low-income communities
- Improve access to personal finance credit scores
- Expand the availability and amount of childcare subsidies to reflect the cost of care more adequately
- Increase access to broadband internet
- Pass fair chance hiring policies for county and local employees, and work with employers to adopt fair chance hiring policies for themselves
- Shift funding from industrial recruitment to support small businesses and social enterprises
- Support people with disabilities and those in recovery, veterans, and reentry populations to live their lives as fully included members of the community by implementing key employment initiatives like Competitive Integrated Employment and Employment First

#### INDICATOR 3: SHORT-TERM SUSPENSIONS

- Disrupt the school-to-prison pipeline, beginning with early childhood programs by reducing the use of school suspensions and expulsions and increasing the use of counseling services and community-based programs and initiatives
- Increase racial, ethnic, gender, and disability status diversity among school and childcare leadership and staff and the institutions that train them

#### INDICATOR 4: INCARCERATION RATE

- Ensure access to behavioral health treatment, adequate medical care, and stable housing for those returning from incarceration
- Expand existing or create community Medication Assisted Treatment programs for people with substance use disorder detained in prisons and jails or transitioning to and from prison
- Improve access to treatment for substance use disorders, physical illnesses, and mental illnesses
- Improve resources and legislation pertaining to jails and prisons to reduce harmful impact of incarceration and foster successful reintegration into the community
- Increase access to multisystemic therapy for juvenile offenders
- Invest in public health alternatives to traditional law enforcement and sentencing, particularly for behavioral health issues

#### INDICATOR 5: ADVERSE CHILDHOOD EXPERIENCES

- Improve data available on trauma and ACEs at the local level
- Increase funding for and embed community-rooted, culturally affirming family and community support programs into existing initiatives

#### INDICATOR 6: THIRD GRADE READING PROFICIENCY

- Reinforce the talent pipeline for early educators for children from birth through third grade by increasing compensation through dedicated funding, ensuring pay parity, and sustaining investments in training and professional development
## INDICATOR 7: ACCESS TO EXERCISE OPPORTUNITIES

- Increase, promote, improve, and maintain the number of safe and well-lit sidewalks, bike trails and lanes, walking trails, and greenways to improve connectivity and accessibility
- Promote, sustain, and expand multimodal transportation options to increase access to places for physical activity

## INDICATOR 8: LIMITED ACCESS TO HEALTHY FOODS

- Enhance how children and families access programs supporting their well-being, including SNAP, WIC, CACFP, Medicaid, and NCCARE360 through better data and analysis, infrastructure, and integration
- Provide financial incentives such as "Double Up Food Bucks" and Produce Prescriptions for SNAP/FNS recipients for purchasing fresh fruit and vegetables from grocery stores and farmers markets
- Continue, expand, and institutionalize the Supplemental Nutrition Assistance Program (SNAP) online purchasing pilot
- Support equitable, food-oriented development that drives economic growth in low-income and historically marginalized communities
- Support regional food hubs connecting local farmers, growers, producers, and ranchers with expanded market opportunities and the community to improved access to local, nutritious food
- Implement competitive pricing for healthy foods
- Collaborate with community partners to provide nutritious options at convenience stores and pantries
- Support farmers markets and enable Electronic Benefit Transfer payment at farmers markets
- Support, promote, and encourage participation in the School Breakfast and National School Lunch Programs

## INDICATOR 9: SEVERE HOUSING PROBLEMS

- Increase measures and funding to provide tenants with access to mediation, legal representation, and legal education to secure and protect housing
- Remove legal barriers, institute enabling legislation, and facilitate lending to promote Community Land Trusts and other shared equity models of homeownership
- Simplify and expand the Weatherization Assistance Program, Low-Income Energy Assistance Programs, and other healthy homes and utility assistance programs by affirmatively engaging low-income communities through targeted outreach to help families meet their energy needs
- Support funding, loans, and other resources for housing providers in agricultural areas to improve safe and healthy home environments for migrant workers
- Support programs designed to increase home ownership for historically disenfranchised communities

## INDICATOR 10: DRUG OVERDOSE DEATHS

- **Center Equity and Lived Experiences** by acknowledging systems that have disproportionately harmed historically marginalized people (HMP), implementing programs that reorient those systems, and increasing access to comprehensive, culturally competent, and linguistically appropriate drug user health services for HMPs
- **Prevent** future addiction and address trauma by supporting children and families
- **Reduce Harm** by moving beyond just opioids to address polysubstance use
- **Connect to Care** by increasing treatment access for justice-involved people and expanding access to housing and employment supports to recover from the pandemic together

## The following priority areas are from North Carolina’s Opioid and Substance Use Action Plan (OSUAP), https://www.ncdhhs.gov/about/department-initiatives/overdose-epidemic/north-carolinas-opioid-and-substance-use-action-plan/.

## INDICATOR 11: TOBACCO USE

### Point of Sale

- Remove state preemption of local government regulations on the sale, promotion, distribution, and display of tobacco products
- Revise zoning ordinances to control placement of shops that sell tobacco, limiting the number of these shops per area and ensuring they are placed a safe distance from children’s areas

### Price and Funding

- Fund comprehensive state tobacco control programs to levels recommended by Centers for Disease Control and Prevention (CDC)
- Increase the price of tobacco products by raising the current state tax on cigarettes and increase other tobacco product taxes to parallel levels

*Continued on next page*
**INDICATOR 11: TOBACCO USE CONTINUED**

*Providing Barrier-Free Access to Tobacco Treatment*
- Expand Medicaid coverage for all tobacco cessation treatment, including counseling and treatment for parents in any pediatric setting, and group counseling; and expand the accessibility of tobacco use treatment for Medicaid beneficiaries into more settings and modalities, with a broader array of providers
- Increase access to treatment based on the N.C. Tobacco Treatment Standard of Care, to include counseling and FDA-approved medications
- Provide nicotine replacement options and services to the uninsured and underinsured
- Support Tobacco Treatment Specialist Training for people serving those with commercial tobacco product related inequities and disparities

*Raise State Minimum Sales Age/ Increase Retailer Compliance*
- Raise state minimum sales age from 18 to 21 to match federal law. Educate retailers about the federal law and increase retailer compliance with checking a photo ID to prevent sales to anyone under age 21

**Providing Barrier-Free Access to Tobacco Treatment**
- Enforce the federal law that calls for smoke-free multi-unit public housing and promote smoke-free multi-unit affordable housing
- Implement state and local tobacco-free and smoke-free air policies that include electronic cigarettes
- Increase the number of tobacco-free public parks
- Recommend an electronic cigarette policy for restaurants and bars

**INDICATOR 12: EXCESSIVE DRINKING**

- Consider local ordinances related to the sale and consumption of alcohol at local events, including adoption, implementation, and regulation of alcohol social districts

**INDICATOR 13: SUGAR-SWEETENED BEVERAGE CONSUMPTION**

- Integrate “Rethink Your Drink” toolkit into school curricula, promoting water as a healthy alternative to sweetened beverages
- Establish healthy food procurement policies that support public and private investment in healthy food, and increase availability of healthy alternatives to sugary drinks
- Ensure access to safe and clean water in schools at water-filling stations that have been tested for safety
- Limit “default beverage” options for children’s meals at food venues to include only milk, 100% fruit juice, or water
- Implement healthy choice beverage in vending machines at schools and parks

**INDICATOR 14: HIV DIAGNOSIS**

- Expand affordable housing programs for people living with HIV
- Expand North Carolina’s provider network for HIV care and prevention services
- Identify and address gaps in HIV healthcare access for formerly incarcerated populations
- Identify barriers to HIV post exposure prophylaxis being delivered by pharmacists
- Improve provider comfort with incorporating sexual health assessments into routine healthcare services
- Increase access to pre-exposure prophylaxis (PrEP) for individuals at high risk for HIV transmission
- Increase the number of harm reduction programs, including needle exchange programs
- Increase the number of people who know their HIV status and are linked to prevention or treatment services through high impact, coordinated interventions

**INDICATOR 15: TEEN BIRTHS**

*The Perinatal Health Equity Collective Policy Workgroup prioritized the following NC Perinatal Health Strategic Plan (PHSP) strategy that aligns with the 2022 NC SHIP.*

*The numbers included with the prioritized policies refer to the strategy numbers in the PHSP, https://wicws.dph.ncdhhs.gov/phsp/.*

- 12F. Increase same-day access to all methods of contraception

**INDICATOR 16: UNINSURED**

- Expand Medicaid, including expanding recipient eligibility criteria
- Determine the need for expanding and sustaining financial support for Community Health Workers
- Determine the need for sustaining health clinics for the uninsured
- Repurpose savings and surpluses created by Medicaid transformation and expansion and leverage the community benefit programs of health systems to fund programs for the uninsured
### INDICATOR 17: PRIMARY CARE CLINICIANS

- Expand healthcare provider training onsite in rural communities
- Increase funding for provider loan repayment programs
- Leverage Medicaid, including Medicaid Expansion, to support the viability of all primary care clinicians in rural settings

### INDICATOR 18: EARLY PREGNATAL CARE

The Perinatal Health Equity Collective Policy Workgroup prioritized the following NC Perinatal Health Strategic Plan (PHSP) strategy that aligns with the 2022 NC SHIP. The numbers included with the prioritized policies refer to the strategy numbers in the PHSP, https://wicws.dph.ncdhhs.gov/phsp/.

- 1. Perinatal health care providers should participate in training around health equity, implicit bias, and cultural competency
- 7E. Increase the number of Prepaid Health Plans (PHPs) that cover doula services
- 7G. Elevate the role of community health workers in addressing the social drivers of health
- 9A. Expand Medicaid to provide affordable, comprehensive health, behavioral health, and dental insurance coverage, including mobile health and telehealth for all
- 9I. Implement the NC Area Health Education Centers (AHEC) Scholars Program to recruit and train students of color and students from rural backgrounds to become providers in underserved areas
- 10A. Expand the use of evidence-based and evidence-informed models of perinatal care highlighted in the Maternal Health Innovation Program, including doula services, group prenatal care, group child visits, and community health workers

### INDICATOR 19: SUICIDE

The priorities included below are the focus areas for the North Carolina Suicide Prevention Action Plan (NC SPAP), https://injuryfreenc.dph.ncdhhs.gov/preventionResources/docs/CSP-ActionPlanFinal.pdf.

1. Create a coordinated infrastructure
2. Reduce access to lethal means
3. Increase community awareness and prevention
4. Identify populations at risk
5. Provide crisis intervention with a specific focus on people with increased risk
6. Provide access to and delivery of suicide care
7. Measure our impact and revise strategies based on results

### INDICATOR 20: INFANT MORTALITY

The Perinatal Health Equity Collective Policy Workgroup prioritized the following NC Perinatal Health Strategic Plan (PHSP) strategy that aligns with the 2022 NC SHIP. The numbers included with the prioritized policies refer to the strategy numbers in the PHSP, https://wicws.dph.ncdhhs.gov/phsp/.

- 1D. Provide training to all NCDHHS staff and ongoing professional development on equity that builds understanding of and competencies to advance health equity
- 1E. Perinatal health care providers should participate in training around health equity, implicit bias, and cultural competency
- 7E. Increase the number of Prepaid Health Plans (PHPs) that cover doula services
- 7G. Elevate the role of community health workers in addressing the social drivers of health
- 7J. Expand efforts to prevent infant deaths related to unsafe sleep environments
- 9A. Expand Medicaid to provide affordable, comprehensive health, behavioral health, and dental insurance coverage, including mobile health and telehealth for all
- 10A. Expand the use of evidence-based and evidence-informed models of perinatal care highlighted in the Maternal Health Innovation Program, including doula services, group prenatal care, group child visits, and community health workers
- 10F. Adopt maternal and neonatal risk-appropriate levels of care that align with national standards
- 10Q. Support the creation of a statewide 24-hour breastfeeding support hotline
- 12F. Increase same-day access to all methods of contraception

### INDICATOR 21: LIFE EXPECTANCY

<table>
<thead>
<tr>
<th>Falls Prevention</th>
<th>Brain Health and Dementia Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster partnerships to increase awareness of fall risk factors</td>
<td>Educate individuals, caregivers, and healthcare providers about cognitive decline risk factors, including screening for potential hearing loss and evidence-based interventions to support brain health</td>
</tr>
<tr>
<td>Advance access to fall prevention interventions</td>
<td>Increase use of screening and diagnostic assessment to identify early signs of cognitive decline risk factors and dementia to reduce risk, slow decline and manage symptoms</td>
</tr>
<tr>
<td>Cultivate strategic partnerships with traditional and nontraditional agencies and organizations addressing falls</td>
<td>Improve access to and use of clinical and community services for people with Alzheimer’s disease and related dementias (ADRD)</td>
</tr>
</tbody>
</table>

**Radon Testing and Mitigation**

- Reduce exposure to radon including through increasing grant funds to eligible homeowners for mitigation, improving access to free radon test kits and education, and requiring public schools to test and mitigate for high levels of radon
HEALTHY NORTH CAROLINA 2030
JANUARY 2020

STATE HEALTH
IMPROVEMENT PLAN 2023

NC STATE HEALTH
IMPROVEMENT PLAN
DECEMBER 2020

STATE HEALTH
IMPROVEMENT PLAN 2022

NEXT STEPS
SEPTEMBER 2023 - JUNE 2024

Adopted new Community Council structure
Expanded network of multi-sector partners across the state
Aligned with existing groups and plans
Identified priorities (policies and programs) to advance HNC 2030 indicators
Began action planning
Reflected on learnings and best practices

Built NC SHIP Scorecard with assigned tasks
Opened HNC 2030 Resource Center
Presentations/collaborations with multiple partners

Facilitate work groups toward action.
Review priorities.
Connect on related data, policies, resources, topics, etc., across disciplines and work groups.
Engage partners in aligning with plan.

Establish training and capacity strengthening toolbox to support action.
Track ongoing progress in Scorecard.
Convene NC SHIP Community Council - July 2024.
Prepare Mid-Course Review/ State Health Assessment.
STATE HEALTH IMPROVEMENT PLAN

SECTION III
HNC 2030 Indicators

SOCIAL AND ECONOMIC FACTORS

Poverty..............................................................36-39
Unemployment ..................................................40-43
Short-term Suspensions...................................44-47
Incarceration Rate..............................................48-51
Adverse Childhood Experiences......................52-55
Third Grade Reading Proficiency .....................56-58
HEALTH INDICATOR 1: POVERTY

WHAT RESULT DO WE WANT?
All people in North Carolina are financially stable and have lifetime economic prosperity.

WHY IS THIS IMPORTANT?
“The current scale of community development is insufficient to address the many complex causes of poverty and to ensure the vital conditions that shape health, wealth, and well-being are met for all Americans. Addressing poverty and meeting the vital conditions are in the direct interest of stakeholders beyond the field of community development, including government officials, businesses and business owners, educators, and healthcare providers and payers. New business models are needed to closely align the financial interests of those who benefit from a healthier, more productive population and those who create the conditions that promote human flourishing.”

“The nation's dominant narrative, which states that people can achieve the American Dream of economic success through resilience and grit and by taking personal responsibility, causes great harm. We have stigmatized poverty with racist and misogynistic language such as “welfare queens and deadbeat dads,” instead of acknowledging our history. This narrative perpetuates White privilege and tells those in stigmatized groups that opportunity is there if they seize it and work twice as hard. Working twice as hard to overcome systemic and structural barriers harms health. Evidence shows how disparities in health outcomes increase with education and income, which contradicts a narrative that emphasizes personal responsibility and hard work.”

WHAT DOES THIS INDICATOR MEASURE?
• Reports how many people in the United States are very poor
• Data are from the American Community Survey that is administered by the U.S. Census Bureau annually
• Data are disaggregated by race/ethnicity, gender
• County level data are available
• Survey data are weighted, thus percentages are estimates
• The American Community Survey Five-Year estimates only provide disaggregated data for gender and race/ethnicity as above or below the FPL (100%)

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th></th>
<th>Baseline 2013-2017</th>
<th>Recent 2017-2021</th>
<th>Target 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-2017</td>
<td>36.5%</td>
<td>32.3%</td>
<td>27.0%</td>
</tr>
</tbody>
</table>

HOW ARE WE DOING?
• The overall percentage of individuals at or below 200% FPL trended downward from 2014 to 2021.
• Women historically experience higher rates of poverty than men. In 2021, 15% of women lived below the federal poverty level compared to 12.3% of men.
• Caution should be used in comparing race/ethnicity across populations due to the effect of smaller population size. This makes percentages for Native Hawaiian/Other Pacific Islander and American Indian/Alaskan Native less stable.

HNC 2030 HEADLINE INDICATOR:
Percent of individuals with incomes at or below 200% of the Federal Poverty Level (FPL)
CURRENT DATA TRENDED OVER TIME

Figure 11. Percent of individuals below 200% Federal Poverty Level in North Carolina (2014-2021)

PERCENT BELOW 200% FPL

YEAR

Data source: N.C. State Center for Health Statistics, American Community Survey, 5 year rolling estimates

Figure 12. Percent of individuals below Federal Poverty Level in North Carolina by race/ethnicity (2016-2021)

PERCENT BELOW FPL

YEAR

Data source: N.C. State Center for Health Statistics, American Community Survey, 5 year rolling estimates
THE STORY BEHIND THE CURVE

According to the North Carolina Justice Center, in 2019 the federal poverty guideline was $25,750 combined income for a family or household of four.

- 1.4 million North Carolinians, or about 1 in every 7 people in the state, lived in poverty
- 1 in 5 North Carolinians under 18, or over 430,000 children, lived in poverty

Higher rates of poverty among women are connected to the lack of support for working parents.

In 2019, the poverty rate among North Carolina women was more than 20 percent higher than for men.

- 786,000 women, or 14.9 percent, experienced poverty
- 600,000 men, or 12.2 percent, experienced poverty

Young children have the highest poverty rate of any age group.

Many people were close to poverty before the COVID-19 pandemic began.

WHAT COULD WORK TO TURN THE CURVE?

The NC SHIP Community Council’s Poverty and Unemployment Work Group is continuing to form and identify priorities for action planning. The following policies were proposed in the 2022 NC SHIP report and are under consideration.

PROPOSED POLICY INITIATIVES

- Create and expand legislation and advocate with employers to provide paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers
- Ease negative impact of “benefits cliffs” caused by reductions in benefits, by lengthening phase-out periods
- Eliminate taxation on sanitary products including menstrual supplies, diapers, and breastfeeding supplies
- Expand Medicaid eligibility
- Expand the availability and amount of childcare subsidies to reflect the cost of care more adequately
- Raise the minimum wage to $15.00 per hour
- Restore the North Carolina Earned Income Tax Credit
- Support “early college while in high school” programs, such as REdACh and SEarCh

WHAT OTHER DATA DO WE NEED?

- Economic Mobility: Job market (income); Savings rate; Ownership (home, business, investment)
THE COVID-19 PANDEMIC REQUIRE A MORAL RESPONSE THAT TARGETS THE ROOT CAUSES OF LONGSTANDING POVERTY AND INEQUITY TO BRING SHARED PROSPERITY TO ALL NORTH CAROLINIANS.

- Logan Rockefeller Harris, North Carolina Justice Center (2020)

RECOMMENDED READING/LISTENING


ACTION PLAN
Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer 2023-2024 NC SHIP Community Council Scorecard at https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm.

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Care Services Association (CCSA)</td>
<td><a href="https://www.childcareservices.org/">https://www.childcareservices.org/</a></td>
</tr>
<tr>
<td>Communities in Partnership (CIP)</td>
<td><a href="https://communitiesinpartnership.org/">https://communitiesinpartnership.org/</a></td>
</tr>
<tr>
<td>Cooperative Christian Ministry</td>
<td><a href="https://cooperativeministry.com/">https://cooperativeministry.com/</a></td>
</tr>
<tr>
<td>Crisis Assistance Ministry</td>
<td><a href="https://www.crisisassistance.org/">https://www.crisisassistance.org/</a></td>
</tr>
<tr>
<td>End Poverty Durham</td>
<td><a href="http://endpovertydurham.org/">http://endpovertydurham.org/</a></td>
</tr>
<tr>
<td>Equity Before Birth</td>
<td><a href="https://www.equitybeforebirth.com/">https://www.equitybeforebirth.com/</a></td>
</tr>
<tr>
<td>Good Shepard Wilmington</td>
<td><a href="https://www.goodshepherdwilmington.org/">https://www.goodshepherdwilmington.org/</a></td>
</tr>
<tr>
<td>GreenLight Fund-Charlotte</td>
<td><a href="https://greenlightfund.org/sites/charlotte/">https://greenlightfund.org/sites/charlotte/</a></td>
</tr>
<tr>
<td>Latin American Coalition</td>
<td><a href="https://latinamericancoalition.org/">https://latinamericancoalition.org/</a></td>
</tr>
<tr>
<td>Mary Reynolds Babcock Foundation</td>
<td><a href="https://www.mrbf.org/">https://www.mrbf.org/</a></td>
</tr>
<tr>
<td>NAACP</td>
<td><a href="https://naacp.org/">https://naacp.org/</a></td>
</tr>
<tr>
<td>NC Coalition Against Domestic Violence</td>
<td><a href="https://nccadv.org/">https://nccadv.org/</a></td>
</tr>
<tr>
<td>NC Council of Churches</td>
<td><a href="https://ncchurches.org/">https://ncchurches.org/</a></td>
</tr>
<tr>
<td>NC Early Childhood Foundation (NCECF)</td>
<td><a href="https://buildthefoundation.org/">https://buildthefoundation.org/</a></td>
</tr>
<tr>
<td>NCCARE360</td>
<td><a href="https://nccare360.org/">https://nccare360.org/</a></td>
</tr>
<tr>
<td>North Carolina Community Action Association</td>
<td><a href="https://www.nccaa.net/">https://www.nccaa.net/</a></td>
</tr>
<tr>
<td>North Carolina Department of Commerce</td>
<td><a href="https://www.commerce.nc.gov/">https://www.commerce.nc.gov/</a></td>
</tr>
<tr>
<td>North Carolina Early Education Coalition</td>
<td><a href="https://nceeducationcoalition.org/">https://nceeducationcoalition.org/</a></td>
</tr>
<tr>
<td>North Carolina Justice Center</td>
<td><a href="https://www.ncjustice.org/">https://www.ncjustice.org/</a></td>
</tr>
<tr>
<td>North Carolina Network of Grantmakers (NCNG)</td>
<td><a href="https://ncgrantmakers.org/">https://ncgrantmakers.org/</a></td>
</tr>
<tr>
<td>North Carolina Poor People’s Campaign A National Call for Moral Revival</td>
<td><a href="https://ppp-nc.org/">https://ppp-nc.org/</a></td>
</tr>
<tr>
<td>Raising Wages NC</td>
<td><a href="https://raisingwagesnc.org/">https://raisingwagesnc.org/</a></td>
</tr>
<tr>
<td>StepUp Durham</td>
<td><a href="https://www.stepupdurham.org/">https://www.stepupdurham.org/</a></td>
</tr>
<tr>
<td>The Duke Endowment</td>
<td><a href="https://www.dukeendowment.org/">https://www.dukeendowment.org/</a></td>
</tr>
<tr>
<td>The Harrelson Center</td>
<td><a href="http://harrelsoncenter.org/">http://harrelsoncenter.org/</a></td>
</tr>
<tr>
<td>Z. Smith Reynolds Foundation</td>
<td><a href="https://www.zsr.org/">https://www.zsr.org/</a></td>
</tr>
</tbody>
</table>
HEALTH Indicator 2: UNEMPLOYMENT

WHAT RESULT DO WE WANT?
All people of working age in North Carolina have equitable pathways to fulfilling employment throughout life.

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.¹

WHAT DOES THIS INDICATOR MEASURE?
- Data are disaggregated by race, gender, county, poverty level, and age group
- Data are from the American Community Survey
- Measures how many of us, aged 16 and older and looking for work, are unemployed
- Survey is administered annually by the U.S. Census Bureau
- This indicator uses 60 months of collected data
  - Example: 2017-2021 ACS 5-year estimates
  - Date collected between: January 1, 2017, and December 31, 2021

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th>BASELINE 2013-2017</th>
<th>RECENT 2017-2021</th>
<th>TARGET 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2%</td>
<td>5.3%</td>
<td>Reduce disparity ratio to 1.7 or lower</td>
</tr>
</tbody>
</table>

HOW ARE WE DOING?
The American Community Survey, 5Y estimated unemployment was 7.2% in 2017. The equivalent rate in 2021 was 5.3%. Comparison can not be made until the 2018-2022 estimate is released.

The disparity ratio between white and other race/ethnicities have not significantly changed during the 2014-2021 time period.
CURRENT DATA TRENDED OVER TIME

Figure 14. Percent of population aged 16 and older who are unemployed but seeking work in North Carolina (2014-2021)

Figure 15. Percent of population aged 16 and older who are unemployed but seeking work in North Carolina by race/ethnicity (2014-2021)

Figure 16. Percent of population aged 20 and older who are unemployed but seeking work in North Carolina by gender (2014-2021)
THE STORY BEHIND THE CURVE

North Carolina needs a plan that “incorporates strategies to build a more resilient economy by focusing on rural communities and equitable, inclusive practices.”

“Typical state economic development plans traditionally focus on issues such as industry recruitment strategies, incentives to encourage business expansion and relocation, support for the development of industrial properties, and state tax policies – all very important activities. Every business survey conducted – nationally and in-state – identifies acquiring and growing the right talent as a crucial factor. The ability to find high-quality employees is essential to a business’s success. It is also what enables individuals and communities to advance their economic situation – making it the single most important issue to ensure North Carolina’s competitiveness.”

“The North Carolina Department of Commerce outlines three goals to guide the state’s strategy:
1. Prepare North Carolina’s workforce for career and entrepreneurial success.
2. Prepare North Carolina’s businesses for success by growing and attracting a talented workforce.
3. Prepare communities across North Carolina to be more competitive in growing and attracting a talented workforce and businesses.”

WHAT OTHER DATA DO WE NEED?

- Amount and sources of post-secondary education support for economically challenged
- Amount of childcare subsidy assistance provided for economically challenged working parents
- Availability of job programs statewide
- Availability of resources for wealth building or financial management opportunities statewide
- Geocoded data showing distribution of broadband internet
- Sources for minority-owned businesses
**WHAT COULD WORK TO TURN THE CURVE?**

The NC SHIP Community Council’s Poverty and Unemployment Work Group is continuing to form and identify priorities for action planning. The following policies were proposed in the 2022 NC SHIP report and are under consideration.

Support people with disabilities and those in recovery, veterans, and reentry populations to live their lives as fully included members of the community by implementing key employment initiatives like Competitive Integrated Employment and Employment First.

### PROPOSED POLICY INITIATIVES

- Create and expand legislation and advocate with employers to provide paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers
- Expand access to higher educational opportunities
- Expand Medicaid eligibility
- Expand the availability and amount of childcare subsidies to reflect the cost of care more adequately
- Expand transit options in rural and low-income communities
- Improve access to personal finance credit scores
- Increase access to broadband internet
- Pass fair chance hiring policies for county and local employees, and work with employers to adopt fair chance hiring policies for themselves
- Shift funding from industrial recruitment to support small businesses and social enterprises
- Support people with disabilities and those in recovery, veterans, and reentry populations to live their lives as fully included members of the community by implementing key employment initiatives like Competitive Integrated Employment and Employment First

### RECOMMENDED READING/LISTENING


### ACTION PLAN

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at [https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm](https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm).

### NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care4Carolina</td>
<td><a href="https://care4carolina.com/all-resources/">https://care4carolina.com/all-resources/</a></td>
</tr>
<tr>
<td>Economic Development Partnership of North Carolina</td>
<td><a href="https://edpnc.com/">https://edpnc.com/</a></td>
</tr>
<tr>
<td>Hinton Rural Life Center</td>
<td><a href="https://www.hintoncenter.org/">https://www.hintoncenter.org/</a></td>
</tr>
<tr>
<td>Just Economics of Western North Carolina</td>
<td><a href="https://www.justeconomicswnc.org/issues/living-wage/">https://www.justeconomicswnc.org/issues/living-wage/</a></td>
</tr>
<tr>
<td>NCCCARE360</td>
<td><a href="https://nccare360.org/">https://nccare360.org/</a></td>
</tr>
<tr>
<td>North Carolina Association of County Directors of Social Services (NCACDSS)</td>
<td><a href="https://www.ncacadss.org/">https://www.ncacadss.org/</a></td>
</tr>
<tr>
<td>North Carolina Community Action Association</td>
<td><a href="https://www.nccaa.net/">https://www.nccaa.net/</a></td>
</tr>
<tr>
<td>North Carolina Department of Commerce</td>
<td><a href="https://www.commerce.nc.gov/">https://www.commerce.nc.gov/</a></td>
</tr>
<tr>
<td>North Carolina Department of Labor</td>
<td><a href="https://www.labor.nc.gov/">https://www.labor.nc.gov/</a></td>
</tr>
<tr>
<td>Open Integration Coalition, Inc.</td>
<td><a href="https://www.oic-inc.com/">https://www.oic-inc.com/</a></td>
</tr>
<tr>
<td>Raising Wages NC</td>
<td><a href="https://raisingwagesnc.org/">https://raisingwagesnc.org/</a></td>
</tr>
<tr>
<td>The Broadband ReConnect Program</td>
<td><a href="https://www.usda.gov/reconnect">https://www.usda.gov/reconnect</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 3: SHORT-TERM SUSPENSIONS

WHAT RESULT DO WE WANT?
All people in North Carolina are supported by a K-12 educational system that values diversity, equity, and inclusion 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.  

WHAT DOES THIS INDICATOR MEASURE?
A short-term suspension means that the student is out-of-school for 10 days or less. The rate is derived from a count of the number of short-term suspensions and may reflect multiple suspensions by one or more students. The data include suspensions across all grades:

- Data are disaggregated by grade, race, gender, socioeconomic status, and disability
- No student level data
- Rates are per 1,000 enrolled students

HNC 2030 HEADLINE INDICATOR:
The short-term suspension rate in middle and high school educational facilities

HOW ARE WE DOING?
In response to the COVID-19 pandemic, starting in March of the 2019-2020 school year and continuing through the 2020-2021 school year, public schools across the state employed unprecedented methods to ensure continued learning by utilizing various modes of instruction and student outreach. As such, caution should be taken when comparing data reported for the 2019-2020 and 2020-2021 school years to data reported for prior and subsequent years.

BASELINE DATA FROM HNC 2030
- BASELINE 2017-2018: 139 per 1,000 enrolled students
- RECENT 2021: 146.6* per 1,000 enrolled students
- TARGET 2030: 80 per 1,000 enrolled students

CURRENT DATA TRENDED OVER TIME

Figure 18. Short-term suspension rate for all acts reported in (2016-2021)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate per 1000 students</td>
<td>137.337</td>
<td>139.0</td>
<td>130.949</td>
<td>97.974</td>
<td>13.259</td>
<td>146.57</td>
</tr>
<tr>
<td>Total Short-term Suspensions</td>
<td>208530</td>
<td>211228</td>
<td>203298</td>
<td>152873</td>
<td>19482</td>
<td>217928</td>
</tr>
<tr>
<td>HNC 2030 Target</td>
<td>80</td>
<td>80</td>
<td>80</td>
<td>80</td>
<td>80</td>
<td>80</td>
</tr>
</tbody>
</table>

Data source: N.C. Department of Public Instruction Consolidated Data Report.
Figure 19. Short-term suspension rate for all acts reported by gender

Data source: N.C. Department of Public Instruction Consolidated Data Report.

Figure 20. Short-term suspension rate by race/ethnicity

Data source: N.C. Department of Public Instruction Consolidated Data Report.
THE STORY BEHIND THE CURVE

“Trauma-informed school-wide interventions are associated with decreased office discipline referrals, physical aggression incidents, and out-of-school suspensions.” Suspensions are often linked to adverse childhood experiences (ACEs). Blodgett & Dorado (2016) reviewed the literature for trauma-informed school practice and alignment with educational practice. Communities with higher ACE scores had “higher rates of suspension and unexcused absences and lower rates of graduation from high school and progression to post-secondary school than communities with relatively low prevalence of ACEs.”

WHAT OTHER DATA DO WE NEED?

• Accurate data for short-term suspensions
• Data tracking for suspensions and expulsions from early childhood programs
• Suspension data for 4- to 7-year-olds

WHAT COULD WORK TO TURN THE CURVE?

The Short-Term Suspensions Work Group identified the following priorities for action planning. Work group members engaged in discussions and review of best practices to reduce the use of school suspensions and expulsions and increase diversity among school and childcare leadership and staff.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disrupt the school-to-prison pipeline, beginning with early childhood programs by reducing the use of school suspensions and expulsions and increasing the use of counseling services and community-based programs and initiatives</td>
<td>Children who are suspended or expelled between birth and age 4 are more likely to experience those forms of exclusionary discipline during their K-12 education, which also makes them more likely to become involved with the criminal justice system as adults (EducationNC, 2022). There are a disproportionate number of black and brown children being pushed out of early childhood education spaces.</td>
</tr>
<tr>
<td>Increase racial, ethnic, gender, and disability status diversity among school and childcare leadership and staff and the institutions that train them</td>
<td>Diversity among school and childcare leadership and staff and the institutions that train them cultivates belonging, affirms identities, and creates more inclusive spaces, including adding credible messengers in schools with lived experiences. Educator diversity benefits all students, regardless of race or ethnicity (The Education Trust, 2022).</td>
</tr>
</tbody>
</table>
LETS SHIFT THE PERSPECTIVE
FROM "WHAT IS WRONG WITH YOU?"
TO "WHAT HAS HAPPENED TO YOU?"
- Blodgett & Dorado, 2016, p. 59

RECOMMENDED READING/LISTENING
EducationNC. (August 2022). Pre-K suspensions and expulsions can have dire effects- but we don't know how common they are. https://www.ednc.org/pre-k-suspensions-expulsions-dire-effects-how-common/.
Governor’s DRIVE Task Force: https://governor.nc.gov/issues/education/drive-task-force

ACTION PLAN
Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm.

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action4Equity</td>
<td><a href="https://www.action4equityws.org/">https://www.action4equityws.org/</a></td>
</tr>
<tr>
<td>Center for Racial Equity in Education (CREED)</td>
<td><a href="https://www.creed-nc.org/">https://www.creed-nc.org/</a></td>
</tr>
<tr>
<td>Education Justice Alliance</td>
<td><a href="https://www.ejanc.org/">https://www.ejanc.org/</a></td>
</tr>
<tr>
<td>EPIC (Empowered Parents in Community)</td>
<td><a href="https://epic-nc.org/">https://epic-nc.org/</a></td>
</tr>
<tr>
<td>Exceptional Children’s Assistance Center (ECAC)</td>
<td><a href="https://www.ecac-parentcenter.org/">https://www.ecac-parentcenter.org/</a></td>
</tr>
<tr>
<td>LatinxEd</td>
<td><a href="https://latinxed.org/">https://latinxed.org/</a></td>
</tr>
<tr>
<td>Legal Aid of North Carolina</td>
<td><a href="https://legalaidnc.org/">https://legalaidnc.org/</a></td>
</tr>
<tr>
<td>Love Our Children NC</td>
<td><a href="https://loveourchildrencnc.org/">https://loveourchildrencnc.org/</a></td>
</tr>
<tr>
<td>National Black Child Development Institute (BCDI)-Charlotte</td>
<td><a href="https://www.bcdi-charlotte.org/">https://www.bcdi-charlotte.org/</a></td>
</tr>
<tr>
<td>NC Child Care Commission</td>
<td><a href="https://ncchildcare.ncdhhs.gov/Home/Child-Care-Commission">https://ncchildcare.ncdhhs.gov/Home/Child-Care-Commission</a></td>
</tr>
<tr>
<td>North Carolina Association of Educators (NCAE)</td>
<td><a href="https://www.ncae.org/">https://www.ncae.org/</a></td>
</tr>
<tr>
<td>North Carolina Department of Instruction (NC DPI)</td>
<td><a href="https://www.dpi.nc.gov/">https://www.dpi.nc.gov/</a></td>
</tr>
<tr>
<td>North Carolina PTA</td>
<td><a href="https://ncpta.org/">https://ncpta.org/</a></td>
</tr>
<tr>
<td>North Carolina School Boards Association</td>
<td><a href="https://www.ncsba.org/">https://www.ncsba.org/</a></td>
</tr>
<tr>
<td>Prevent Child Abuse North Carolina</td>
<td><a href="https://preventchilabusenc.org/">https://preventchilabusenc.org/</a></td>
</tr>
<tr>
<td>Rural Opportunity Institute</td>
<td><a href="https://www.ruralopportunity.org/">https://www.ruralopportunity.org/</a></td>
</tr>
<tr>
<td>Triad Restorative Justice</td>
<td><a href="http://www.triadjr.org/">http://www.triadjr.org/</a></td>
</tr>
<tr>
<td>UNC School of Social Work</td>
<td><a href="https://ssw.unc.edu/">https://ssw.unc.edu/</a></td>
</tr>
<tr>
<td>Village of Wisdom</td>
<td><a href="https://www.villageofwisdom.org/">https://www.villageofwisdom.org/</a></td>
</tr>
<tr>
<td>we are (working to extend anti-racist education)</td>
<td><a href="https://www.weare-nc.org/">https://www.weare-nc.org/</a></td>
</tr>
</tbody>
</table>
WHAT RESULT DO WE WANT?
North Carolina embraces a fair and equitable justice system, free from racism and bias, where safety is foundational to all aspects of a free society, and all communities are free from harm and violence.

WHY IS THIS IMPORTANT?
“People of color, notably African American men, are imprisoned at disproportionate rates and tend to face harsher punishment for similar crimes as their white counterparts. There are enormous health, social, and economic consequences of incarceration for both the imprisoned person, their families, and our communities.”

WHAT DOES THIS INDICATOR MEASURE?
The indicator measures the rate of incarceration for people aged 13 years and older who enter the N.C. prison system during a calendar year. The rates are based on the jurisdictional population with sentences greater than one year. The data are obtained from the N.C. Department of Public Safety Automated Query System which is updated every six months.

HNC 2030 HEADLINE INDICATOR:
Number of people aged 13 and older entering North Carolina prisons per 100,000 population

The data can be disaggregated by:
- Race/Ethnicity
- Gender
- Prison Entries/Prison Exits/Prison Populations
- Age/Age Group
- Citizenship
- Country of Birth
- County of Conviction
- County of Residence
- Crime Category
- Marital Status

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2021</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per 100,000 population</td>
<td>341</td>
<td>167.3</td>
<td>150</td>
</tr>
</tbody>
</table>

HOW ARE WE DOING?
The overall rate of incarceration in N.C. prisons has seen a significant drop from 233 per 100,000 population aged 13 and older in 2014 to 167 /100,000 in 2021. The incarceration rate for females has been stable with only small variations in the rates from 2014-2021. The incarceration rate for males dropped significantly in 2020 to a rate of 293/100,000 population. Black/African American people continue to have higher rates of incarceration than White/Caucasian or Hispanic people. The incarceration rate for Black/African American people was 2.5 times that of White/Caucasian people and 5 times greater than Hispanic people.
CURRENT DATA TRENDED OVER TIME

Figure 22. Incarceration rate in North Carolina prisons (2014 - 2021)


Figure 23. Incarceration rate in North Carolina prisons by race/ethnicity (2014 - 2021)


Figure 24. Incarceration rate in North Carolina prisons by gender (2014 - 2021)

THE STORY BEHIND THE CURVE

According to SAMHSA, an estimated 18% of the general population has a mental illness. However, an estimated 44% of those in jail and 37% of those in prison have a mental illness.\(^2\)

An estimated 11% of the 18- to 25-year-old population, and 6% of those over 25 years old have a substance use disorder. The estimated prevalence of substance use disorder in jails is 63% in jails, and 58% in prisons.\(^3\)

People with these disorders have challenges in getting appropriate treatment and incarceration often exacerbates their symptoms. This can lead to individuals staying incarcerated longer than those without behavioral health concerns. Upon release from incarceration, people with behavioral health issues face many barriers to successful reentry into the community, such as lack of health care, job skills, education, stable housing, and poor connection with community behavioral health providers. These factors may jeopardize their recovery and increase their probability of relapse and re-arrest.\(^4\)

WHAT OTHER DATA DO WE NEED?

- Better data for local jails
- Data not only identifying race but other factors that affect the incarceration rate for those recently jailed or imprisoned: food and housing security, community medical/mental health resources, access to quality early education, local unemployment rate, etc.
- Demographics about people incarcerated or detained by the U.S. Marshals Service (USMS) and Immigration and Customs Enforcement (ICE)
- Descriptive statistics that capture racial equity training provided for court system personnel
- How interactions with school resource officers affect students (This data could be used to improve school-based programs to optimize identifying at risk students early and implementing interventions that decrease to the incarceration rate.)
- Impact of COVID-19 pandemic on prison population
- Inventory of mental health and substance use disorder services (screening and treatment) provided in jail health settings
- Inventory of policies regarding use of force and duty to report excessive use of force at every level of the justice system
- Methodology for reporting racial data in the Administrative Office of the Courts

WHAT COULD WORK TO TURN THE CURVE?

The Incarceration Work Group identified the following priorities for action planning.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure access to behavioral health treatment, adequate medical care, and stable housing for those returning from incarceration</td>
<td>Behavioral health treatment, adequate medical care, and stable housing for those returning from incarceration supports reintegration and reduces the probability of relapse and re-arrest. Many jails are not equipped with the staff or finances to run their own Medication Assisted Treatment (MAT) programs.</td>
</tr>
<tr>
<td>Expand existing or create community Medication Assisted Treatment programs for people with substance use disorder detained in prisons and jails or transitioning to and from prison</td>
<td>Partnering with local entities would allow for improved continuation of care and decrease risky pauses in therapy. Community follow-up is critical for success with MAT programs.</td>
</tr>
<tr>
<td>Improve access to treatment for substance use disorders, physical illnesses, and mental illnesses</td>
<td>To ensure people get adequate, timely treatment in the community which will directly reduce incarceration rates.</td>
</tr>
<tr>
<td>Improve resources and legislation pertaining to jails and prisons to reduce harmful impact of incarceration and foster successful reintegration into the community</td>
<td>Addressing the allocation of resources and tailoring legislation to recognize prisons and jails separately will inherently reduce the harmful impact of incarceration.</td>
</tr>
<tr>
<td>Increase access to multisystemic therapy for juvenile offenders</td>
<td>When multisystemic therapy is viewed as collaboration of various systems to create diversion programs targeting vulnerable age groups, this can reduce the likelihood of recidivism and incarceration and reduce delinquent or antisocial behavior and alcohol and drug use among juvenile offenders.</td>
</tr>
<tr>
<td>Invest in public health alternatives to traditional law enforcement and sentencing, particularly for behavioral health issues</td>
<td>When serious mental health issues are identified along with the propensity for impulsivity, subacute facilities should exist to house individuals before the crime is committed. Adequate support and treatment should be available to those in need. Improved post-release follow-up contributes to reduced recidivism.</td>
</tr>
</tbody>
</table>
“THE DATA SHOW THAT WE ARE GOING IN THE RIGHT DIRECTION, BUT JUST NOT FAST ENOUGH.”
- 2021 NC SHIP Symposia participant

RECOMMENDED READING/LISTENING


ACTION PLAN

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm.

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arise Collective</td>
<td><a href="https://arise-collective.org/">https://arise-collective.org/</a></td>
</tr>
<tr>
<td>Leading Into New Communities (LINC), Inc.</td>
<td><a href="https://www.growingchange.org/">https://www.growingchange.org/</a></td>
</tr>
<tr>
<td>National Council of Juvenile and Family Court Judges</td>
<td><a href="https://linnc.org/">https://linnc.org/</a></td>
</tr>
<tr>
<td>NC Department of Public Safety, Division of Juvenile Justice and Delinquency Prevention</td>
<td><a href="https://www.ncdps.gov/our-organization/juvenile-justice-and-delinquency-prevention">https://www.ncdps.gov/our-organization/juvenile-justice-and-delinquency-prevention</a></td>
</tr>
<tr>
<td>North Carolina Department of Adult Correction</td>
<td><a href="https://www.dac.nc.gov/">https://www.dac.nc.gov/</a></td>
</tr>
<tr>
<td>North Carolina Department of Public Instruction (NC DPI)</td>
<td><a href="https://www.dpi.nc.gov/">https://www.dpi.nc.gov/</a></td>
</tr>
<tr>
<td>North Carolina Harm Reduction Coalition (NCHRC)</td>
<td><a href="https://www.nchrc.org/">https://www.nchrc.org/</a></td>
</tr>
<tr>
<td>North Carolina Justice Academy</td>
<td><a href="https://ncdoj.gov/ncja/">https://ncdoj.gov/ncja/</a></td>
</tr>
<tr>
<td>The National Council of Juvenile and Family Court Judges (NCJCJ)</td>
<td><a href="https://www.njcjcj.org/">https://www.njcjcj.org/</a></td>
</tr>
<tr>
<td>UNC Chapel Hill- NC Formerly Incarcerated Transition (FIT) Program</td>
<td><a href="https://www.med.unc.edu/fammed/service-to-the-community/clinical-care/formerly-incarcerated-transition-program/">https://www.med.unc.edu/fammed/service-to-the-community/clinical-care/formerly-incarcerated-transition-program/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 5: ADVERSE CHILDHOOD EXPERIENCES

WHAT RESULT DO WE WANT?
All children in North Carolina thrive in safe, stable, and nurturing environments.

WHY IS THIS IMPORTANT?
Numerous studies have found a consistently strong relationship between an increasing number of Adverse Childhood Experience (ACEs) and poor health outcomes in adults. While the National Survey of Children’s Health does not capture the timing of ACEs or the onset of poor health outcomes, a similar dose-response relationship is found between ACEs and health outcomes in children. In 2017-2018, the percentage of children with complex or poor physical and social-emotional health increased as the number of parent-reported ACEs increased. For example, 14.3% of children with no ACEs had special health care needs, increasing to 43.5% among children with four or more ACEs. The same pattern was found between number of ACEs and poorly rated physical health, difficulty making and keeping friends, behavior or conduct problems, anxiety, and depression.¹

HNC 2030 HEADLINE INDICATOR:
Percent of children with two or more adverse childhood experiences

WHAT DOES THIS INDICATOR MEASURE?
Indicator is percentage of children having experienced at least two of the following:
- Parent/guardian divorced or separated
- Parent/guardian died
- Parent/guardian served time in jail
- Saw or heard parents or adults slap, hit, kick, punch one another in the home
- Was a victim of violence or witnessed violence in his or her neighborhood
- Lived with anyone who was mentally ill, suicidal, or severely depressed
- Lived with anyone who had a problem with alcohol or drugs
- Was treated or judged unfairly because of his or her race or ethnic group

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th></th>
<th>Baseline 2016-2017</th>
<th>Recent 2020-2021</th>
<th>Target 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23.6%</td>
<td>17.8%</td>
<td>18.0%</td>
</tr>
</tbody>
</table>

Reported in 2018 using 2015 data

HOW ARE WE DOING?
The data from the National Survey of Children’s Health are weighted to be representative of the United States population of non-institutionalized children ages 0-17. Caution should be used in interpreting trend data. Multi-year estimates are not an exact average of single year estimates since weighted population sizes change from year to year. Even multi-year estimates may obscure the precise timing of trend changes.

- Overall, the estimate of two or more adverse childhood experiences has decreased from 23.6% (2016-2017) to 17.8% (2020-2021).
- Data for race/ethnicity show that the highest percentage of adverse childhood experiences are reported for Black/African American and “other.” The percentage is almost twice as high for these race/ethnicity groups compared to White/Caucasian group.
- A slight increase in percentages for females was reported in both 2018-2019 and 2020-2021 estimates. Caution should be used in interpreting reported adverse childhood experiences across genders due to the range of confidence intervals.
- The data suggest an association between family household income and the percentage of adverse childhood experiences reported.

“COMMUNITY-ROOTED, CULTURALLY AFFIRMING FAMILY AND COMMUNITY SUPPORT PROGRAMS CREATE Safe, STABLE, AND NURTURING ENVIRONMENTS FOR ALL CHILDREN TO THRIVE.”
- Dr. Wanda Boone, CEO, Together for Resilient Youth
CURRENT DATA TRENDED OVER TIME

Figure 25. Percent of children with two or more adverse childhood experiences in North Carolina (2016 - 2021)

Percentages and population estimates are weighted to represent child population in the United States of America. Data source: National Survey of Children's Health (NSCH) (census.gov), 2 year estimate.

Figure 26. Percent of children with two or more adverse childhood experiences in North Carolina by gender (2016 - 2021)

Percentages and population estimates are weighted to represent child population in the United States of America. Data source: National Survey of Children's Health (NSCH) (census.gov), 2 year estimate.

Figure 27. Percent of children with two or more adverse childhood experiences in North Carolina by race/ethnicity (2016 - 2021)

Percentages and population estimates are weighted to represent child population in the United States of America. Data source: National Survey of Children's Health (NSCH) (census.gov), 2 year estimate.
ADVERSE CHILDHOOD EXPERIENCES

THE STORY BEHIND THE CURVE

“Childhood adversity changes our biological systems – those with higher ACE scores have greater health risks over the course of a lifetime.”

Research consistently shows that ACEs are common.

“Historical and ongoing traumas due to systemic racism and discrimination or the impacts of multigenerational poverty resulting from limited educational and economic opportunities intersect and exacerbate the experience of other ACEs, leading to disproportionate effects in certain populations (Nurious, Logan-Greene, and Green, 2012, as cited in CDC, 2020)."

WHAT OTHER DATA DO WE NEED?

• Children’s mental services
• Current and accurate local data on Adverse Childhood Experiences (ACEs) and Positive Childhood Experiences (PCEs) at the county, zip code, and/or census tract level
• Data linking schools and youth performance in socially vulnerable areas
• Food insecurity
• Housing instability
• Interpersonal violence
• Lack of transportation

WHAT COULD WORK TO TURN THE CURVE?

The Adverse Childhood Experiences Work Group identified the following priorities for action planning. Work group members engaged in discussions and review of best practices and resources related to community-led solutions and data. The work group recognizes there is a strong correlation between poverty and ACEs. Strategies that reduce poverty, such as increasing employment opportunities with living wages and affordable housing reduce stress on families, which results in preventing many of the ACEs.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve data available on trauma and ACEs at the local level</td>
<td>Local data allow communities to identify services or resources needed to prevent ACEs and build resilience.</td>
</tr>
<tr>
<td>Increase funding for and embed community-rooted, culturally affirming family and community support programs into existing initiatives</td>
<td>Community-led solutions are led by, look like, and inclusive of the voice of the community. Increased funding is needed to embed culturally affirming programs into the work already being done by communities to create safe, stable, and nurturing environments for all children to thrive.</td>
</tr>
</tbody>
</table>
RECOMMENDED READING/LISTENING

Building Better Childhoods Toolkit: [https://buildingbetterchildhoods.org/](https://buildingbetterchildhoods.org/)

Building Healthy & Resilient Communities Across North Carolina: One Community at a Time: [https://indd.adobe.com/view/f9cca8b9-d326-4666-99d0-afe7ea06bd73](https://indd.adobe.com/view/f9cca8b9-d326-4666-99d0-afe7ea06bd73)


Family Violence Prevention and Services Act (FVPSA): Background and Funding: [https://sgp.fas.org/crs/misc/R42838.pdf](https://sgp.fas.org/crs/misc/R42838.pdf)

Healthy & Resilient Communities Dashboard: [https://www.smartstart.org/healthy-resilient-communities-dashboard-launched/](https://www.smartstart.org/healthy-resilient-communities-dashboard-launched/)

ACTION PLAN

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at [https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm](https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm).

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action4Equity</td>
<td><a href="https://www.action4equityws.org/">https://www.action4equityws.org/</a></td>
</tr>
<tr>
<td>CaroNova</td>
<td><a href="https://caronova.org/">https://caronova.org/</a></td>
</tr>
<tr>
<td>Center for Trauma Resilient Communities</td>
<td><a href="https://www.crossnore.org/center-for-trauma-resilient-communities/">https://www.crossnore.org/center-for-trauma-resilient-communities/</a></td>
</tr>
<tr>
<td>EarlyWell Initiative</td>
<td><a href="https://ncchild.org/intro-earlywell/">https://ncchild.org/intro-earlywell/</a></td>
</tr>
<tr>
<td>Empowered Parents in Community (EPIC)</td>
<td><a href="https://epic-nc.org/">https://epic-nc.org/</a></td>
</tr>
<tr>
<td>Equity Before Birth (EEB)</td>
<td><a href="https://www.equitybeforebirth.com/">https://www.equitybeforebirth.com/</a></td>
</tr>
<tr>
<td>Get Happy</td>
<td><a href="https://www.gethappync.org/">https://www.gethappync.org/</a></td>
</tr>
<tr>
<td>Healthy &amp; Resilient Communities Initiative (NCHRCI)</td>
<td><a href="https://www.smartstart.org/resilience-intro/">https://www.smartstart.org/resilience-intro/</a></td>
</tr>
<tr>
<td>MDC</td>
<td><a href="https://www.mdcinc.org/">https://www.mdcinc.org/</a></td>
</tr>
<tr>
<td>Mobilizing African American Mothers through Empowerment</td>
<td><a href="https://maameinc.org/">https://maameinc.org/</a></td>
</tr>
<tr>
<td>NC Child</td>
<td><a href="https://ncchild.org/">https://ncchild.org/</a></td>
</tr>
<tr>
<td>NC Council for Women &amp; Youth Involvement</td>
<td><a href="https://ncadmin.nc.gov/divisions/council-women-youth">https://ncadmin.nc.gov/divisions/council-women-youth</a></td>
</tr>
<tr>
<td>NC Department of Public Instruction (DPI) Office of Academic Standards</td>
<td><a href="https://www.dpi.nc.gov/districts-schools/classroom-resources/academic-standards">https://www.dpi.nc.gov/districts-schools/classroom-resources/academic-standards</a></td>
</tr>
<tr>
<td>North Carolina Coalition Against Domestic Violence (NCCADV)</td>
<td><a href="https://nccadv.org/">https://nccadv.org/</a></td>
</tr>
<tr>
<td>Our Children’s Place of Coastal Horizons</td>
<td><a href="https://coastalhorizons.org/services/justice-services/our-childrens-place/">https://coastalhorizons.org/services/justice-services/our-childrens-place/</a></td>
</tr>
<tr>
<td>Prevent Child Abuse North Carolina</td>
<td><a href="https://preventchildabusenc.org/">https://preventchildabusenc.org/</a></td>
</tr>
<tr>
<td>Public School Forum of North Carolina</td>
<td><a href="https://www.ncforum.org/">https://www.ncforum.org/</a></td>
</tr>
<tr>
<td>Resources for Resilience</td>
<td><a href="https://resourcesforresilience.com/">https://resourcesforresilience.com/</a></td>
</tr>
<tr>
<td>Smart Start</td>
<td><a href="https://www.smartstart.org/">https://www.smartstart.org/</a></td>
</tr>
<tr>
<td>StandUp-SpeakOut NC</td>
<td><a href="https://susonc.org/">https://susonc.org/</a></td>
</tr>
<tr>
<td>Together for Resilient Youth (TRY)</td>
<td><a href="https://try4resilience.org/">https://try4resilience.org/</a></td>
</tr>
<tr>
<td>UNC Chapel Hill- Injury Prevention Research Center</td>
<td><a href="https://iprc.unc.edu/">https://iprc.unc.edu/</a></td>
</tr>
<tr>
<td>UNC Gillings School of Global Public Health</td>
<td><a href="https://sph.unc.edu/">https://sph.unc.edu/</a></td>
</tr>
<tr>
<td>UNC School of Social Work</td>
<td><a href="https://ssw.unc.edu/">https://ssw.unc.edu/</a></td>
</tr>
<tr>
<td>Village of Wisdom</td>
<td><a href="https://www.villageofwisdom.org/">https://www.villageofwisdom.org/</a></td>
</tr>
<tr>
<td>YWCA of Asheville</td>
<td><a href="https://www.ywcaofasheville.org/">https://www.ywcaofasheville.org/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 6: THIRD GRADE READING PROFICIENCY

WHAT RESULT DO WE WANT?
All children in North Carolina can discover the joy of reading at an early age and are supported in the home, school, and community to be lifelong readers.

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.1

WHAT DOES THIS INDICATOR MEASURE?
The percentage of children grades three through five who have achieved a three or higher on END OF GRADE (EOG) testing for reading. A score of three is the minimum score required to be considered proficient.

Data are disaggregated by grade, race, gender, socioeconomic status, and disability.

The indicator uses NC Department of Public Instruction (DPI) percentages already calculated in the available DPI data set. Numerators and denominators are also available, along with a masking variable for proficiencies below 5%, proficiencies 95% or higher, and small denominators (<10).

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th>BASELINE 2018-2019</th>
<th>RECENT 2021</th>
<th>TARGET 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>56.8%</td>
<td>46.0%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

CURRENT DATA TRENDED OVER TIME

Figure 29. Percent of children who are proficient in reading at the end of third grade across populations in North Carolina

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>76%</td>
<td>72%</td>
<td>62%</td>
<td>52%</td>
<td>42%</td>
<td>41%</td>
</tr>
<tr>
<td>70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Disaggregated proficiency data reveal that low income, racial bias and inequity, disability, homelessness, and child abuse/neglect continue to create barriers to opportunity for North Carolina’s children.3
- Persistent racial disparities in NC’s third grade reading scores have changed little over the years.4

A STRONG EARLY EDUCATION SYSTEM SUPPORTS OUR CURRENT WORKFORCE AND BUILDS A WORKFORCE FOR NORTH CAROLINA’S FUTURE. - Child Care for NC: United for Change

HNC 2030 HEADLINE INDICATOR:
Percent of children reading at a proficient level or above based on third grade End-of-Grade exams in North Carolina

"A STRONG EARLY EDUCATION SYSTEM SUPPORTS OUR CURRENT WORKFORCE AND BUILDS A WORKFORCE FOR NORTH CAROLINA’S FUTURE." - Child Care for NC: United for Change

Data Source: North Carolina Department of Public Instruction
THE STORY BEHIND THE CURVE

Dialogue from the 2022 NC SHIP Community Council Meeting and Symposia:

- Reading scores have been declining for over a decade
- Young children do not receive enough instruction in phonics to become fluent readers
- Fluency improves comprehension
- Reading is taught in a vacuum without giving students an opportunity to learn reading in science and history
- Home reading habits have deteriorated
- Cuts in spending for education generally mean cuts to personnel

“In 2019, results on national and international exams showed stagnant or declining American performance in reading and widening gaps between high and low performers. The causes are multifaceted, but many experts point to a shortage of educators trained in phonics and phonemic awareness — the foundational skills of linking the sounds of spoken English to the letters that appear on the page. The pandemic has compounded those issues.”
THIRD GRADE READING PROFICIENCY

WHAT OTHER DATA DO WE NEED?

- How per student spending and teacher pay in NC compares to other states.
- How much North Carolina spends per student each year.
- Factors that influence teacher recruitment and retention in NC.

WHAT COULD WORK TO TURN THE CURVE?

The Third Grade Reading Proficiency Work Group identified the following priority for action planning. Work group members engaged in discussions and review of best practices and resources related to reinforcing the talent pipeline for educators.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinforce the talent pipeline for early educators for children from birth through third grade by increasing compensation through dedicated funding, ensuring pay parity, and sustaining investments in training and professional development</td>
<td>High-quality early care and learning is connected to third grade reading outcomes and has been prioritized by multi-sector stakeholders as an action area to improve proficiency (NC Pathways to Grade-Level Reading Initiative, 2019). A strong early education system also supports the current and future workforce to provide high-quality learning opportunities for all children to learn, grow, and succeed. Without increased investment in early educators, there will continue to be low compensation, high turnover, and a dwindling workforce pipeline (Child Care for NC: United for Change, 2023).</td>
</tr>
</tbody>
</table>

RECOMMENDED READING/LISTENING

Child Care for NC: United for Change: [https://childcarefornc.org/](https://childcarefornc.org/)
General Assembly of NC- House Bill 483- Auto Subsidy Eligibility/Childcare Teacher/Pilot: [https://www.ncleg.gov/Sessions/2023/Bills/House/PDF/H483v0.pdf](https://www.ncleg.gov/Sessions/2023/Bills/House/PDF/H483v0.pdf)

ACTION PLAN

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at [https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm](https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm).

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Book Harvest</td>
<td><a href="https://bookharvest.org/">https://bookharvest.org/</a></td>
</tr>
<tr>
<td>Care and Learning (CandL) Coalition</td>
<td><a href="https://buildthefoundation.org/2022/07/candl-pilot-listening-sessions/">https://buildthefoundation.org/2022/07/candl-pilot-listening-sessions/</a></td>
</tr>
<tr>
<td>Child Care Services Association (CCSA)</td>
<td><a href="https://www.childcareservices.org/">https://www.childcareservices.org/</a></td>
</tr>
<tr>
<td>MomsRising</td>
<td><a href="https://www.momsrising.org/campaigns/north-carolina">https://www.momsrising.org/campaigns/north-carolina</a></td>
</tr>
<tr>
<td>National Black Child Development Institute (NBCDI)- Charlotte</td>
<td><a href="https://www.bcdi-charlotte.org/">https://www.bcdi-charlotte.org/</a></td>
</tr>
<tr>
<td>National Domestic Workers Alliance</td>
<td><a href="https://www.domesticworkers.org/">https://www.domesticworkers.org/</a></td>
</tr>
<tr>
<td>NC Campaign for Grade-Level Reading</td>
<td><a href="https://buildthefoundation.org/initiative/campaign-for-grade-level-reading/">https://buildthefoundation.org/initiative/campaign-for-grade-level-reading/</a></td>
</tr>
<tr>
<td>NC Chamber</td>
<td><a href="https://ncchamber.com/">https://ncchamber.com/</a></td>
</tr>
<tr>
<td>NC Child</td>
<td><a href="https://ncchild.org/">https://ncchild.org/</a></td>
</tr>
<tr>
<td>NC Department of Public Instruction Office of Early Learning (OEL)</td>
<td><a href="https://www.dpi.nc.gov/districts-schools/classroom-resources/office-early-learning-oel">https://www.dpi.nc.gov/districts-schools/classroom-resources/office-early-learning-oel</a></td>
</tr>
<tr>
<td>NC Early Childhood Foundation</td>
<td><a href="https://buildthefoundation.org/">https://buildthefoundation.org/</a></td>
</tr>
<tr>
<td>NC Early Education Coalition</td>
<td><a href="https://nceeducationcoalition.org/">https://nceeducationcoalition.org/</a></td>
</tr>
<tr>
<td>NC Head Start Association</td>
<td><a href="https://headstartnc.org/">https://headstartnc.org/</a></td>
</tr>
<tr>
<td>NCDHHS Division of Child Development and Early Education</td>
<td><a href="https://ncchildcare.ncdhhs.gov/">https://ncchildcare.ncdhhs.gov/</a></td>
</tr>
<tr>
<td>Reach Out and Read Carolinas</td>
<td><a href="https://www.rorcarolinas.org/">https://www.rorcarolinas.org/</a></td>
</tr>
<tr>
<td>Smart Start</td>
<td><a href="https://www.smartstart.org/">https://www.smartstart.org/</a></td>
</tr>
<tr>
<td>The Hunt Institute</td>
<td><a href="https://hunt-institute.org/">https://hunt-institute.org/</a></td>
</tr>
<tr>
<td>Think Babies NC Alliance</td>
<td><a href="https://ncearlyeducationcoalition.org/think-babies-nc/">https://ncearlyeducationcoalition.org/think-babies-nc/</a></td>
</tr>
</tbody>
</table>
STATE HEALTH IMPROVEMENT PLAN

HNC 2030 Indicators

PHYSICAL ENVIRONMENT FACTORS

Access to Exercise Opportunities.................................60-63

Limited Access to Healthy Foods.................................64-69

Severe Housing Problems ...........................................70-73
HEALTH INDICATOR 7: ACCESS TO EXERCISE OPPORTUNITIES

WHAT RESULT DO WE WANT?
All people in North Carolina have equitable and adaptive/adaptable access to physical activity opportunities across the lifespan.

WHY IS THIS IMPORTANT?
Exercise is essential for physical, social, and mental well-being. All North Carolina residents need equitable access to safe areas where they can be physically active. Equitable community environments support physical activity behaviors and provide safe exercise opportunities for the entire community. These spaces should be crime-free and accessible by public transit. They should also include safe and well-lit sidewalks, walking trails, greenways, and bike lanes.1,2,3

Access to safe exercise space has been highly correlated to a community’s increased level of physical activity.4 Among adolescents, access has been shown to increase time spent in vigorous physical activity, and to lower obesity rates.5

Regular physical activity decreases risk for premature morbidity and mortality. Regular exercise habits have been linked to improved brain health and balance in elderly populations. It can lower risk for obesity, depression, anxiety, and dementia. Conversely, lack of physical activity can lead to serious chronic diseases, including cancer, diabetes, and heart disease. To reduce risk of chronic disease, the Centers for Disease Control and Prevention (CDC) recommends that adults engage in 150 minutes of physical exercise/physical activity per week, and children engage in a minimum of 60 minutes of physical exercise per day.6,7

WHAT DOES THIS INDICATOR MEASURE?
Access to exercise opportunities measures the percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Individuals are considered to have access to exercise opportunities if they:

• reside in a census block that is within a half mile of a park, or
• reside in an urban census block that is within one mile of a recreational facility, or
• reside in a rural census block that is within three miles of a recreational facility.

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th></th>
<th>BASELINE 2010/2018</th>
<th>RECENT 2020/2022</th>
<th>TARGET 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>73%</td>
<td>75%</td>
<td>92%</td>
</tr>
</tbody>
</table>

Reported in 2019 for 2010/2018 data

HOW ARE WE DOING?

• The HNC 2030 target seeks to increase access to exercise opportunities from 73% to 92% by 2030.
• The measure is not inclusive of all exercise opportunities within a community. For instance, sidewalks, which serve as locations for running or walking; malls, which may have walking clubs; and schools, which may have gyms open to community members, are not able to be captured in the measure.

• This measure is not appropriate for measuring progress. The data sources and definitions have changed over time, making them incomparable.
CURRENT DATA

Figure 32. Percent of people with access to exercise opportunities in North Carolina (2022)

Data Source: Access to Exercise Opportunities | County Health Rankings & Roadmaps

THE STORY BEHIND THE CURVE

Multiple factors can impact individual access to exercise opportunities. These factors include income, race/ethnicity, geography, and disabilities. Low-income communities may have fewer parks recreational facilities, in contrast to more affluent communities. People of color are less likely to live near parks. Compared to metropolitan populations, residents of rural areas face additional barriers to activity opportunities. Finally, parks and recreational facilities may lack appropriate accommodations for individuals with physical disabilities, rendering these areas inaccessible to this population.

Dialogue from the 2022 NC State Health Improvement Plan Community Council Meeting and Symposia

- How is equity defined and how do you measure it?
- How is accessibility defined and how do you measure it?
- How is the impact of infrastructure, like walking trails, measured?
- There is a grading system for community parks that uses a check list and looks at who has access, whether equipment is ADA, whether wheelchair swings are available, safety condition and disrepair of the equipment, and timing of those who are using the park.

Policies and investment are needed to support development and expansion of community parks, transit options, sidewalk improvements, and to increase the number of greenways, walking trails and bike paths.

Community partners such as childcare facilities, schools, churches, and workplaces provide essential services and infrastructure, in promoting access to physical activities. Supporting the efforts of these entities can improve access for all residents. The COVID-19 pandemic affected physical access to facilities and interrupted the efforts of some community partnerships. Improved capabilities for partnering and providing for safe distancing will help to promote the reemergence and increased potential for robust equitable access to exercise opportunities for all.

WHAT OTHER DATA DO WE NEED?

- Asset mapping of existing ride share programs
- Available bike and pedestrian plans
- Communities adopting complete street plans
- Findings of walk audits
- Long-term equitable funding for sidewalks, bike trails and lanes, walking trails, and greenways
- Miles of sidewalks built, trails, and bicycle infrastructure
- Reporting of unsafe sidewalks, bike trails and lanes, walking trails, and greenways
WHAT COULD WORK TO TURN THE CURVE?

The Access to Exercise Opportunities Work Group recommended an updated focus from access to exercise opportunities to access to physical activity opportunities to be more inclusive, as physical activity refers to any bodily movement that requires energy. This is aligned with CDC’s shift toward more inclusive and holistic language such as physical activity and movement.

The Work Group identified the following priorities for action planning related to safe and well-lit sidewalks, bike trails and lanes, walking trails, greenways, and multi-modal transit options.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase, promote, improve, and maintain the number of safe and well-lit sidewalks, bike trails and lanes, walking trails, and greenways to improve connectivity and accessibility</td>
<td>Safe, accessible, and well-maintained lit sidewalks, bike trails and lanes, walking trails, and greenways create opportunities for physical activity. Improving connectivity of sidewalks, trails, lanes, and greenways encourages walking and biking in communities. Promoting existing sidewalks, bike trails and lanes, walking trails, and greenways increases community awareness and opportunities to connect to wider transportation networks. Ongoing improvements and maintenance are needed to ensure safety and accessibility.</td>
</tr>
<tr>
<td>Promote, sustain, and expand multimodal transportation options to increase access to places for physical activity</td>
<td>Multimodal transportation options increase access, enhance quality of life, and ensure safety (NCDOT, 2023). Multimodal transportation options include walking, biking, transit, rail, cars, and trucks.</td>
</tr>
</tbody>
</table>

RECOMMENDED READING/LISTENING


CDC Active People Healthy Nation: https://www.cdc.gov/physicalactivity/activepeoplehealthynation/index.html

CDC Moving Matters Communication Campaign: https://www.cdc.gov/physicalactivity/activepeoplehealthynation/moving-matters.html


ChangeLab Solutions - The Planner’s Playbook: a community-centered approach to improving health and equity: https://www.changelabsolutions.org/product/planners-playbook

Connect Beyond- A Regional Mobility Initiative: https://www.connect-beyond.com/


North Carolina Department of Transportation- Complete Streets Policy: https://www.ncdot.gov/divisions/integrated-mobility/multimodal-planning/

North Carolina Department of Transportation- Integrated Mobility Division: https://www.ncdot.gov/divisions/integrated-mobility

ACTION PLAN

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm.

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance of Disability Advocates</td>
<td><a href="https://adanc.org/services/advocacy/">https://adanc.org/services/advocacy/</a></td>
</tr>
<tr>
<td>American Association of Retired Persons (AARP) Livable Communities</td>
<td><a href="https://www.aarp.org/livable-communities/">https://www.aarp.org/livable-communities/</a></td>
</tr>
<tr>
<td>BikeWalkNC</td>
<td><a href="https://www.bikewalknc.org/">https://www.bikewalknc.org/</a></td>
</tr>
<tr>
<td>Blue Cross Blue Shield Foundation</td>
<td><a href="https://www.bcbsncfoundation.org/">https://www.bcbsncfoundation.org/</a></td>
</tr>
<tr>
<td>Boy Scouts of America (Multiple councils across NC)</td>
<td><a href="https://www.scouting.org/">https://www.scouting.org/</a></td>
</tr>
<tr>
<td>Boys &amp; Girls Clubs of North Carolina</td>
<td><a href="https://www.ncclubs.org/">https://www.ncclubs.org/</a></td>
</tr>
<tr>
<td>Bull City Fit</td>
<td><a href="https://www.bullcityfit.com/">https://www.bullcityfit.com/</a></td>
</tr>
<tr>
<td>Centralina Regional Council</td>
<td><a href="https://centralina.org/">https://centralina.org/</a></td>
</tr>
<tr>
<td>Children Wellness Initiative Network (WIN) - Walk Cabarrus</td>
<td><a href="https://walkcabarrus.com/our-mission/">https://walkcabarrus.com/our-mission/</a></td>
</tr>
<tr>
<td>Children's Healthy Weight Research (CHWR)- UNC Center for Health Promotion and Disease Prevention</td>
<td><a href="https://chwr.web.unc.edu/">https://chwr.web.unc.edu/</a></td>
</tr>
<tr>
<td>Durham Parks &amp; Recreation (DPR)</td>
<td><a href="https://www.dprplaymore.org/">https://www.dprplaymore.org/</a></td>
</tr>
</tbody>
</table>
**ACCESS TO EXERCISE OPPORTUNITIES**

"ADOPTING A COMPLETE STREETS POLICY SECURES INFRASTRUCTURE AND IMPROVES CONNECTIVITY AND ACCESSIBILITY FOR SIDEWALKS, BIKE TRAILS AND LANES, WALKING TRAILS, AND GREENWAYS."

- 2022-2023 NC SHIP Access to Exercise Opportunities Work Group

### NC PARTNERS WHO CAN HELP US CONTINUED

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eat Smart Move More North Carolina</td>
<td><a href="https://www.eatsmartmovemorenc.com/">https://www.eatsmartmovemorenc.com/</a></td>
</tr>
<tr>
<td>Edgecombe, Craven Area Rural Transit System (CARTS)</td>
<td><a href="https://www.cravencountync.gov/165/Transportation-CARTS">https://www.cravencountync.gov/165/Transportation-CARTS</a></td>
</tr>
<tr>
<td>Girl Scouts of the USA (Multiple councils across NC)</td>
<td><a href="https://www.girlscouts.org/">https://www.girlscouts.org/</a></td>
</tr>
<tr>
<td>Go NAPSACC (Nutrition and Physical Activity Self-Assessment for Child Care)</td>
<td><a href="https://gonapsacc.org/">https://gonapsacc.org/</a></td>
</tr>
<tr>
<td>Great Trails State Coalition</td>
<td><a href="https://greattrailsstatecoalition.org/">https://greattrailsstatecoalition.org/</a></td>
</tr>
<tr>
<td>Kate B. Reynolds Charitable Trust</td>
<td><a href="https://kbr.org/">https://kbr.org/</a></td>
</tr>
<tr>
<td>Kids in Parks</td>
<td><a href="https://www.kidsparks.com/">https://www.kidsparks.com/</a></td>
</tr>
<tr>
<td>Lumber River Council of Governments</td>
<td><a href="https://www.lumberrivercog.org/">https://www.lumberrivercog.org/</a></td>
</tr>
<tr>
<td>MDC</td>
<td><a href="https://www.mdcinc.org/">https://www.mdcinc.org/</a></td>
</tr>
<tr>
<td>National Recreation and Park Association</td>
<td><a href="https://www.nrpa.org/">https://www.nrpa.org/</a></td>
</tr>
<tr>
<td>NC Alliance for Safe Transportation</td>
<td><a href="https://www.besafencog.org/">https://www.besafencog.org/</a></td>
</tr>
<tr>
<td>NC Alliance of Metropolitan Planning Organizations</td>
<td><a href="https://www.ncampo.org/">https://www.ncampo.org/</a></td>
</tr>
<tr>
<td>NC Council of Churches</td>
<td><a href="https://www.ncchurches.org/">https://www.ncchurches.org/</a></td>
</tr>
<tr>
<td>NC Department of Health and Human Services-Division of Public Health, Community and Clinical Connections for Prevention and Health Branch</td>
<td><a href="https://www.communityclinicalconnections.com/">https://www.communityclinicalconnections.com/</a></td>
</tr>
<tr>
<td>NC Department of Natural and Cultural Resources</td>
<td><a href="https://www.dncr.nc.gov/">https://www.dncr.nc.gov/</a></td>
</tr>
<tr>
<td>NC Governor’s Highway Safety Program</td>
<td><a href="https://www.ncdot.gov/Initiatives-policies/safety/ghsp">https://www.ncdot.gov/Initiatives-policies/safety/ghsp</a></td>
</tr>
<tr>
<td>NC Main Street &amp; Rural Planning Center (Dept. Commerce)</td>
<td><a href="https://www.commerce.nc.gov/about-us/divisions-programs/rural-economic-development-division/nc-main-street-rural-planning-center">https://www.commerce.nc.gov/about-us/divisions-programs/rural-economic-development-division/nc-main-street-rural-planning-center</a></td>
</tr>
<tr>
<td>NC Rural Center</td>
<td><a href="https://www.ncruralcenter.org/">https://www.ncruralcenter.org/</a></td>
</tr>
<tr>
<td>NC State Design National Learning Initiative</td>
<td><a href="https://naturalearning.org/">https://naturalearning.org/</a></td>
</tr>
<tr>
<td>NC State Extension- Agricultural &amp; Human Sciences</td>
<td><a href="https://cals.ncsu.edu/agricultural-and-human-sciences/about/">https://cals.ncsu.edu/agricultural-and-human-sciences/about/</a></td>
</tr>
<tr>
<td>NC State Extension- Steps to Health</td>
<td><a href="https://ncstepstohealth.ces.ncsu.edu/">https://ncstepstohealth.ces.ncsu.edu/</a></td>
</tr>
<tr>
<td>NCDOT- Integrated Mobility Division</td>
<td><a href="https://www.ncdot.gov/divisions/integrated-mobility/">https://www.ncdot.gov/divisions/integrated-mobility/</a></td>
</tr>
<tr>
<td>North Carolina Association of Metropolitan Planning Organizations</td>
<td><a href="https://www.ncampo.org/mpos/">https://www.ncampo.org/mpos/</a></td>
</tr>
<tr>
<td>North Carolina Department of Transportation (NCDOT)</td>
<td><a href="https://www.ncdot.gov/">https://www.ncdot.gov/</a></td>
</tr>
<tr>
<td>North Carolina Recreation and Park Association (NCRPA)</td>
<td><a href="https://www.ncrpa.net/">https://www.ncrpa.net/</a></td>
</tr>
<tr>
<td>Piedmont Land Conservancy</td>
<td><a href="https://www.piedmontland.org/">https://www.piedmontland.org/</a></td>
</tr>
<tr>
<td>Poe Center for Health Education</td>
<td><a href="https://www.poehealth.org/">https://www.poehealth.org/</a></td>
</tr>
<tr>
<td>Rails-to-Trails Conservancy</td>
<td><a href="https://www.railstotrails.org/">https://www.railstotrails.org/</a></td>
</tr>
<tr>
<td>Safe Routes to School</td>
<td><a href="https://www.ncdot.gov/divisions/integrated-mobility/safety/Pages/safe-routes-school.aspx">https://www.ncdot.gov/divisions/integrated-mobility/safety/Pages/safe-routes-school.aspx</a></td>
</tr>
<tr>
<td>Smart Start</td>
<td><a href="https://www.smartstart.org/">https://www.smartstart.org/</a></td>
</tr>
<tr>
<td>Sustain Charlotte</td>
<td><a href="https://www.sustaincharlotte.org/">https://www.sustaincharlotte.org/</a></td>
</tr>
<tr>
<td>The Capital Area Metropolitan Planning Organization</td>
<td><a href="https://www.campo-nc.us/">https://www.campo-nc.us/</a></td>
</tr>
<tr>
<td>The Trust for Public Land</td>
<td><a href="https://www.tpl.org/">https://www.tpl.org/</a></td>
</tr>
<tr>
<td>The Walking Classroom</td>
<td><a href="https://www.thewalkingclassroom.org/">https://www.thewalkingclassroom.org/</a></td>
</tr>
<tr>
<td>UNC Highway Safety Research Center</td>
<td><a href="https://www.hsrc.unc.edu/">https://www.hsrc.unc.edu/</a></td>
</tr>
<tr>
<td>UNC Injury Prevention Research Center</td>
<td><a href="https://iprnc.unc.edu/">https://iprnc.unc.edu/</a></td>
</tr>
<tr>
<td>University of North Carolina at Chapel Hill- Center for Health Promotion and Disease Prevention</td>
<td><a href="https://hpdp.unc.edu/">https://hpdp.unc.edu/</a></td>
</tr>
<tr>
<td>University of North Carolina Wilmington- Community Engagement, College of Health and Human Services</td>
<td><a href="https://uncw.edu/academics/colleges/chhs/community-engagement/">https://uncw.edu/academics/colleges/chhs/community-engagement/</a></td>
</tr>
<tr>
<td>Vision Zero Network</td>
<td><a href="https://visionzeronetwork.org/">https://visionzeronetwork.org/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 8: LIMITED ACCESS TO HEALTHY FOODS

WHAT RESULT DO WE WANT?
All people in North Carolina have equitable access to affordable, nutritious, culturally appropriate foods.

WHY IS THIS IMPORTANT?
• Access to foods that support healthy eating patterns contributes to an individual’s health throughout his or her life.
• Healthy eating habits include controlling calories; eating a variety of foods and beverages from all the food groups; and limiting intake of saturated and trans fats, added sugars, and sodium. Healthy eating can help lower the risk for chronic disease.
• Evidence also shows that poor nutrition and an unhealthy diet are risk factors for high blood pressure, diabetes, and cancer. According to the 2015 - 2020 Dietary Guidelines for Americans, healthy eating patterns include: a variety of vegetables; fruits, especially whole fruits; grains, at least half of which are whole grains; fat-free or low-fat dairy; protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), unsalted nuts and seeds, and soy products; and oils.
• Some research has shown that increased access to healthy foods corresponds with healthier dietary practices.

Source: Healthy People 2030

WHAT DOES THIS INDICATOR MEASURE?
• Limited Access to Healthy Foods measures the percentage of the population that is low income and does not live close to a grocery store. The numerator is the number of people who are low income and do not live close to a grocery store. Living close to a grocery store is defined differently in rural and nonrural areas; in rural areas, it means living less than 10 miles from a grocery store; in nonrural areas, less than one mile. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size. The denominator is the 2010 U.S. census population. The data come from the US Department of Agriculture. Data reported in the 2023 County Health Rankings and Roadmaps was last updated in 2019.

• Food Insecurity estimates the percentage of the population who did not have access to a reliable source of food during the past year. The measure uses information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey. The data reported in the 2023 County Health Rankings and Roadmaps was last updated in 2020.

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th>BASELINE 2015</th>
<th>RECENT 2015</th>
<th>TARGET 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>7%</td>
<td>8%*</td>
<td>5%</td>
</tr>
</tbody>
</table>

Reported in 2019 using 2015 data
Reported in 2023 using 2019 data

HOW ARE WE DOING?
• The HNC 2030 target seeks to decrease limited access to healthy foods from 7% to 5% by 2030.
• County Health Rankings & Roadmaps discontinued this metric in 2020 rendering it inappropriate for measuring progress.
• The Food Insecurity measure provides an alternative measure for tracking progress on access to healthy foods.
• Both measures have limitations due to changes in definitions and frequency of data updates and reporting.
CURRENT DATA

Figure 33. Percent of people with limited access to healthy foods (2019 data)

Data source: County Health Rankings and Roadmaps.

Figure 34. Percent of people with food insecurity (2020 data)

Data source: County Health Rankings and Roadmaps.
## Limited Access to Healthy Foods

<table>
<thead>
<tr>
<th>County</th>
<th>People with Limited Access to Healthy Foods (2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>715,223</td>
</tr>
<tr>
<td>Alamance</td>
<td>16,794</td>
</tr>
<tr>
<td>Alexander</td>
<td>2,825</td>
</tr>
<tr>
<td>Alleghany</td>
<td>222</td>
</tr>
<tr>
<td>Anson</td>
<td>1,247</td>
</tr>
<tr>
<td>Ashe</td>
<td>2,897</td>
</tr>
<tr>
<td>Avery</td>
<td>34</td>
</tr>
<tr>
<td>Beaufort</td>
<td>4,389</td>
</tr>
<tr>
<td>Bertie</td>
<td>5,211</td>
</tr>
<tr>
<td>Bladen</td>
<td>2,522</td>
</tr>
<tr>
<td>Brunswick</td>
<td>9,253</td>
</tr>
<tr>
<td>Buncombe</td>
<td>23,393</td>
</tr>
<tr>
<td>Burke</td>
<td>9,096</td>
</tr>
<tr>
<td>Cabarrus</td>
<td>14,719</td>
</tr>
<tr>
<td>Caldwell</td>
<td>12,760</td>
</tr>
<tr>
<td>Camden</td>
<td>105</td>
</tr>
<tr>
<td>Carteret</td>
<td>5,120</td>
</tr>
<tr>
<td>Caswell</td>
<td>715</td>
</tr>
<tr>
<td>Catawba</td>
<td>15,108</td>
</tr>
<tr>
<td>Chatham</td>
<td>2,890</td>
</tr>
<tr>
<td>Cherokee</td>
<td>873</td>
</tr>
<tr>
<td>Chowan</td>
<td>2,409</td>
</tr>
<tr>
<td>Clay</td>
<td>116</td>
</tr>
<tr>
<td>Cleveland</td>
<td>5,938</td>
</tr>
<tr>
<td>Columbus</td>
<td>2,134</td>
</tr>
<tr>
<td>Craven</td>
<td>9,000</td>
</tr>
<tr>
<td>Cumberland</td>
<td>43,317</td>
</tr>
<tr>
<td>Currituck</td>
<td>109</td>
</tr>
<tr>
<td>Dare</td>
<td>2,885</td>
</tr>
<tr>
<td>Davidson</td>
<td>15,547</td>
</tr>
<tr>
<td>Davie</td>
<td>3,458</td>
</tr>
<tr>
<td>Duplin</td>
<td>3,697</td>
</tr>
<tr>
<td>Durham</td>
<td>21,595</td>
</tr>
<tr>
<td>Edgecombe</td>
<td>5,406</td>
</tr>
<tr>
<td>Forsyth</td>
<td>49,909</td>
</tr>
<tr>
<td>Franklin</td>
<td>1,315</td>
</tr>
<tr>
<td>Gaston</td>
<td>24,534</td>
</tr>
<tr>
<td>Gates</td>
<td>962</td>
</tr>
<tr>
<td>Graham</td>
<td>90</td>
</tr>
<tr>
<td>Granville</td>
<td>5,068</td>
</tr>
<tr>
<td>Greene</td>
<td>15</td>
</tr>
<tr>
<td>Guilford</td>
<td>35,596</td>
</tr>
<tr>
<td>Halifax</td>
<td>3,497</td>
</tr>
<tr>
<td>Harnett</td>
<td>7,530</td>
</tr>
<tr>
<td>Haywood</td>
<td>1,936</td>
</tr>
<tr>
<td>Henderson</td>
<td>8,665</td>
</tr>
<tr>
<td>Hertford</td>
<td>2,812</td>
</tr>
<tr>
<td>Hoke</td>
<td>3,690</td>
</tr>
<tr>
<td>Hyde</td>
<td>1,748</td>
</tr>
<tr>
<td>Iredell</td>
<td>9,176</td>
</tr>
<tr>
<td>Jackson</td>
<td>749</td>
</tr>
<tr>
<td>Johnston</td>
<td>4,861</td>
</tr>
<tr>
<td>Jones</td>
<td>9</td>
</tr>
<tr>
<td>Lee</td>
<td>4,713</td>
</tr>
<tr>
<td>Lenoir</td>
<td>7,920</td>
</tr>
<tr>
<td>Lincoln</td>
<td>5,385</td>
</tr>
<tr>
<td>Macon</td>
<td>1,159</td>
</tr>
<tr>
<td>Madison</td>
<td>1,300</td>
</tr>
<tr>
<td>Martin</td>
<td>976</td>
</tr>
<tr>
<td>McDowell</td>
<td>576</td>
</tr>
<tr>
<td>Mecklenburg</td>
<td>50,345</td>
</tr>
<tr>
<td>Mitchell</td>
<td>270</td>
</tr>
<tr>
<td>Montgomery</td>
<td>1,908</td>
</tr>
<tr>
<td>Moore</td>
<td>6,027</td>
</tr>
<tr>
<td>Nash</td>
<td>5,234</td>
</tr>
<tr>
<td>New Hanover</td>
<td>17,887</td>
</tr>
<tr>
<td>Northampton</td>
<td>103</td>
</tr>
<tr>
<td>Onslow</td>
<td>25,795</td>
</tr>
<tr>
<td>Orange</td>
<td>2,914</td>
</tr>
<tr>
<td>Pamlico</td>
<td>456</td>
</tr>
<tr>
<td>Pasquotank</td>
<td>4,073</td>
</tr>
<tr>
<td>Pender</td>
<td>2,978</td>
</tr>
<tr>
<td>Perquimans</td>
<td>310</td>
</tr>
<tr>
<td>Person</td>
<td>2,007</td>
</tr>
<tr>
<td>Pitt</td>
<td>14,247</td>
</tr>
<tr>
<td>Polk</td>
<td>331</td>
</tr>
<tr>
<td>Randolph</td>
<td>14,537</td>
</tr>
<tr>
<td>Richmond</td>
<td>5,220</td>
</tr>
</tbody>
</table>

Data source: County Health Rankings and Roadmaps, 2023

## People with Food Insecurity (2020)

<table>
<thead>
<tr>
<th>County</th>
<th>People with Food Insecurity (2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>1,245,870</td>
</tr>
<tr>
<td>Alamance</td>
<td>21,830</td>
</tr>
<tr>
<td>Alexander</td>
<td>5,040</td>
</tr>
<tr>
<td>Alleghany</td>
<td>1,940</td>
</tr>
<tr>
<td>Anson</td>
<td>3,540</td>
</tr>
<tr>
<td>Ashe</td>
<td>3,780</td>
</tr>
<tr>
<td>Avery</td>
<td>2,460</td>
</tr>
<tr>
<td>Beaufort</td>
<td>6,620</td>
</tr>
<tr>
<td>Bertie</td>
<td>3,160</td>
</tr>
<tr>
<td>Bladen</td>
<td>5,420</td>
</tr>
<tr>
<td>Brunswick</td>
<td>18,000</td>
</tr>
<tr>
<td>Buncombe</td>
<td>35,600</td>
</tr>
<tr>
<td>Burke</td>
<td>14,650</td>
</tr>
<tr>
<td>Cabarrus</td>
<td>21,730</td>
</tr>
<tr>
<td>Caldwell</td>
<td>12,260</td>
</tr>
<tr>
<td>Camden</td>
<td>1,090</td>
</tr>
<tr>
<td>Carteret</td>
<td>8,700</td>
</tr>
<tr>
<td>Caswell</td>
<td>3,190</td>
</tr>
<tr>
<td>Catawba</td>
<td>20,910</td>
</tr>
<tr>
<td>Chatham</td>
<td>7,820</td>
</tr>
<tr>
<td>Cherokee</td>
<td>4,660</td>
</tr>
<tr>
<td>Chowan</td>
<td>2,060</td>
</tr>
<tr>
<td>Clay</td>
<td>1,760</td>
</tr>
<tr>
<td>Cleveland</td>
<td>15,350</td>
</tr>
<tr>
<td>Columbus</td>
<td>9,250</td>
</tr>
<tr>
<td>Craven</td>
<td>13,770</td>
</tr>
<tr>
<td>Cumberland</td>
<td>54,170</td>
</tr>
<tr>
<td>Currituck</td>
<td>2,810</td>
</tr>
<tr>
<td>Dare</td>
<td>4,500</td>
</tr>
<tr>
<td>Davidson</td>
<td>23,520</td>
</tr>
<tr>
<td>Davie</td>
<td>5,520</td>
</tr>
<tr>
<td>Duplin</td>
<td>8,040</td>
</tr>
<tr>
<td>Durham</td>
<td>35,870</td>
</tr>
<tr>
<td>Edgecombe</td>
<td>8,570</td>
</tr>
<tr>
<td>Forsyth</td>
<td>49,350</td>
</tr>
<tr>
<td>Franklin</td>
<td>8,020</td>
</tr>
<tr>
<td>Gaston</td>
<td>31,070</td>
</tr>
<tr>
<td>Gates</td>
<td>1,460</td>
</tr>
<tr>
<td>Graham</td>
<td>1,420</td>
</tr>
<tr>
<td>Granville</td>
<td>6,750</td>
</tr>
<tr>
<td>Greene</td>
<td>3,130</td>
</tr>
<tr>
<td>Guilford</td>
<td>70,990</td>
</tr>
<tr>
<td>Halifax</td>
<td>9,060</td>
</tr>
<tr>
<td>Harnett</td>
<td>18,430</td>
</tr>
<tr>
<td>Haywood</td>
<td>8,820</td>
</tr>
<tr>
<td>Henderson</td>
<td>14,310</td>
</tr>
<tr>
<td>Hertford</td>
<td>3,530</td>
</tr>
<tr>
<td>Hoke</td>
<td>8,250</td>
</tr>
<tr>
<td>Hyde</td>
<td>860</td>
</tr>
<tr>
<td>Iredell</td>
<td>20,690</td>
</tr>
<tr>
<td>Jackson</td>
<td>6,650</td>
</tr>
<tr>
<td>Johnston</td>
<td>23,460</td>
</tr>
<tr>
<td>Jones</td>
<td>1,630</td>
</tr>
<tr>
<td>Lee</td>
<td>8,940</td>
</tr>
<tr>
<td>Lenoir</td>
<td>9,560</td>
</tr>
<tr>
<td>Lincoln</td>
<td>10,810</td>
</tr>
<tr>
<td>Macon</td>
<td>5,380</td>
</tr>
<tr>
<td>Madison</td>
<td>3,130</td>
</tr>
<tr>
<td>Martin</td>
<td>3,500</td>
</tr>
<tr>
<td>McDowell</td>
<td>7,010</td>
</tr>
<tr>
<td>Mecklenburg</td>
<td>119,030</td>
</tr>
<tr>
<td>Mitchell</td>
<td>2,190</td>
</tr>
<tr>
<td>Montgomery</td>
<td>3,750</td>
</tr>
<tr>
<td>Moore</td>
<td>11,900</td>
</tr>
<tr>
<td>Nash</td>
<td>13,040</td>
</tr>
<tr>
<td>New Hanover</td>
<td>31,620</td>
</tr>
<tr>
<td>Northampton</td>
<td>2,830</td>
</tr>
<tr>
<td>Onslow</td>
<td>27,880</td>
</tr>
<tr>
<td>Orange</td>
<td>14,970</td>
</tr>
<tr>
<td>Pamlico</td>
<td>1,760</td>
</tr>
<tr>
<td>Pasquotank</td>
<td>4,860</td>
</tr>
<tr>
<td>Pender</td>
<td>7,920</td>
</tr>
<tr>
<td>Perquimans</td>
<td>1,680</td>
</tr>
<tr>
<td>Person</td>
<td>5,600</td>
</tr>
<tr>
<td>Pitt</td>
<td>25,960</td>
</tr>
<tr>
<td>Polk</td>
<td>2,670</td>
</tr>
<tr>
<td>Randolph</td>
<td>20,500</td>
</tr>
<tr>
<td>Richmond</td>
<td>7,750</td>
</tr>
</tbody>
</table>

Data source: County Health Rankings and Roadmaps, 2023
THE STORY BEHIND THE CURVE

- There are barriers to, and disparities in, the accessibility and availability of foods that support healthy eating patterns. Data from 2012 - 2013 show that the average distance from U.S. households to the nearest supermarket was 2.19 miles. Individuals without a vehicle or access to convenient public transportation, or who do not have food venues with healthy choices within walking distance, have limited access to foods that support healthy eating patterns.

- Transportation and distance to sources of healthy foods impact low-income and rural communities, especially older adults living in rural communities. Overall, for those who do not have access to a car or public transportation, the cost of travel time to find healthier options in addition to out-of-pocket expenses may be too high.

- Another barrier to accessibility of healthy food choices is living in a food desert. In food deserts, food sources are lacking or limited, particularly in low-income areas that are also more likely to have a higher share of convenience stores and small food markets. These options tend to carry foods of lower nutritional quality compared to large chain supermarkets, which may have a wider variety of healthy options.

- Improving access to foods that support healthy eating patterns is one method for addressing health disparities and population health. Several strategies that aim to “improve diet by altering food environments” are being considered and implemented.

- For example, a study has shown that a small financial incentive increased the use of Supplemental Nutrition Assistance Program (SNAP) benefits in participating farmers markets – resulting in increased access to healthy foods.

- Several strategies have also been proposed to encourage more equitable access to healthy food choices, such as, “attracting and opening supermarkets in underserved neighborhoods, selling healthy foods at reduced prices, and limiting the total number of per capita fast-food restaurants in a community.”

Source: Healthy People 2030 11-20

WHAT OTHER DATA DO WE NEED?

- Access to locally grown food
- Availability of funding for SNAP “Double of Food Bucks” and GusNIP
- Gaps in nutrition service programs, including SNAP, WIC, CACFP, Medicaid, and NCCARE360
- Number/percentage of children receiving free/reduced school meals
- Opportunities for land use development
- Referrals for food assistance through NCCARE360
WHAT COULD WORK TO TURN THE CURVE?

The Limited Access to Healthy Foods Work Group identified the following priorities for action planning related to equitable access to food nutrition services, supporting the state’s food system, and access to school meals.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance how children and families access programs supporting their well-being, including SNAP, WIC, CACFP, Medicaid, and NCCARE360 through better data and analysis, infrastructure, and integration</td>
<td>Improved data and analysis, infrastructure, and integration of programs supporting well-being, would enable better connection to resources and services in a timely manner.</td>
</tr>
<tr>
<td>Provide financial incentives such as “Double Up Food Bucks” and Produce Prescriptions for SNAP/ FNS recipients for purchasing fresh fruit and vegetables from grocery stores and farmers markets</td>
<td>Programs like “Double Up Food Bucks” and Produce Prescriptions increase access to healthy foods, more business for local farmers and growers, and boost local economies.</td>
</tr>
<tr>
<td>Continue, expand, and institutionalize the Supplemental Nutrition Assistance Program (SNAP) online purchasing pilot</td>
<td>The Supplemental Nutrition Assistance Program (SNAP) online purchasing pilot increases food access by allowing people who receive SNAP benefits to select and pay for their groceries online at participating retailers.</td>
</tr>
<tr>
<td>Support equitable, food-oriented development that drives economic growth in low-income and historically marginalized communities</td>
<td>An equitable food system ensures all, including low-income and historically marginalized communities, can fully participate, prosper, and benefit. Having an equitable food system creates economic opportunities and access to healthy, affordable, and culturally appropriate food (PolicyLink, 2023).</td>
</tr>
<tr>
<td>Support regional food hubs connecting local farmers, growers, producers, and ranchers with expanded market opportunities and the community to improved access to local, nutritious food</td>
<td>Additional market opportunities improve community access to local, nutritious food and supports the local agricultural economy.</td>
</tr>
<tr>
<td>Implement competitive pricing for healthy foods</td>
<td>Competitive pricing can include incentives, subsidies, or price discounts for healthy foods and beverages as well as disincentives or increased pricing for unhealthy foods and beverages (CHR&amp;R, 2021). Competitive pricing can increase sales and consumption of healthy foods.</td>
</tr>
<tr>
<td>Collaborate with community partners to provide nutritious options at food banks and pantries and soup kitchens</td>
<td>Providing nutritious options at food banks and pantries and soup kitchens brings together hunger relief efforts with nutrition information and healthy eating opportunities for individuals and families with low incomes (CHR&amp;R, 2020).</td>
</tr>
<tr>
<td>Support farmers markets and enable Electronic Benefit Transfer payment at farmers markets</td>
<td>The ability to accept Electronic Benefit Transfer (EBT) payment at farmers markets increases access to fresh, local fruits and vegetables for people who receive SNAP benefits and increases market sales.</td>
</tr>
<tr>
<td>Support, promote, and encourage participation in the School Breakfast and National School Lunch Programs</td>
<td>The School Breakfast and National School Lunch Programs increase access to healthy food in schools and childcare centers. The programs provide nutritionally balanced, low-cost, or no-cost lunches to children each school day.</td>
</tr>
</tbody>
</table>
LIMITED ACCESS TO HEALTHY FOODS

EQUITABLE ACCESS TO HEALTHY FOODS BENEFITS COMMUNITIES AND FOOD SYSTEMS BY PROVIDING MORE BUSINESS FOR LOCAL FARMERS AND GROWERS AND BOOSTING LOCAL ECONOMIES.


RECOMMENDED READING/LISTENING

Cape Fear Collective- Food Hardship Index: https://healthycommunitiesnc.org/profile/geo/cape-fear#limited-access-to-healthy-foods


NCDHHS Healthy Opportunities Pilots: https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots


USDA- SNAP Online Purchasing Pilot: https://www.fns.usda.gov/snap/online-purchasing-pilot

ACTION PLAN

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm.

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance of Disability Advocates</td>
<td><a href="https://adanc.org/services/advocacy/">https://adanc.org/services/advocacy/</a></td>
</tr>
<tr>
<td>American Association of Retired Persons (AARP) Livable Communities</td>
<td><a href="https://www.aarp.org/livable-communities/">https://www.aarp.org/livable-communities/</a></td>
</tr>
<tr>
<td>BikeWalkNC</td>
<td><a href="https://www.bikewalknc.org/">https://www.bikewalknc.org/</a></td>
</tr>
<tr>
<td>Blue Cross Blue Shield Foundation</td>
<td><a href="https://www.bcbsncfoundation.org/">https://www.bcbsncfoundation.org/</a></td>
</tr>
<tr>
<td>Boy Scouts of America (Multiple councils across NC)</td>
<td><a href="https://www.scouting.org/">https://www.scouting.org/</a></td>
</tr>
<tr>
<td>Boys &amp; Girls Clubs of North Carolina</td>
<td><a href="https://www.ncclubs.org/">https://www.ncclubs.org/</a></td>
</tr>
<tr>
<td>Bull City Fit</td>
<td><a href="https://www.bullcityfit.com/">https://www.bullcityfit.com/</a></td>
</tr>
<tr>
<td>Centralina Regional Council</td>
<td><a href="https://centralina.org/">https://centralina.org/</a></td>
</tr>
<tr>
<td>Children’s Healthy Weight Research (CHWR)- UNC Center for Health Promotion and Disease Prevention</td>
<td><a href="https://chwr.web.unc.edu/">https://chwr.web.unc.edu/</a></td>
</tr>
<tr>
<td>Durham Parks &amp; Recreation (DPR)</td>
<td><a href="https://www.dprplaymore.org/">https://www.dprplaymore.org/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 9: SEVERE HOUSING PROBLEMS

WHAT RESULT DO WE WANT?
All people in North Carolina have safe, affordable, quality housing opportunities.

WHY IS THIS IMPORTANT?

- Housing instability encompasses several challenges, such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. These experiences may negatively affect physical health and make it harder to access health care.
- Households are cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more than 50% of their income on housing. Cost-burdened households have little left over each month to spend on other necessities such as food, clothing, utilities, and health care. Black and Hispanic households are almost twice as likely as white households to be cost burdened.

Source: Healthy People 2030 1-7

WHAT DOES THIS INDICATOR MEASURE?

This composite measure indicates how many of us live in housing that we cannot afford, that may be crowded, and even have serious problems with kitchens and bathrooms.

- The indicator is reported in the Robert Wood Johnson County Health Rankings (CHR)
- Composite measure of four housing problems
- Data are three years old when presented
- Does not include “non-severe” housing problems that could have a significant impact on health
- Severe Housing Cost Burden measures the percentage of households that spend 50% or more of their household income on housing. The 2023 CHR used data from 2017-2021 for this measure.

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>REPORTED</td>
<td>16.1%</td>
<td>14.0%</td>
<td>14.0%</td>
</tr>
</tbody>
</table>

HNC 2030 HEADLINE INDICATOR: Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities

IN OUR PURSUIT OF HEALTH EQUITY, HOUSING STANDS OUT AS A CORE ISSUE ACROSS THE STATE. EVERY HOME IMPROVEMENT IS A STEP CLOSER TO A HEALTHIER STATE. MOREOVER, BY PROMOTING HOMEOWNERSHIP WITHIN HISTORICALLY DISENFRANCHED COMMUNITIES WE AREN’T JUST RECTIFYING PAST WRONGS BUT CRAFTING A DIVERSE, VIBRANT, AND EQUITABLE FUTURE FOR RESIDENTS.

- Stephen J. Sills, PhD, Chief Impact Officer, United Way of Forsyth County

HOW ARE WE DOING?

- The HNC 2030 target seeks to decrease the percentage of North Carolina households with severe housing problems from 16.1% to 14.0% by 2030.
- Because housing cost burden is rapidly rising, a new measure captures households that spend 50% or more of their household income on housing.
Figure 35. Percent of households with severe housing problems in North Carolina (2015-2019 data)

Figure 36. Percent of households with housing cost burden 50% or more of household income (2017-2021 data)

THE STORY BEHIND THE CURVE

- Housing quality refers to the physical condition of a person’s home as well as the quality of the social and physical environment in which the home is located. Aspects of housing quality include air quality, home safety, space per individual, and the presence of mold, asbestos, or lead.

- Housing quality is affected by factors like a home’s design and age.

- Poor-quality housing is associated with various negative health outcomes, including chronic disease and injury and poor mental health.

- The quality of a home’s neighborhood is shaped in part by how well individual homes are maintained, and widespread residential deterioration in a neighborhood can negatively affect mental health.

- Both home design and structure significantly influence housing quality and may affect mental and physical health.

- Steps, balconies, and windows are features of home design that may present a threat to safety, especially for individuals with physical disabilities. Breakable glass, low windowsills, and poorly constructed stairs may increase the risk of injury from a fall.

Source: Healthy People 2030 8-17
SEVERE HOUSING PROBLEMS

WHAT OTHER DATA DO WE NEED?

- Access to digital equity broadband map
- Community land trusts
- Conditions of housing stock geographically across the state
- Licensed and qualified builders for weatherization and lead abatement
- Loss of affordable housing
- Manufactured home regulations
- Mediation, legal representation, and legal education available for IDD (Intellectual or Developmental Disabilities) populations and others with disabilities
- Mediation, legal representation, and legal education available for eviction defense
- Resources for migrant farm worker housing

WHAT COULD WORK TO TURN THE CURVE?

The Severe Housing Problems Work Group prioritized the following policies for action planning. Work group members engaged in thorough discussions with considerations of existing plans and resources and review of research on housing needs, burdens, and efforts to increase access to safe, affordable, quality housing opportunities.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase measures and funding to provide tenants with access to mediation, legal representation, and legal education to secure and protect housing</td>
<td>Increased access to mediation and legal education for tenants may preserve housing, prevent displacement, and forestall homelessness. Mediation provides an opportunity for the tenant and landlord to resolve and understand issues that could lead to displacement.</td>
</tr>
<tr>
<td>Remove legal barriers, institute enabling legislation, and facilitate lending to promote Community Land Trusts and other shared equity models of homeownership</td>
<td>Community land trusts (CLTs) and shared equity models of homeownership remove land costs thereby making homeownership more affordable.</td>
</tr>
<tr>
<td>Simplify and expand the Weatherization Assistance Program, Low-Income Energy Assistance Programs, and other healthy homes and utility assistance programs by affirmatively engaging low-income communities through targeted outreach to help families meet their energy needs</td>
<td>The current application process for home and utility assistance programs is difficult to navigate and may prevent families from receiving assistance. Targeted outreach provides an opportunity to connect communities with available home and utility assistance programs to improve the conditions of their homes and meet their energy needs.</td>
</tr>
<tr>
<td>Support funding, loans, and other resources for housing providers in agricultural areas to improve safe and healthy home environments for migrant workers</td>
<td>The lack of quality housing has potentially severe impacts on the health and well-being of migrant workers. Housing quality for migrant workers affects their ability to provide a reliable, safe, and affordable food supply for North Carolina.</td>
</tr>
<tr>
<td>Support programs designed to increase home ownership for historically disenfranchised communities</td>
<td>In the last twenty years, there has been a decline in home ownership in people of color. Communities thrive when there is a healthy balance of owners and renters.</td>
</tr>
</tbody>
</table>

RECOMMENDED READING/LISTENING


**ACTION PLAN**

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at [https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm](https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm).

**NC PARTNERS WHO CAN HELP US**

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACLU of North Carolina (American Civil Liberties Union of North Carolina)</td>
<td><a href="https://www.acluofnorthcarolina.org/en/about/about-us">https://www.acluofnorthcarolina.org/en/about/about-us</a></td>
</tr>
<tr>
<td>Asheville-Buncombe Community Land Trust</td>
<td><a href="https://abclt.org/">https://abclt.org/</a></td>
</tr>
<tr>
<td>Carolinas Council of Housing Redevelopment &amp; Codes Officials</td>
<td><a href="http://www.carolinascouncil.org">www.carolinascouncil.org</a></td>
</tr>
<tr>
<td>Charlotte Center for Legal Advocacy</td>
<td><a href="https://charlottelegaladvocacy.org/">https://charlottelegaladvocacy.org/</a></td>
</tr>
<tr>
<td>Community Development Block Grant Program</td>
<td><a href="https://www.hud.gov/program_offices/comm_planning/cdbg">https://www.hud.gov/program_offices/comm_planning/cdbg</a></td>
</tr>
<tr>
<td>Community Home Trust</td>
<td><a href="https://communityhometrust.org/">https://communityhometrust.org/</a></td>
</tr>
<tr>
<td>Durham Community Land Trustees</td>
<td><a href="https://www.dclt.org/">https://www.dclt.org/</a></td>
</tr>
<tr>
<td>El Centro Hispano, Inc.</td>
<td><a href="https://elcentronc.org/">https://elcentronc.org/</a></td>
</tr>
<tr>
<td>Fair Housing Project</td>
<td><a href="https://www.fairhousingnc.org/">https://www.fairhousingnc.org/</a></td>
</tr>
<tr>
<td>Farm Labor Organizing Committee</td>
<td><a href="https://floc.com/">https://floc.com/</a></td>
</tr>
<tr>
<td>Federal Housing Administration Veterans Affairs</td>
<td><a href="https://www.va.gov/housing-assistance/">https://www.va.gov/housing-assistance/</a></td>
</tr>
<tr>
<td>Habit for Humanity of North Carolina</td>
<td><a href="https://habitatnc.org/">https://habitatnc.org/</a></td>
</tr>
<tr>
<td>Legal Aid of North Carolina</td>
<td><a href="https://legalaidnc.org/">https://legalaidnc.org/</a></td>
</tr>
<tr>
<td>LISC Charlotte</td>
<td><a href="https://www.lisc.org/charlotte/">https://www.lisc.org/charlotte/</a></td>
</tr>
<tr>
<td>MDC</td>
<td><a href="https://www.mdcinc.org/">https://www.mdcinc.org/</a></td>
</tr>
<tr>
<td>National Institute for Minority Economic Development</td>
<td><a href="https://theinstitutenc.org/">https://theinstitutenc.org/</a></td>
</tr>
<tr>
<td>NC Realtors</td>
<td><a href="https://www.ncrealtors.org/">https://www.ncrealtors.org/</a></td>
</tr>
<tr>
<td>NC Rural Center</td>
<td><a href="https://www.ncruralcenter.org/">https://www.ncruralcenter.org/</a></td>
</tr>
<tr>
<td>North Carolina Association of Community Development Corporations</td>
<td><a href="https://www.ncacdc.org/">https://www.ncacdc.org/</a></td>
</tr>
<tr>
<td>North Carolina Coalition to End Homelessness</td>
<td><a href="https://www.ncceh.org/">https://www.ncceh.org/</a></td>
</tr>
<tr>
<td>North Carolina Community Action Association</td>
<td><a href="https://www.nccaa.net/">https://www.nccaa.net/</a></td>
</tr>
<tr>
<td>North Carolina Department of Administration (NC DOA) Indian Affairs</td>
<td><a href="https://ncadmin.nc.gov/divisions/american-indian-affairs">https://ncadmin.nc.gov/divisions/american-indian-affairs</a></td>
</tr>
<tr>
<td>North Carolina Department of Environmental Quality</td>
<td><a href="https://deq.nc.gov/">https://deq.nc.gov/</a></td>
</tr>
<tr>
<td>North Carolina Farm Bureau</td>
<td><a href="https://www.ncfb.org/">https://www.ncfb.org/</a></td>
</tr>
<tr>
<td>North Carolina Housing Coalition</td>
<td><a href="https://nchousing.org/">https://nchousing.org/</a></td>
</tr>
<tr>
<td>North Carolina Housing Finance Agency</td>
<td><a href="https://www.nchfa.com/">https://www.nchfa.com/</a></td>
</tr>
<tr>
<td>North Carolina Justice Center</td>
<td><a href="https://www.ncjustice.org/">https://www.ncjustice.org/</a></td>
</tr>
<tr>
<td>North Carolina Pro Bono Resource Center</td>
<td><a href="https://ncprobono.org/">https://ncprobono.org/</a></td>
</tr>
<tr>
<td>North Carolina Regional Council of Governments</td>
<td><a href="https://www.ncarccog.com/">https://www.ncarccog.com/</a></td>
</tr>
<tr>
<td>North Carolina State Employee Credit Union</td>
<td><a href="https://www.ncsecu.org/">https://www.ncsecu.org/</a></td>
</tr>
<tr>
<td>Pisgah Legal Services</td>
<td><a href="https://www.pisgahlegal.org/">https://www.pisgahlegal.org/</a></td>
</tr>
<tr>
<td>Rural Forward</td>
<td><a href="https://www.mdcinc.org/projects/rural-forward/">https://www.mdcinc.org/projects/rural-forward/</a></td>
</tr>
<tr>
<td>The Episcopal Diocese of North Carolina- Affordable Housing</td>
<td><a href="https://www.episdionc.org/affordable-housing/">https://www.episdionc.org/affordable-housing/</a></td>
</tr>
<tr>
<td>UNC Greensboro Center for Housing &amp; Community Studies</td>
<td><a href="https://chcs.uncg.edu/">https://chcs.uncg.edu/</a></td>
</tr>
<tr>
<td>Weatherization Assistance Program</td>
<td><a href="https://deq.nc.gov/energy-climate/state-energy-office/weatherization-assistance-program">https://deq.nc.gov/energy-climate/state-energy-office/weatherization-assistance-program</a></td>
</tr>
</tbody>
</table>
STATE HEALTH IMPROVEMENT PLAN

HNC 2030 Indicators

HEALTH BEHAVIORS

Drug Overdose Deaths..................................................76-79
Tobacco Use..................................................................80-85
Excessive Drinking.......................................................86-89
Sugar-Sweetened Beverage Consumption.......................90-94
HIV Diagnosis .............................................................96-101
Teen Birth.....................................................................102-104
HEALTH INDICATOR 10: DRUG OVERDOSE DEATHS

WHAT RESULT DO WE WANT?
All people in North Carolina receive person-centered substance use care without fear of stigma and feel supported by the community regardless of ability, age, gender-identity, income, lived experience, nationality, neighborhood, or race.

WHY IS THIS IMPORTANT?
The rise in overdose deaths in recent years is driven by illegally manufactured fentanyl. In 2021, more than 77% of overdose deaths in the state likely involved fentanyl, often in combination with other substances.

Priorities for North Carolina’s Opioid and Substance Use Action Plan, 3.0, include:
- Equity and lived experiences at the center
- Reduce harm: Move beyond just opioids to address polysubstance use
- Connect to care: Increase treatment access for justice-involved people
- Expand access to housing and employment supports, and recover from the pandemic together
- Prevent future addiction and address trauma by supporting children and families

HNC 2030 HEADLINE INDICATOR: Drug overdose deaths in North Carolina per 100,000 population, age-adjusted

WHAT DOES THIS INDICATOR MEASURE?
- Number of people who die because of drug poisoning per 100,000 population (age-adjusted rate to vintage population)
- The data are disaggregated by race/ethnicity, county, and gender

Drug categories included:
- heroin
- natural opioid analgesics, including morphine and codeine and semisynthetic opioids, including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone
- methadone, a synthetic opioid
- synthetic opioid analgesics other than methadone, including drugs such as fentanyl and tramadol
- cocaine
- psychostimulants with abuse potential, which includes methamphetamine.

Drug overdose deaths involve medical examiners whose cases can be delayed while cause of death determinations await toxicology reports before they can be completed. Small numbers in subgroups can make rates unstable and may necessitate the combining of years.

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th>BASELINE 2018</th>
<th>RECENT 2021</th>
<th>TARGET 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.4</td>
<td>39.8</td>
<td>18.0</td>
</tr>
</tbody>
</table>

HOW ARE WE DOING?
- The drug poisoning death rate has nearly tripled in the last seven years.
- The disparity ratio between males and females is widening. Since 2016, the rate of drug poisoning deaths for males is twice that for females.
- Caution should be used in interpreting rates for American Indian/Alaskan Native, Asian/Pacific Islander, and Hispanic due to small number effect.
CURRENT DATA TRENDED OVER TIME

**Figure 37. Drug overdose death rate in North Carolina (2014-2021)**

Data source: N.C. State Center for Health Statistics, Vital Statistics

**Figure 38. Drug overdose death rate in North Carolina by race/ethnicity (2014-2021)**

Data source: N.C. State Center for Health Statistics, Vital Statistics

**Figure 39. Drug overdose death rate in North Carolina by gender (2014-2021)**

Data source: N.C. State Center for Health Statistics, Vital Statistics
Drug Overdose Deaths

The Story Behind the Curve

Prescription medications have been a major driver of the opioid epidemic, but illicit drugs (heroin and synthetic fentanyl) are also increasingly contributing to this problem. Additionally, North Carolina and many other states are identifying fentanyl and opioid analogues in other kinds of illicit drugs (including cocaine, methamphetamine and counterfeit pills). People using these substances may unknowingly be exposed to opioids and are at high risk of opioid overdose. Using harm reduction techniques for safer use and having naloxone on-hand can help prevent fatal opioid overdose.3

What Other Data Do We Need?

- Availability of substance use disorder (SUD) treatment providers and facilities
- Housing providers and employers who support people with SUD
- Programs and outcome metrics connecting justice-involved people to SUD care

What Could Work to Turn the Curve?

The following priority areas are from North Carolina’s Opioid and Substance Use Action Plan (OSUAP). For additional information refer to the current OSUAP and data dashboard at https://www.ncdhhs.gov/about/department-initiatives/overdose-epidemic/north-carolinas-opioid-and-substance-use-action-plan/.

Recommended Reading/Listening

Injury and Violence Prevention Branch Overdose Data: https://injuryfreenc.dph.ncdhhs.gov/DataSurveillance/Overdose.htm
Naloxone Saves: http://www.naloxonesaves.org/
NC Opioid Settlements CORE-NC: Community Opioid Resources Engine for North Carolina: https://ncopioidsettlement.org/
North Carolina Harm Reduction Coalition: https://www.nchrc.org/
Stop the Stigma Resource Guide: https://www.ncdhhs.gov/media/8589/download
FROM 2000 TO 2022, MORE THAN 36,000 NORTH CAROLINIANS LOST THEIR LIVES TO DRUG OVERDOSE.

- North Carolina Opioid and Substance Use Action Plan Data Dashboard

ACTION PLAN

The Opioid and Substance Use Action Plan broadens its focus to include polysubstance use and centers equity and lived experience (OSUAP, 2021). Strategies included in the action plan are available at https://www.ncdhhs.gov/about/department-initiatives/overdose-epidemic/north-carolinas-opioid-and-substance-use-action-plan.


NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governor’s Institute</td>
<td><a href="https://governorsinstitute.org/">https://governorsinstitute.org/</a></td>
</tr>
<tr>
<td>NCDHHS DPH Injury and Violence Prevention Branch</td>
<td><a href="https://injuryfreenc.dph.ncdhhs.gov/">https://injuryfreenc.dph.ncdhhs.gov/</a></td>
</tr>
<tr>
<td>Mountain Area Health Education Center</td>
<td><a href="https://mahec.net/substance-use/index">https://mahec.net/substance-use/index</a></td>
</tr>
<tr>
<td>NC Council of Churches</td>
<td><a href="https://www.ncchurches.org/">https://www.ncchurches.org/</a></td>
</tr>
<tr>
<td>NCDHHS North Carolina Treatment Accountability for Safer Communities (NC TASC)</td>
<td><a href="https://www.ncdhhs.gov/assistance/mental-health-substance-abuse/">https://www.ncdhhs.gov/assistance/mental-health-substance-abuse/</a></td>
</tr>
<tr>
<td>NCDHHS Division of Mental Health, Developmental Disabilities and Substance Use Services</td>
<td><a href="https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse-services">https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse-services</a></td>
</tr>
<tr>
<td>North Carolina Area Health Education Centers (NC AHEC)</td>
<td><a href="https://www.ncahec.net/">https://www.ncahec.net/</a></td>
</tr>
<tr>
<td>North Carolina Association of Pharmacists (NCAP)</td>
<td><a href="https://www.ncpharmacists.org/">https://www.ncpharmacists.org/</a></td>
</tr>
<tr>
<td>North Carolina Harm Reduction Coalition (NCHRC)</td>
<td><a href="https://www.nchrc.org/">https://www.nchrc.org/</a></td>
</tr>
<tr>
<td>North Carolina Medical Board</td>
<td><a href="https://www.ncmedboard.org/">https://www.ncmedboard.org/</a></td>
</tr>
<tr>
<td>North Carolina’s Certified Peer Support Specialist Program Opioid Response Network (ORN)-funded by the Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
<td><a href="https://pss.unc.edu/">https://pss.unc.edu/</a></td>
</tr>
<tr>
<td>Health Services Administration (SAMHSA)</td>
<td><a href="https://opioidresponsenetwork.org/">https://opioidresponsenetwork.org/</a></td>
</tr>
<tr>
<td>Recovery Communities of North Carolina</td>
<td><a href="https://www.rnc.org/">https://www.rnc.org/</a></td>
</tr>
<tr>
<td>Stop the Addiction Fatality Epidemic (SAFE) Project</td>
<td><a href="https://www.safeproject.us/">https://www.safeproject.us/</a></td>
</tr>
<tr>
<td>UNC Injury Prevention Research Center (IPRC)</td>
<td><a href="https://iprc.unc.edu/research/">https://iprc.unc.edu/research/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 11: TOBACCO USE

WHAT RESULT DO WE WANT?
All people in North Carolina live in communities that support tobacco-free/e-cigarette-free lifestyles.

WHY IS THIS IMPORTANT?
Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined—and thousands more die from other tobacco-related causes such as involuntary exposure to secondhand smoke, fires caused by smoking (more than 1,000 deaths/year nationwide) and smokeless tobacco use.

WHAT DOES THIS INDICATOR MEASURE?

ADULT

- Percent of Tobacco Use Across the Population: Percent of Adults Reporting Current Use of E-Cigarettes, Cigarettes, Cigars, Smokeless Tobacco, Pipes, and/or Hookah.
  
  SMOKELESS TOBACCO
  - Question: “Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?”
  - Respondents who answer “every day” or “some days” are considered current users.

  CIGARS
  - Question: “During the past 30 days, did you smoke cigars, cigarillos, or little cigars?”
  - Respondents who answer “every day” or “some days” are considered current users.

  HOOKAH
  - Question: “During the past 30 days, have you used a hookah or water pipe?”
  - Respondents who answer “every day” or “some days” are considered current users.

- The number of noninstitutionalized adults who use one or more of these tobacco products daily or on some days.
- Beginning in 2021, data are reported annually by sex, race/ethnicity, and age.

BASELINE DATA FROM HNC 2030

ADULT

<table>
<thead>
<tr>
<th>Baseline 2015</th>
<th>Recent 2018</th>
<th>Target 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.6%</td>
<td>20.4%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

YOUTH HIGH SCHOOL*

<table>
<thead>
<tr>
<th>Baseline 2017</th>
<th>Recent 2018</th>
<th>Target 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.8%</td>
<td>27.3%</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

YOUTH MIDDLE SCHOOL*

<table>
<thead>
<tr>
<th>Baseline 2018</th>
<th>Recent 2019</th>
<th>Target 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.8%</td>
<td>10.4%</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

AS PROVIDERS, GOING TOBACCO-FREE IS THE RIGHT THING TO DO FOR THE HEALTH AND WELLBEING OF OUR PATIENTS.

- Mary Ward, President, retired, McLeod Centers for Wellbeing

*Note: The 2021 NC Youth Tobacco Survey (YTS) was pushed back to Spring 2022 and administered electronically for the first time ever. The response rate was much lower than desired, likely due to lingering Covid-related challenges that schools were facing. Due to the methodology change and the low response rate, caution must be used in using the data, especially with trend data and comparing to previous years. Therefore, updated trend data will not be presented in the 2023 NC SHIP for youth tobacco use.

HOW ARE WE DOING?

- Tobacco product use (including e-cigarettes) among adults has decreased from 23.8% in 2018 to 20.7% in 2021.
- Among adults, males have greater reported use of any tobacco product than females.
- Among various race/ethnicities, White/Caucasian use of tobacco products remains high at 22.3% in 2021.
- In the online Youth Tobacco Survey conducted in 2022, 5.2% of middle school students and 12.3% of high school students reported tobacco use.
CURRENT DATA TRENDED OVER TIME

Figure 40. Tobacco use among adults in North Carolina (2018-2021)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PERCENT OF ADULTS USING TOBACCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>23.8%</td>
</tr>
<tr>
<td>2019</td>
<td>22.9%</td>
</tr>
<tr>
<td>2020</td>
<td>22.6%</td>
</tr>
<tr>
<td>2021</td>
<td>20.7%</td>
</tr>
</tbody>
</table>

Data source: Behavioral Risk Factor Surveillance System (BRFSS), N.C. State Center for Health Statistics

Figure 41. Tobacco use among adults in North Carolina by gender (2018-2021)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PERCENT OF ADULTS USING TOBACCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>29.9%</td>
</tr>
<tr>
<td>2019</td>
<td>26.7%</td>
</tr>
<tr>
<td>2020</td>
<td>27.3%</td>
</tr>
<tr>
<td>2021</td>
<td>25.2%</td>
</tr>
</tbody>
</table>

Data source: Behavioral Risk Factor Surveillance System (BRFSS), N.C. State Center for Health Statistics

Figure 42. Tobacco use among adults in North Carolina by race/ethnicity (2018-2021)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PERCENT OF ADULTS USING TOBACCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>25.9%</td>
</tr>
<tr>
<td>2019</td>
<td>24.0%</td>
</tr>
<tr>
<td>2020</td>
<td>24.4%</td>
</tr>
<tr>
<td>2021</td>
<td>22.3%</td>
</tr>
</tbody>
</table>

Data source: Behavioral Risk Factor Surveillance System (BRFSS), N.C. State Center for Health Statistics
THE STORY BEHIND THE CURVE

• Almost half of all young people who have ever used a cigarette started with menthol.
• Young people use e-cigarettes for social reasons and because they come in flavors.
• 76% of youth under 21 who got their e-cigarettes from social sources got them from someone under 21.
• 2 out of 3 of young people who currently use e-cigarettes are seriously thinking about quitting.
• 24% of young people who have never tried an e-cigarette are open to trying one in the next year.

Although a majority of cigarette smokers makes a quit attempt each year in the United States, less than one-third use evidence-based methods which include FDA-approved tobacco treatment medications and behavioral counseling to support quit attempts. Nationally, one of the largest disparities is in the behavioral health population.²

WHAT OTHER DATA DO WE NEED?

• Additional data on tobacco use among young people, including dual-use and multi-use and combinations of nicotine with other drugs
• Better understanding of health disparities regarding tobacco use and exposure to hazardous secondhand smoke and e-cigarette emissions
• Effectiveness of price policies to prevent initiation of e-cigarette use among young people
• Effectiveness of tobacco-free initiatives
• Number of tobacco retailers in North Carolina and the retailer violation rates (Synar survey)
• Prevalence of commercial tobacco use and secondhand smoke exposure among American Indian populations in North Carolina
• Rapid response data are needed for the rapidly changing tobacco marketplaces and point of sale and marketing data from diverse NC communities
• Sale and consumption of new and emerging tobacco products
• Commercial tobacco product usage, secondhand smoke exposure, and cessation among populations that have experienced inequities and disparities

Figure 43. Tobacco use among youth in North Carolina by gender (2022)

Figure 44. Tobacco use among youth in North Carolina by race/ethnicity (2022)
The NC SHIP Tobacco Committee recognizes that effective tobacco policies include CDC and Surgeon General recommendations including tobacco price increases, smoke-free policies, targeted media campaigns, and access to cessation services. Addressing availability, pricing and promotion, advertising and display bans, age of sale, and retailer compliance are strategies for boosting tobacco control efforts.

The term *tobacco* use refers to commercial tobacco use, which includes all tobacco products offered for sale, not tobacco used for sacred and traditional ceremonies by many American Indian tribes and communities.

### WHAT COULD WORK TO TURN THE CURVE?

The NC SHIP Tobacco Committee recognizes that effective tobacco policies include CDC and Surgeon General recommendations including tobacco price increases, smoke-free policies, targeted media campaigns, and access to cessation services. Addressing availability, pricing and promotion, advertising and display bans, age of sale, and retailer compliance are strategies for boosting tobacco control efforts.

The term *tobacco* use refers to commercial tobacco use, which includes all tobacco products offered for sale, not tobacco used for sacred and traditional ceremonies by many American Indian tribes and communities.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>POINT OF SALE</strong></td>
<td>Removing state preemption would allow local governments to implement stronger tobacco control policies. Allowing communities to adopt and implement stronger, innovative, and effective tobacco control policies can discourage initiating use and encourage adult tobacco users to quit (CDC, 2023).</td>
</tr>
<tr>
<td>Remove state preemption of local government regulations on the sale, promotion, distribution, and display of tobacco products</td>
<td>Restricting tobacco retailers from operating near children’s areas reduces availability and exposure. Retail availability of tobacco products increases perceived availability and accessibility of tobacco products and increases brand recognition, especially among youth, which increases the likelihood of tobacco use (Counter Tools, 2023).</td>
</tr>
<tr>
<td>Revise zoning ordinances to control placement of shops that sell tobacco, limiting the number of these shops per area and ensuring they are placed a safe distance from children’s areas</td>
<td></td>
</tr>
<tr>
<td><strong>PRICE AND FUNDING</strong></td>
<td>Funding to the recommended funding level ensures a fully funded and sustained comprehensive tobacco control program with resources sufficient to reduce tobacco use most effectively. States that have made larger investments in comprehensive tobacco control programs have seen larger declines in cigarettes sales than the United States overall, and the prevalence of smoking among adults and youth has declined faster as spending for tobacco control programs has increased (CDC Best Practices for Comprehensive Tobacco Control Programs, 2014 with an update expected in 2024).</td>
</tr>
<tr>
<td>Fund comprehensive state tobacco control programs to levels recommended by Centers for Disease Control and Prevention (CDC)</td>
<td>Sufficient capacity is crucial to achieve the capacity to implement effective comprehensive tobacco control programs. A fully functioning infrastructure at the state/local level supports program sustainability, efficacy, efficiency, and enables programs to plan strategic efforts and foster collaboration (CDC Best Practices for Comprehensive Tobacco Control Programs, 2014 with an update expected in 2024).</td>
</tr>
<tr>
<td>Increase number of paid staff at the state/local level to conduct comprehensive tobacco control programs</td>
<td>Increasing the price of tobacco products reduces tobacco use prevalence and consumption among both adolescents and young adults and increases tobacco use cessation. Raising state tax rates would also bring the state additional revenue, public health benefits, and cost savings (Campaign for Tobacco-Free Kids, 2020).</td>
</tr>
<tr>
<td>Increase the price of tobacco products by raising the current state tax on cigarettes and increase other tobacco product taxes to parallel levels</td>
<td></td>
</tr>
<tr>
<td><strong>PROVIDING BARRIER-FREE ACCESS TO TOBACCO TREATMENT</strong></td>
<td>Expanded Medicaid eligibility increases access to evidence-based tobacco cessation treatment, including counseling, removes barriers that impede access, such as cost, promotes utilization of covered treatment, and disparities among individuals with behavioral health conditions by improving access to treatment (CDC, 2022).</td>
</tr>
<tr>
<td>Expand Medicaid coverage for all tobacco cessation treatment, including counseling and treatment for parents in any pediatric setting, and group counseling; and expand the accessibility of tobacco use treatment for Medicaid beneficiaries into more settings and modalities, with a broader array of providers</td>
<td>Behavioral counseling and FDA approved cessation medications increase the likelihood of successfully quitting tobacco use, particularly when used in combination (CDC, 2020).</td>
</tr>
<tr>
<td>Increase access to treatment based on the N.C. Tobacco Treatment Standard of Care, to include counseling and FDA-approved medications</td>
<td>Removing cost as a barrier increases access to nicotine replacement options and services to the uninsured and underinsured. People who use nicotine replacement therapy along with counseling can nearly double the chances of quitting tobacco use compared to people who try to quit without assistance (American Cancer Society, 2021).</td>
</tr>
<tr>
<td>Provide nicotine replacement options and services to the uninsured and underinsured</td>
<td></td>
</tr>
<tr>
<td>Support Tobacco Treatment Specialist Training for people serving those with commercial tobacco-product related inequities and disparities</td>
<td>People in low-income communities, racial and ethnic minorities, LGBT individuals and individuals with behavioral health conditions, are disproportionately affected by tobacco use (Truth Initiative, 2017). Tobacco Treatment Specialists can provide culturally competent and evidence-based treatment for tobacco use and dependence.</td>
</tr>
</tbody>
</table>

TABLE CONTINUED ON NEXT PAGE
### TABLE CONTINUED

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAISE STATE MINIMUM SALES AGE/ INCREASE RETAILER COMPLIANCE</td>
<td>Nicotine is harmful to developing brains, and its use during adolescence can disrupt the formation of brain circuits that control attention, learning, and susceptibility to addiction. Most youth in North Carolina obtain tobacco products, including e-cigarettes, from retailers. Raising the minimum legal sales age and increasing retailer compliance would prevent and reduce youth tobacco use (NCDHHS, 2022).</td>
</tr>
<tr>
<td>SMOKE-FREE AND TOBACCO-FREE ENVIRONMENTS</td>
<td></td>
</tr>
<tr>
<td>Enforce the federal law that calls for smoke-free multi-unit public housing and promote smoke-free multi-unit affordable housing</td>
<td>Smoke-free multi-unit housing protects residents and staff from exposure to secondhand smoke, saves property owners money on costs to turnover units, and significantly reduces the risk of fire for buildings (American Lung Association, 2022).</td>
</tr>
<tr>
<td>Implement state and local tobacco-free and smoke-free air policies that include electronic cigarettes</td>
<td>Comprehensive tobacco-free and smoke-free air policies can protect everyone from the harmful effects of secondhand smoke and electronic cigarette emissions. State and local tobacco-free and smoke-free air policies can also make it easier for tobacco users to quit and set a social norm that makes it less likely that young people will start using tobacco (CDC, 2022).</td>
</tr>
<tr>
<td>Increase the number of tobacco-free public parks</td>
<td>Tobacco-free policies at public parks protect all visitors from exposure to secondhand smoke and electronic cigarette emissions and can help change social norms about tobacco use (CDC, 2022).</td>
</tr>
<tr>
<td>Recommend an electronic cigarette policy for restaurants and bars</td>
<td>Electronic cigarettes decrease indoor air quality and expose bystanders to risks associated with secondhand exposure. Adding a prohibition to use of electronic cigarettes to North Carolina's successful Smoke-Free Restaurants and Bars law would expand protections for the health of the workforce and customers (Truth Initiative, 2021).</td>
</tr>
</tbody>
</table>

### RECOMMENDED READING/LISTENING

- Centers for Disease Control and Prevention- Secondhand Smoke (2022): [https://www.cdc.gov/tobacco/secondhand-smoke/](https://www.cdc.gov/tobacco/secondhand-smoke/)
- North Carolina Department of Health and Human Services, Tobacco Prevention and Control Branch- Sample Resolution- Protecting Our Kids from Vaping and Nicotine Addiction (September 26, 2022)
## ACTION PLAN

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at [https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm](https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm).

### NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Lung Association</td>
<td><a href="https://www.lung.org/">https://www.lung.org/</a></td>
</tr>
<tr>
<td>American Nonsmokers' Rights Foundation (ANRF)</td>
<td><a href="https://no-smoke.org/">https://no-smoke.org/</a></td>
</tr>
<tr>
<td>American Public Health Association (APHA)</td>
<td><a href="https://www.apha.org/apha-communities/member-sections/community-health-workers">https://www.apha.org/apha-communities/member-sections/community-health-workers</a></td>
</tr>
<tr>
<td>Association of State and Territorial Health Officials (ASTHO)-Tobacco Control Program</td>
<td><a href="https://www.astho.org/About/">https://www.astho.org/About/</a></td>
</tr>
<tr>
<td>BlueCross BlueShield of North Carolina Foundation</td>
<td><a href="https://www.bcbsncfoundation.org/">https://www.bcbsncfoundation.org/</a></td>
</tr>
<tr>
<td>BreatheEasyNC Becoming Tobacco Free</td>
<td><a href="https://breatheasync.org/">https://breatheasync.org/</a></td>
</tr>
<tr>
<td>Campaign for Tobacco Free Kids</td>
<td><a href="https://www.tobaccofreekids.org/">https://www.tobaccofreekids.org/</a></td>
</tr>
<tr>
<td>CenterLink- LGBT HealthLink</td>
<td><a href="https://www.lgbtcenters.org/Programs">https://www.lgbtcenters.org/Programs</a></td>
</tr>
<tr>
<td>Change for Life: Tobacco Free Recovery</td>
<td><a href="https://www.mombaby.org/">https://www.mombaby.org/</a></td>
</tr>
<tr>
<td>Coordinated Approach to Child Health (CATCH) My Breath</td>
<td><a href="https://countertools.org/">https://countertools.org/</a></td>
</tr>
<tr>
<td>Counter Tools</td>
<td><a href="https://countertobacco.org/">https://countertobacco.org/</a></td>
</tr>
<tr>
<td>Countertobacco.org</td>
<td><a href="https://dogwoodhealthtrust.org/">https://dogwoodhealthtrust.org/</a></td>
</tr>
<tr>
<td>Dogwood Health Trust</td>
<td><a href="https://www.dukeunccts.com/">https://www.dukeunccts.com/</a></td>
</tr>
<tr>
<td>Duke - UNC Tobacco Treatment Specialist Training Program</td>
<td><a href="https://www.mcleodcenters.org/wp/">https://www.mcleodcenters.org/wp/</a></td>
</tr>
<tr>
<td>McLeod Centers for Wellbeing</td>
<td><a href="https://naminc.org/">https://naminc.org/</a></td>
</tr>
<tr>
<td>National Alliance on Mental Illness- North Carolina Chapter</td>
<td><a href="https://www.naadac.org/about">https://www.naadac.org/about</a></td>
</tr>
<tr>
<td>National Association of Chronic Disease Directors (NACDD)</td>
<td><a href="https://www.naswnc.org/">https://www.naswnc.org/</a></td>
</tr>
<tr>
<td>National Native Network</td>
<td><a href="https://keepitsacred.itcmi.org/">https://keepitsacred.itcmi.org/</a></td>
</tr>
<tr>
<td>NCDHHS DPH Tobacco Prevention and Control Branch</td>
<td><a href="https://tobaccocontrolandprevention.dph.ncdhhs.gov/">https://tobaccocontrolandprevention.dph.ncdhhs.gov/</a></td>
</tr>
<tr>
<td>North Carolina Alliance For Health (NCAH)</td>
<td><a href="https://www.ncallianceforhealth.org/tobacco-use-prevention/">https://www.ncallianceforhealth.org/tobacco-use-prevention/</a></td>
</tr>
<tr>
<td>North Carolina American Indian Health Board</td>
<td><a href="https://ncaihb.org/">https://ncaihb.org/</a></td>
</tr>
<tr>
<td>North Carolina Area Health Education Centers (NC AHEC)</td>
<td><a href="https://www.ncahec.net/">https://www.ncahec.net/</a></td>
</tr>
<tr>
<td>North Carolina Association of Local Health Directors (NCALHD)</td>
<td><a href="https://www.ncalhd.org/">https://www.ncalhd.org/</a></td>
</tr>
<tr>
<td>North Carolina Association of Pharmacists (NCPHA)</td>
<td><a href="https://www.ncpharmacists.org/">https://www.ncpharmacists.org/</a></td>
</tr>
<tr>
<td>North Carolina Department of Public Instruction (NC DPI)</td>
<td><a href="https://www.dpi.nc.gov/">https://www.dpi.nc.gov/</a></td>
</tr>
<tr>
<td>North Carolina Medical Board</td>
<td><a href="https://www.ncmedboard.org/">https://www.ncmedboard.org/</a></td>
</tr>
<tr>
<td>North Carolina Public Health Association (NCPHA)</td>
<td><a href="https://ncpha.memberclicks.net/">https://ncpha.memberclicks.net/</a></td>
</tr>
<tr>
<td>Parents Against Vaping e-Cigarettes (PAVe)</td>
<td><a href="https://www.parentsagainstvaping.org/">https://www.parentsagainstvaping.org/</a></td>
</tr>
<tr>
<td>QuitlineNC</td>
<td><a href="https://www.quitlinenc.com/">https://www.quitlinenc.com/</a></td>
</tr>
<tr>
<td>Rescue Agency</td>
<td><a href="https://www.rescueagency.com/">https://www.rescueagency.com/</a></td>
</tr>
<tr>
<td>Sandhills Center</td>
<td><a href="https://www.sandhillscenter.org/">https://www.sandhillscenter.org/</a></td>
</tr>
<tr>
<td>School Nurse Association of North Carolina (SNANC)</td>
<td><a href="https://www.snanc.com/home">https://www.snanc.com/home</a></td>
</tr>
<tr>
<td>The African American Tobacco Control Leadership Council (AATCLC)</td>
<td><a href="https://www.savingblacklives.org/about">https://www.savingblacklives.org/about</a></td>
</tr>
<tr>
<td>The Center for Black Health &amp; Equity</td>
<td><a href="https://centerforblackhealth.org/">https://centerforblackhealth.org/</a></td>
</tr>
<tr>
<td>The Duke Endowment</td>
<td><a href="https://www.dukeendowment.org/">https://www.dukeendowment.org/</a></td>
</tr>
<tr>
<td>Truth Initiative</td>
<td><a href="https://truthinitiative.org/">https://truthinitiative.org/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 12: EXCESSIVE DRINKING

WHAT RESULT DO WE WANT?
All North Carolina communities support safe and responsible use of alcohol.

WHY IS THIS IMPORTANT?

- Excessive alcohol use is the third leading preventable cause of death in North Carolina. In 2021, there were over 6,300 deaths due to excessive alcohol use in North Carolina. Ninety percent of excessive drinkers are not alcohol dependent.
- Excessive drinking is associated with injuries, violence, and chronic conditions including stroke, hypertension, and some cancers.¹

WHAT DOES THIS INDICATOR MEASURE?

HEAVY DRINKING is derived from two questions asked on the annual Behavioral Risk Factor Surveillance System survey:

1. “During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor? One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.”

2. “During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?”

Heavy drinkers are:
- Women and men aged 65 or older who have 8 or more drinks per week.
- Men under 65 who have 15 or more drinks per week.

BINGE DRINKING is derived from a question asked on the annual Behavioral Risk Factor Surveillance System survey:

1. “Considering all types of alcoholic beverages, how many times during the past 30 days did you have [5 for men, 4 for women] or more drinks on an occasion?”

- Binge drinkers are respondents who report one or more episodes.

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th></th>
<th>BASELINE 2018</th>
<th>RECENT 2021</th>
<th>TARGET 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16.0%</td>
<td>16.7%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

HOW ARE WE DOING?

- The percent of adults who report excessive drinking continues to exceed the HNC 2030 target of 12.0%, except for Blacks/African Americans who reported 10.6% excessive drinking in 2021.
- Males continue to report higher percentage of excessive drinking than females.
CURRENT DATA TRENDED OVER TIME

Figure 45. Excessive drinking across populations in North Carolina (2019-2021)

YEAR

Figure 46. Excessive drinking in North Carolina by race/ethnicity (2019-2021)

YEAR

Figure 47. Excessive drinking across populations in North Carolina by gender (2019-2021)

YEAR
EXCESSIVE DRINKING

THE STORY BEHIND THE CURVE
Alcohol consumption increased during the COVID-19 pandemic in 2020 in the United States. The increase could substantially increase the numbers for long-term alcohol-associated liver disease (ALD) and mortality.1

WHAT OTHER DATA DO WE NEED?
- Alcohol Law Enforcement (ALE), the lead enforcement agency for the state’s alcoholic beverage control laws, data
- Availability of inpatient and outpatient treatment, counseling programs, and other community supports
- Data on historically marginalized populations (i.e., racially and ethnically diverse populations, immigrant populations, people experiencing homelessness, LGBTQIA+)
- Emergency medical service calls for excessive alcohol use and related harms

WHAT COULD WORK TO TURN THE CURVE?
The North Carolina State Excessive Alcohol Advisory Committee (NC SEAAC) has identified priority areas related to actions that impact access to alcohol (i.e., focusing on place, product, promotion, and price); reduction of harms (i.e., focusing on short- and long-term harms of alcohol); key populations (i.e., youth, pregnant people, veterans, BIPOC, etc.); and access to care (i.e., increasing screening and brief interventions). All areas center on equity, while highlighting disparities.

RECOMMENDED READING/LISTENING
Guide to Community Preventive Services, Excessive Alcohol Consumption: https://www.thecommunityguide.org/topics/excessive-alcohol-consumption.html
NC Injury and Violence Prevention Branch, Alcohol Data Dashboard: https://dashboards.ncdhhs.gov/t/DPH/views/AlcoholDashboard_2020Update_04042021/Story
NC Injury and Violence Prevention Branch, Alcohol Use and Related Harms Website: https://injuryfreenc.dph.ncdhhs.gov/DataSurveillance/alcohol.htm
The Centers for Disease Control and Prevention Alcohol Program: https://www.cdc.gov/alcohol/about.htm
The Societal Cost of Excessive Drinking in North Carolina, 2017: https://ncmedicaljournal.com/article/55455

ACTION PLAN
Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm.
**EXCESSIVE DRINKING**

**EXCESSIVE ALCOHOL USE IS THE THIRD LEADING PREVENTABLE CAUSE OF DEATH IN NORTH CAROLINA. IN 2021, THERE WERE OVER 6,300 DEATHS DUE TO EXCESSIVE ALCOHOL USE IN NORTH CAROLINA. 90% OF EXCESSIVE DRINKERS ARE NOT ALCOHOL DEPENDENT. EXCESSIVE DRINKING IS ASSOCIATED WITH INJURIES, VIOLENCE, AND CHRONIC CONDITIONS LIKE STROKE, HYPERTENSION, AND SOME CANCERS.**

- NCDHHS, The Excessive Alcohol Use in North Carolina Fact Sheet, June 2023

---

**NC PARTNERS WHO CAN HELP US**

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction Professionals North Carolina</td>
</tr>
<tr>
<td>Community Impact North Carolina</td>
</tr>
<tr>
<td>Forensic Tests for Alcohol - NC DPH Branch</td>
</tr>
<tr>
<td>Mothers Against Drunk Driving North Carolina</td>
</tr>
<tr>
<td>NC Alcohol Policy Alliance</td>
</tr>
<tr>
<td>NC Alcoholic Beverage Control Commission</td>
</tr>
<tr>
<td>NCDHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services</td>
</tr>
<tr>
<td>NCDHHS DPH Injury and Violence Prevention Branch</td>
</tr>
<tr>
<td>North Carolina Area Health Education Centers (NC AHEC)</td>
</tr>
<tr>
<td>North Carolina Fetal Alcohol Syndrome Disorder (FASD) Informed</td>
</tr>
<tr>
<td>North Carolina Preventing Underage Drinking Initiative</td>
</tr>
<tr>
<td>North Carolina Substance Use Disorder Federation</td>
</tr>
<tr>
<td>Proof Alliance NC</td>
</tr>
<tr>
<td>Recovery Communities of North Carolina (RCNC)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="https://www.apnc.org/">https://www.apnc.org/</a></td>
</tr>
<tr>
<td><a href="https://impactcarolina.org/">https://impactcarolina.org/</a></td>
</tr>
<tr>
<td><a href="https://publichealth.nc.gov/chronicdiseaseandinjury/fta/index.htm">https://publichealth.nc.gov/chronicdiseaseandinjury/fta/index.htm</a></td>
</tr>
<tr>
<td><a href="https://www.madd.org/north-carolina/">https://www.madd.org/north-carolina/</a></td>
</tr>
<tr>
<td><a href="https://twitter.com/ncaalcoholpolicy?lang=en">https://twitter.com/ncaalcoholpolicy?lang=en</a></td>
</tr>
<tr>
<td><a href="https://abc.nc.gov/">https://abc.nc.gov/</a></td>
</tr>
<tr>
<td><a href="https://injuryfreenc.dph.ncdhhs.gov/">https://injuryfreenc.dph.ncdhhs.gov/</a></td>
</tr>
<tr>
<td><a href="https://www.ncahec.net/">https://www.ncahec.net/</a></td>
</tr>
<tr>
<td><a href="https://ncfasdinformed.org/">https://ncfasdinformed.org/</a></td>
</tr>
<tr>
<td><a href="https://www.ncpudi.org/">https://www.ncpudi.org/</a></td>
</tr>
<tr>
<td><a href="https://sudfederation.org/">https://sudfederation.org/</a></td>
</tr>
<tr>
<td><a href="https://www.proofalliancenc.org/">https://www.proofalliancenc.org/</a></td>
</tr>
<tr>
<td><a href="https://www.rcnc.org/">https://www.rcnc.org/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 13: SUGAR-SWEETENED BEVERAGE CONSUMPTION

WHAT RESULT DO WE WANT?
All people in North Carolina live in communities that support healthy food and beverage choices.

WHY IS THIS IMPORTANT?
Sugar-sweetened beverages (SSBs) or sugary drinks are leading sources of added sugars in the American diet. Frequently drinking SSBs is associated with weight gain, obesity, type 2 diabetes, heart disease, kidney diseases, non-alcoholic liver disease, tooth decay and cavities, and gout (a type of arthritis). Limiting sugary drink intake can help individuals maintain a healthy weight and have healthy dietary patterns.1

WHAT DOES THIS INDICATOR MEASURE?

HNC 2030 Headline Indicator:
Percent of youth and adults reporting consumption of one or more sugar-sweetened beverages (SSBs) per day

- SSB Consumption among students in grades 9 through 12
- SSB consumption among adults

Adults
Derived from two questions asked on annual Behavioral Risk Factor Surveillance System (BRFSS) survey:

1. “During the past 30 days, how often did you drink regular soda or pop that contains sugar? Do not include diet soda or diet pop.”
2. “During the past 30 days, how often did you drink sugar-sweetened fruit drinks (such as Kool-Aid and lemonade), sweet tea, and sports or energy drinks (such as Gatorade and Red Bull). Do not include 100% fruit juice, diet drinks, or artificially sweetened drinks.”

Respondent gives the number of times per day, week, or month. Answers are recoded to yield number of SSBs consumed per day. The annual survey data are reported annually beginning in 2021 and available for the state with breakdowns for North Carolina Medicaid regions, Local Health Director regions, and Eastern North Carolina, the Piedmont, and Western North Carolina.

Youth
Data from NC Healthy Schools Youth Risk Behavior Survey (YRBS) Students in grades 9 through 12 were asked two survey questions with multiple choice answers in order to collect data for the measure.

1. “During the past 7 days, how many times did you drink a can, bottle, or glass of soda or pop, such as Coke, Pepsi, or Sprite? (Do not count diet soda or diet pop.)”
2. “During the past 7 days, how many times did you drink a can, bottle, or glass of a SSB such as sports drinks (for example, Gatorade or PowerAde), energy drinks (for example, Red Bull or Jolt), lemonade, sweetened tea or coffee drinks, flavored milk, Snapple, or Sunny Delight? (Do not count soda or pop or 100% fruit juice.)”

NC Department of Public Instruction (NC DPI) makes counts, percentages and confidence intervals for those percentages available every 2 years.

Baseline Data from HNC 2030

<table>
<thead>
<tr>
<th></th>
<th>Baseline 2017</th>
<th>Recent 2021</th>
<th>Target 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>34.2%</td>
<td>29.8%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Youth</td>
<td>33.6%</td>
<td>29.8%</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

**SUGAR-SWEETENED BEVERAGE CONSUMPTION**

**HOW ARE WE DOING?**

- SSB consumption questions became part of the annual Behavioral Risk Factor Surveillance System questions in 2021.
- The Youth Risk Behavior Survey (YRBS) is conducted in odd-numbered years.

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.²

**CURRENT DATA TRENDED OVER TIME**

**Figure 48. Sugar-sweetened beverage consumption across adult populations in North Carolina, 2021**

<table>
<thead>
<tr>
<th>PERCENT OF ADULTS CONSUMING ONE OR MORE SUGAR-SWEETENED BEVERAGE PER DAY</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>29.8%</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>29.1%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>30.2%</td>
</tr>
<tr>
<td>Hispanic/LatinX</td>
<td>29.9%</td>
</tr>
<tr>
<td>Male</td>
<td>34.1%</td>
</tr>
<tr>
<td>Female</td>
<td>26.0%</td>
</tr>
</tbody>
</table>

Data source: Behavioral Risk Factor and Surveillance System (BRFSS), N.C. State Center for Health Statistics

**Figure 49. Youth sugar-sweetened beverage consumption in North Carolina, 2015-2021**

<table>
<thead>
<tr>
<th>PERCENT OF YOUTH CONSUMING ONE OR MORE SUGAR-SWEETENED BEVERAGES PER DAY</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>39.2%</td>
</tr>
<tr>
<td>2017</td>
<td>33.6%</td>
</tr>
<tr>
<td>2019</td>
<td>30.1%</td>
</tr>
<tr>
<td>2021</td>
<td>29.8%</td>
</tr>
</tbody>
</table>

Data source: 2015-2021 Youth Behavior Risk Survey (YBRS) and North Carolina Department of Public Instruction (NC DPI)
Figure 50. Youth sugar-sweetened beverage consumption by gender in North Carolina, 2015-2021

Data source: 2015-2021 Youth Behavior Risk Survey (YBRS) and North Carolina Department of Public Instruction (NC DPI)

Figure 51. Youth sugar-sweetened beverage consumption by race in North Carolina, 2015-2021

Data source: 2015-2021 Youth Behavior Risk Survey (YBRS) and North Carolina Department of Public Instruction (NC DPI)

Figure 52. Youth sugar-sweetened beverage consumption by grade level in North Carolina, 2015-2021

Data source: 2015-2021 Youth Behavior Risk Survey (YBRS) and North Carolina Department of Public Instruction (NC DPI)
THE STORY BEHIND THE CURVE

- In 2011-2014, 6 in 10 youth (63%) and 5 in 10 adults (49%) drank an SSB on a given day. On average, US youth consumed 143 calories from SSBs and US adults consumed 145 calories from SSBs on a given day.
- Among youth, SSB intake is higher among boys, adolescents, non-Hispanic Black youth, or youth in families with low incomes.
- Among adults, SSB intake is higher among males, young adults, non-Hispanic Black, or Mexican American adults, or adults with low incomes.
- The prevalence of Americans who drink sugary drinks at least once per day differs geographically.
- For example, 68% of adults living in the Northeast, 67% of adults living in the South, 61% of adults living in the West, and 59% of adults living in the Midwest reported drinking SSBs one or more times per day.
- About 31% of adults in nonmetropolitan counties and 25% of adults in metropolitan counties reported drinking SSBs one or more times per day.
- Americans consume 52% of SSB calories at home and 48% of SSB calories away from home.

WHAT OTHER DATA DO WE NEED?

- Access to safe and clean water in schools
- Adoption of “default beverage” options for children's meals at food venues, including milk, 100% fruit juice, or water
- Availability of healthy alternatives to sugary drinks
- Availability of healthy choice options for vending machine suppliers
- Healthy procurement options
- Public and private investment in healthy food
- School and childcare policies on SSB sales and consumption
- Water quality in communities

WHAT COULD WORK TO TURN THE CURVE?

The Sugar-Sweetened Beverage Consumption Work Group identified the following priorities for action planning related to promotion and access to drinking water in schools, healthy food procurement, and default beverage options for children's meals.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrate “Rethink Your Drink” toolkit into school curricula, promoting water as a healthy alternative to sweetened beverages</td>
<td>Incorporating the “Rethink Your Drink” toolkit into classroom curricula promotes water consumption and teaches students about the relationship between sugar-sweetened beverage consumption and increases in rates of overweight and obesity (SNAP-Ed Toolkit, 2023).</td>
</tr>
<tr>
<td>Establish healthy food procurement policies that support public and private investment in healthy food, and increase availability of healthy alternatives to sugary drinks</td>
<td>Re-aligning food and agriculture policies, such as with health food procurement policies, can increase access to nutritious foods and make food systems more healthy, equitable and sustainable (WHO, 2022).</td>
</tr>
<tr>
<td>Recommend NC Department of Public Instruction (DPI) adopt a statewide policy permitting students to bring water bottles to school (containing only water)</td>
<td>Access to water is an important part of a healthy school nutrition environment. Allowing students to bring water bottles to school promotes water as a healthy alternative to sugar-sweetened beverages. Drinking water also helps children maintain a healthy weight, improves cognitive function, and helps prevent dental cavities (CDC, 2022).</td>
</tr>
<tr>
<td>Ensure access to safe and clean water in schools at water-filling stations that have been tested for safety</td>
<td>Most tap water in the United States is assured by the United States Environmental Protection Agency standards and regulations to be clean and safe for drinking (CDC, 2014). Water quality problems can be identified by having drinking water tested, so problems can be addressed when they exist.</td>
</tr>
<tr>
<td>Limit “default beverage” options for children's meals at food venues to include only milk, 100% fruit juice, or water</td>
<td>Access to healthy beverage options can limit the consumption of sugar-sweetened beverages and provide families with readily accessible healthy alternatives.</td>
</tr>
<tr>
<td>Implement healthy choice beverage in vending machines at schools and parks</td>
<td>Healthy vending options ensure healthy options are readily available.</td>
</tr>
</tbody>
</table>
SUGAR-SWEETENED BEVERAGE CONSUMPTION

RECOMMENDED READING/LISTENING


Healthy Drinks, Healthy Kids: https://healthydrinkshealthykids.org/


ACTION PLAN

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm.

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Centro Hispano, Inc.</td>
<td><a href="https://elcentronc.org/">https://elcentronc.org/</a></td>
</tr>
<tr>
<td>Farm to School Coalition of North Carolina</td>
<td><a href="https://www.farmtoschoolcoalitionnc.org/">https://www.farmtoschoolcoalitionnc.org/</a></td>
</tr>
<tr>
<td>Foundation for Health Leadership &amp; Innovation</td>
<td><a href="https://foundationhli.org/">https://foundationhli.org/</a></td>
</tr>
<tr>
<td>NC Academy of Family Physicians</td>
<td><a href="https://www.ncafp.com/">https://www.ncafp.com/</a></td>
</tr>
<tr>
<td>NC Alliance for Health</td>
<td><a href="https://www.ncallianceforhealth.org/">https://www.ncallianceforhealth.org/</a></td>
</tr>
<tr>
<td>NC Child</td>
<td><a href="https://ncchild.org/">https://ncchild.org/</a></td>
</tr>
<tr>
<td>NCDHHS DPH Community and Clinical Connections for Prevention and Health Branch</td>
<td><a href="https://www.communityclinicalconnections.com/">https://www.communityclinicalconnections.com/</a></td>
</tr>
<tr>
<td>NCDHHS DPH Oral Health Section</td>
<td><a href="https://www.dph.ncdhhs.gov/oralhealth/index.htm">https://www.dph.ncdhhs.gov/oralhealth/index.htm</a></td>
</tr>
<tr>
<td>NC Department of Public Instruction (DPI)</td>
<td><a href="https://www.dpi.nc.gov/">https://www.dpi.nc.gov/</a></td>
</tr>
<tr>
<td>NC Environmental Protection Agency (EPA)</td>
<td><a href="https://www.epa.gov/nc">https://www.epa.gov/nc</a></td>
</tr>
<tr>
<td>NC Environmental Quality (DEQ)</td>
<td><a href="https://www.deq.nc.gov/about/divisions/water-resources">https://www.deq.nc.gov/about/divisions/water-resources</a></td>
</tr>
<tr>
<td>NC Medical Society</td>
<td><a href="https://ncmedsoc.org/">https://ncmedsoc.org/</a></td>
</tr>
<tr>
<td>NC One Water</td>
<td><a href="https://nconewater.org/">https://nconewater.org/</a></td>
</tr>
<tr>
<td>NC Oral Health Collaborative</td>
<td><a href="https://oralhealthnc.org/">https://oralhealthnc.org/</a></td>
</tr>
<tr>
<td>NC Pediatric Society</td>
<td><a href="https://www.ncpedsc.org/">https://www.ncpedsc.org/</a></td>
</tr>
<tr>
<td>NC PTA</td>
<td><a href="https://ncpta.org/">https://ncpta.org/</a></td>
</tr>
<tr>
<td>NC Restaurant and Lodging Association (NCRLA)</td>
<td><a href="https://www.ncrla.org/">https://www.ncrla.org/</a></td>
</tr>
<tr>
<td>NC State Extension- Agricultural &amp; Human Sciences</td>
<td><a href="https://cals.ncsu.edu/agricultural-and-human-sciences/about/">https://cals.ncsu.edu/agricultural-and-human-sciences/about/</a></td>
</tr>
<tr>
<td>The Dairy Alliance</td>
<td><a href="https://thedairyalliance.com/">https://thedairyalliance.com/</a></td>
</tr>
<tr>
<td>The North Carolina Academy of Nutrition and Dietetics</td>
<td><a href="https://www.eatrightnc.org/">https://www.eatrightnc.org/</a></td>
</tr>
<tr>
<td>United Healthcare Community &amp; State</td>
<td><a href="https://www.uhccommunityandstate.com/">https://www.uhccommunityandstate.com/</a></td>
</tr>
<tr>
<td>University of North Carolina at Chapel Hill- Center for Health Promotion and Disease Prevention</td>
<td><a href="https://hpdp.unc.edu/">https://hpdp.unc.edu/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 14: HIV DIAGNOSIS

WHAT RESULT DO WE WANT?
All people in North Carolina experience sexual health with equitable access to quality and culturally competent 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 HEADLINE INDICATOR:
Number of new HIV diagnoses per 100,000 population

WHAT DOES THIS INDICATOR MEASURE?
The indicator measures new HIV infections.

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th>Baseline 2018</th>
<th>Recent 2021</th>
<th>Target 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.9</td>
<td>15.6</td>
<td>6.0</td>
</tr>
</tbody>
</table>

WE CAN WORK TO ADDRESS AND REDUCE STIGMA BY INCORPORATING EDUCATION AND AWARENESS OF HIV INTO PROVIDER TRAININGS, CULTURAL HUMILITY TRAININGS, AND EDUCATION TO YOUTH THROUGHOUT NORTH CAROLINA.

- NC Ending HIV: A Plan to End HIV Together Community-by-Community Hand-in-Hand

HOW ARE WE DOING?

- The estimated rate of HIV infection among newly diagnosed adults and adolescents is highest among Black/African Americans, 13 to 30 years old, and to those who identify as gay, bisexual men, or as men having sex with other men.
- 2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic.
- HIV rates have plateaued over recent years. In an effort to decrease rates, NC DPH and CDC are working closely with community members to implement use of HIV genotype network analysis, a new tool which helps focus services where they can be most effective in decreasing the rate of HIV transmission.
- Because the total number of transgender people living in North Carolina is not known, rates for HIV diagnosis in transgendered individuals cannot be calculated.
- People with lower income, who lack access to quality and culturally competent health care, sex workers, and incarcerated individuals have higher rates of diagnosis and lack resources for prevention and treatment of HIV.1
CURRENT DATA TRENDED OVER TIME

Figure 53. North Carolina newly diagnosed HIV rates (2010-2021*)

YEAR OF DIAGNOSIS

18.3 18.1 15.4 15.8 15.8 15.9 16.3 15.0 13.7 12.3 15.7

TARGET 2030 6.0

*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic.

Because the total number of transgender people living in North Carolina is not known, rates for HIV diagnosis in transgender people cannot be calculated. However, numbers of transgender people living with HIV in North Carolina are available in our annual report https://epi.ncpublichealth.info/cd/stds/annualrpts.html. Data source: Enhanced HIV/AIDS Reporting System (eHARS) (data as of September 2022).

Figure 54. North Carolina newly diagnosed HIV rates by race/ethnicity (2010-2021*)

YEAR OF DIAGNOSIS

55.4
21.7
6.3
3.4
26.9
14.3
6.5

*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic. *Non-Hispanic/LatinX.

Data source: Enhanced HIV/AIDS Reporting System (eHARS) (data as of September 2022).
Figure 55. North Carolina newly diagnosed HIV by gender (2010-2021*)

*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic. Because the total number of transgender people living in North Carolina is not known, rates for HIV diagnosis in transgender people cannot be calculated. However, numbers of transgender people living with HIV in North Carolina are available in our annual report https://epi.ncpublichealth.info/cd/stds/annualrpts.html. Data source: enhanced HIV/AIDS Reporting System (eHARS) (data as of September 2022).

Figure 56. North Carolina newly diagnosed HIV among men by race/ethnicity (2010-2021*)

*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic. *Non-Hispanic/Latino.

Because the total number of transgender people living in North Carolina is not known, rates for HIV diagnosis in transgender people cannot be calculated. However, numbers of transgender people living with HIV in North Carolina are available in our annual report https://epi.ncpublichealth.info/cd/stds/annualrpts.html. Data source: enhanced HIV/AIDS Reporting System (eHARS) (data as of September 2022).
**Figure 57. North Carolina newly diagnosed HIV among women by race/ethnicity (2010-2021*)**

YEAR OF DIAGNOSIS

<table>
<thead>
<tr>
<th>YEAR</th>
<th>American Indian/Alaska Native^Women</th>
<th>Black/African American^Women</th>
<th>Asian/Pacific Islander^Women</th>
<th>Hispanic/LatinX^Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>28.6</td>
<td>9.4</td>
<td>3.3</td>
<td>1.8</td>
</tr>
<tr>
<td>2011</td>
<td>25.8</td>
<td>9.1</td>
<td>3.0</td>
<td>1.5</td>
</tr>
<tr>
<td>2012</td>
<td>22.1</td>
<td>8.5</td>
<td>2.8</td>
<td>1.3</td>
</tr>
<tr>
<td>2013</td>
<td>19.4</td>
<td>8.0</td>
<td>2.6</td>
<td>1.1</td>
</tr>
<tr>
<td>2014</td>
<td>16.7</td>
<td>7.5</td>
<td>2.4</td>
<td>0.9</td>
</tr>
<tr>
<td>2015</td>
<td>14.8</td>
<td>7.0</td>
<td>2.2</td>
<td>0.7</td>
</tr>
<tr>
<td>2016</td>
<td>13.0</td>
<td>6.5</td>
<td>2.0</td>
<td>0.5</td>
</tr>
<tr>
<td>2017</td>
<td>11.2</td>
<td>6.0</td>
<td>1.8</td>
<td>0.4</td>
</tr>
<tr>
<td>2018</td>
<td>9.4</td>
<td>5.5</td>
<td>1.6</td>
<td>0.3</td>
</tr>
<tr>
<td>2019</td>
<td>7.6</td>
<td>5.0</td>
<td>1.4</td>
<td>0.2</td>
</tr>
<tr>
<td>2020*</td>
<td>15.7</td>
<td>7.6</td>
<td>2.0</td>
<td>1.5</td>
</tr>
<tr>
<td>2021</td>
<td>13.1</td>
<td>6.5</td>
<td>1.8</td>
<td>1.3</td>
</tr>
</tbody>
</table>

*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic.  ^Non-Hispanic/LatinX.

Because the total number of transgender people living in North Carolina is not known, rates for HIV diagnosis in transgender people cannot be calculated. However, numbers of transgender people living with HIV in North Carolina are available in our annual report [https://epi.ncpublichealth.info/cd/stds/annualrpts.html](https://epi.ncpublichealth.info/cd/stds/annualrpts.html). Data source: enhanced HIV/AIDS Reporting System (eHARS) (data as of September 2022).

**Figure 58. North Carolina disparities in new HIV diagnoses among race/ethnicities (2010-2021*)**

YEAR OF DIAGNOSIS

<table>
<thead>
<tr>
<th>YEAR</th>
<th>American Indian/Alaska Native^ and White/Caucasian^</th>
<th>Black/African American^ and White/Caucasian^</th>
<th>Asian/Pacific Islander^ and White/Caucasian^</th>
<th>Hispanic/LatinX and White/Caucasian^</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>8.9</td>
<td>3.5</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>2011</td>
<td>8.9</td>
<td>3.5</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>2012</td>
<td>8.9</td>
<td>3.5</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>2013</td>
<td>8.9</td>
<td>3.5</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>2014</td>
<td>8.9</td>
<td>3.5</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>2015</td>
<td>8.9</td>
<td>3.5</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>2016</td>
<td>8.9</td>
<td>3.5</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>2017</td>
<td>8.9</td>
<td>3.5</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>2018</td>
<td>8.9</td>
<td>3.5</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>2019</td>
<td>8.9</td>
<td>3.5</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>2020*</td>
<td>8.2</td>
<td>5.1</td>
<td>2.7</td>
<td>1.2</td>
</tr>
<tr>
<td>2021</td>
<td>8.2</td>
<td>5.1</td>
<td>2.7</td>
<td>1.2</td>
</tr>
</tbody>
</table>

*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic.  ^Non-Hispanic/LatinX.

Data source: Enhanced HIV/AIDS Reporting System (eHARS) (data as of September 2022).
THE STORY BEHIND THE CURVE

Thousands of people in the United States are diagnosed with HIV every year. Many people have HIV for years before they know it. Testing everyone aged 13 to 64 for HIV at least once in their lifetime — and testing people at high risk for HIV at least once a year — can lead to early diagnosis and treatment.2

People must feel safe when seeking health care. This means acknowledging the person respectfully – especially for transgender individuals. Good quality sexual health education across the lifespan helps to normalize and integrate sexual health as a standard component of overall health awareness. Clinical staff must receive training specific to clinical care for transgender people.

Non-traditional testing and notification systems are needed. These could include multiple ways for people to notify others of exposure, such as a website for anonymous contact notification. Home-based STI testing and virtual clinical visits could improve early detection.

WHAT OTHER DATA DO WE NEED?

- Availability of PrEP (pre-exposure prophylaxis) within community
- Community awareness of sexual health
- Distribution of screening and testing opportunities to evaluate equitable access to care and saturation of data
- Incidence of gonorrhea and chlamydia because of their higher prevalence
- Map coverage of social media platforms used by the at-risk community
- Time to treatment from initial diagnosis – consider a metric for multiple sexually transmitted infections (STIs)

WHAT COULD WORK TO TURN THE CURVE?

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand affordable housing programs for people living with HIV</td>
<td>Stable housing allows people living with HIV/AIDS to access comprehensive healthcare and adhere to HIV treatment (HOPWA, 2023).</td>
</tr>
<tr>
<td>Expand North Carolina's provider network for HIV care and prevention services</td>
<td>Expanding the provider network for HIV care and prevention services would increase the availability and coordination of outpatient healthcare and support services for individuals living with HIV in North Carolina.</td>
</tr>
<tr>
<td>Identify and address gaps in HIV healthcare access for formerly incarcerated populations</td>
<td>Many barriers exist between correctional facilities and community providers, which can affect the care and services incarcerated people receive while in the facility and during their re-entry process (HRSA, 2020).</td>
</tr>
<tr>
<td>Identify barriers to HIV post exposure prophylaxis (PEP) being delivered by pharmacists</td>
<td>North Carolina's licensed, practicing, immunizing pharmacists have authority to dispense, deliver, or administer post-exposure prophylaxis (PEP) medications for prevention of HIV, pursuant to standing order. (NCDHHS, 2022). Any barriers to pharmacists' ability to deliver these medications must be identified in order to be addressed.</td>
</tr>
<tr>
<td>Improve provider comfort with incorporating sexual health assessments into routine healthcare services</td>
<td>Continuing professional development for providers, as well as residency and medical school programs on sexual health helps to normalize the topic and discussion as well as address stigma.</td>
</tr>
<tr>
<td>Increase access to pre-exposure prophylaxis (PrEP) for individuals at high risk for HIV transmission</td>
<td>Pre-exposure prophylaxis (PrEP) is an HIV prevention medication initiated before and continued throughout periods of potential exposure to HIV. PrEP is highly effective when taken as prescribed (CDC, 2021).</td>
</tr>
<tr>
<td>Increase the number of harm reduction programs, including needle exchange programs</td>
<td>Harm reduction services can lessen harms associated with drug use and related behaviors that increase the risk of infectious diseases, including HIV (SAMHSA, 2023).</td>
</tr>
<tr>
<td>Increase the number of people who know their HIV status and are linked to prevention or treatment services through high impact, coordinated interventions</td>
<td>Awareness of HIV status can lead to early diagnosis and treatment for people with HIV and those that do not have HIV can make decisions about sex, drug use, and health care that can help prevent HIV (CDC, 2022).</td>
</tr>
</tbody>
</table>
**RECOMMENDED READING/LISTENING**


NCDHHS - HIV Care: [https://epi.dph.ncdhhs.gov/cd/hiv/program.html](https://epi.dph.ncdhhs.gov/cd/hiv/program.html)


**ACTION PLAN**

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at [https://schs.dph.ncdhhs.gov/units/ladas/hnc.htm](https://schs.dph.ncdhhs.gov/units/ladas/hnc.htm).

**NC PARTNERS WHO CAN HELP US**

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>CarolinaCare Partnership</td>
<td><a href="https://www.carolinascare.org/">https://www.carolinascare.org/</a></td>
</tr>
<tr>
<td>Duke University- Health Justice Clinic</td>
<td><a href="https://law.duke.edu/healthjustice/">https://law.duke.edu/healthjustice/</a></td>
</tr>
<tr>
<td>Durham County Department of Public Health – Formerly Incarcerated Transitions (FIT) Program</td>
<td><a href="https://www.dcopublichealth.org/services/std-hiv-testing">https://www.dcopublichealth.org/services/std-hiv-testing</a></td>
</tr>
<tr>
<td>Equality North Carolina</td>
<td><a href="https://equalitync.org/issues/hiv_aids_work/">https://equalitync.org/issues/hiv_aids_work/</a></td>
</tr>
<tr>
<td>Getting To Zero Mecklenburg</td>
<td><a href="https://www.mecknc.gov/HealthDepartment/GettingToZero/Pages/Home.aspx">https://www.mecknc.gov/HealthDepartment/GettingToZero/Pages/Home.aspx</a></td>
</tr>
<tr>
<td>House of Mercy</td>
<td><a href="https://www.thehouseofmercy.org/">https://www.thehouseofmercy.org/</a></td>
</tr>
<tr>
<td>Mecklenburg County Public Health- HIV/STI Division</td>
<td><a href="https://health.mecknc.gov/clinical-services/STDtesting">https://health.mecknc.gov/clinical-services/STDtesting</a></td>
</tr>
<tr>
<td>NC Board of Pharmacy</td>
<td><a href="http://www.ncbop.org/">http://www.ncbop.org/</a></td>
</tr>
<tr>
<td>NC Council of Churches</td>
<td><a href="https://www.ncchurches.org/">https://www.ncchurches.org/</a></td>
</tr>
<tr>
<td>NCDHHS HIV Care Program</td>
<td><a href="https://epi.dph.ncdhhs.gov/cd/hiv/program.html">https://epi.dph.ncdhhs.gov/cd/hiv/program.html</a></td>
</tr>
<tr>
<td>NCDHHS Medicaid Be Smart Family Planning Program</td>
<td><a href="https://ncgov.servicenowservices.com/sp_beneficiary?id=kb_article&amp;sys_id=389050c51b5424906aacdb1ee54bcba8&amp;table=kb_knowledge">https://ncgov.servicenowservices.com/sp_beneficiary?id=kb_article&amp;sys_id=389050c51b5424906aacdb1ee54bcba8&amp;table=kb_knowledge</a></td>
</tr>
<tr>
<td>NCDHHS DPH Injury and Violence Prevention Branch</td>
<td><a href="https://www.injuryfreenc.ncdhhs.gov/">https://www.injuryfreenc.ncdhhs.gov/</a></td>
</tr>
<tr>
<td>North Carolina Institute of Medicine (NCIOM)</td>
<td><a href="https://nciom.org/">https://nciom.org/</a></td>
</tr>
<tr>
<td>North Carolina Area Health Education Centers (NC AHEC)</td>
<td><a href="https://www.ncahec.net/">https://www.ncahec.net/</a></td>
</tr>
<tr>
<td>North Carolina Association of Pharmacists (NCAP)</td>
<td><a href="https://www.ncpharmacists.org/">https://www.ncpharmacists.org/</a></td>
</tr>
<tr>
<td>North Carolina Community Health Center Association (NCHCA)</td>
<td><a href="https://www.nccha.org/">https://www.nccha.org/</a></td>
</tr>
<tr>
<td>North Carolina Harm Reduction Coalition (NCHRC) – Syringe Exchange Program</td>
<td><a href="https://www.nchrc.org/about/">https://www.nchrc.org/about/</a></td>
</tr>
<tr>
<td>North Carolina Sheriffs’ Association (NCSA)</td>
<td><a href="https://ncsheriffs.org/">https://ncsheriffs.org/</a></td>
</tr>
<tr>
<td>Regional AIDS Interfaith Network (RAIN)</td>
<td><a href="https://carolinaraain.org/">https://carolinaraain.org/</a></td>
</tr>
<tr>
<td>The North Carolina Barbers Association</td>
<td><a href="https://www.ncbih.org/home">https://www.ncbih.org/home</a></td>
</tr>
<tr>
<td>The Task Force for Global Health - Coalition for Global Hepatitis Elimination</td>
<td><a href="https://taskforce.org/viral-hepatitis/">https://taskforce.org/viral-hepatitis/</a></td>
</tr>
<tr>
<td>UNC Center for Health Equity Research (CHER) - TRANSforming the Carolinas Project</td>
<td><a href="https://www.med.unc.edu/cher/">https://www.med.unc.edu/cher/</a></td>
</tr>
<tr>
<td>UNC Chapel Hill Center for AIDS Research</td>
<td><a href="http://unccfar.org/">http://unccfar.org/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 15: TEEN BIRTH

WHAT RESULT DO WE WANT?
All people in North Carolina live in communities that 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 lives and their own.

WHAT DOES THIS INDICATOR MEASURE?

```
TEEN BIRTH RATE = \frac{\text{Number of births to women ages 15-19 years}}{\text{Number of women ages 15-19 years}} \times 1,000
```

The data are produced annually using ages and counts from resident birth certificate data. The data are disaggregated by county, race, and perinatal care region. This indicator is often referred to as the fertility rate.

BASELINE DATA FROM HNC 2030

```
<table>
<thead>
<tr>
<th></th>
<th>BASELINE 2018</th>
<th>RECENT 2021</th>
<th>TARGET 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of births to females aged 15-19 per 1,000 population</td>
<td>18.7</td>
<td>16.0</td>
<td>10.0</td>
</tr>
</tbody>
</table>
```

“THE ECONOMIC, SOCIAL, AND ENVIRONMENTAL CONDITIONS WHERE PEOPLE LIVE, LEARN, WORK, WORSHIP, AND PLAY ALL AFFECT PERINATAL HEALTH OUTCOMES.”

- 2022-2026 NC Perinatal Health Strategic Plan

HOW ARE WE DOING?
• Births to females aged 15-19 years old have seen a steady decline across all race/ethnicities since 2010, with the exception of Hispanic/Latinx, however caution must be used in interpreting data from small populations.
According to the National Campaign to Prevent Teen and Unplanned Pregnancy, teen childbearing costs taxpayers in North Carolina over $325 million annually, and nationally the annual cost is over $9.4 billion. Additionally, pregnancy and birth are significant contributors to high school dropout rates among girls, with only about 50 percent of teen mothers receiving a high school diploma by age 22, compared to 90 percent of women who do not give birth as a teen. Teen mothers are also more likely to rely on public assistance, be poor as adults, and more likely to have children with poorer health outcomes over the course of their lives than children born to older mothers.
TEEN BIRTH

WHAT OTHER DATA DO WE NEED?

- Barriers to access contraception specific to adolescents
- Data on school-based clinics that provide reproductive health services
- Data that helps providers better understand utilization of services
- Data to identify gaps in community resources and services
- Location of contraceptive health services (public and private)

WHAT COULD WORK TO TURN THE CURVE?

The NC Perinatal Health Strategic Plan (PHSP) serves as a statewide guide to improve maternal and infant health and the health of all people of reproductive age. The PHSP includes three primary goals and beneath each goal are the four points to move that goal forward, and beneath each point are strategies to carry out the work that will improve health and health equity across the state. Refer to the PHSP for points and strategies. [PHSP, page 1].

- Goal 1- Address Economic and Social Inequities
- Goal 2- Strengthen Families and Communities
- Goal 3- Improve Health Care for All People of Reproductive Age

The Perinatal Health Equity Collective Policy Workgroup prioritized the following PHSP strategy that aligns with the 2022 NC SHIP. The numbers included with the prioritized policies refer to the strategy numbers in the PHSP.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>12F. Increase same-day access to all methods of contraception</td>
<td>Same-day access to all methods of contraception improves health care for all people of reproductive age. Pregnant teenagers 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.</td>
</tr>
</tbody>
</table>

RECOMMENDED READING/LISTENING

2022-2026: NC Perinatal Health Strategic Plan: https://wicws.dph.ncdhhs.gov/phsp/

ACTION PLAN

The Perinatal Health Equity Collective (PHEC) Data and Evaluation Work Group compiles data annually for the Perinatal Health Equity Strategic Plan’s data indicators and monitors new data sources. In addition, they promote data quality improvement and assist other PHEC work groups to move data to action, focusing on a research action plan and providing technical assistance for the environmental scanning process.

Progress on the Perinatal Health Equity Strategic Plan is also being tracked internally by the North Carolina Division of Public Health; the most recent plan is available on the Division of Public Health's website at https://wicws.dph.ncdhhs.gov/phsp/.

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fact Forward</td>
<td><a href="https://www.facforward.org/">https://www.facforward.org/</a></td>
</tr>
<tr>
<td>NC Academy of Family Physicians</td>
<td><a href="https://www.ncafp.com/">https://www.ncafp.com/</a></td>
</tr>
<tr>
<td>NCDHHS Adolescent Pregnancy Prevention Program</td>
<td><a href="https://teenpregnancy.dph.ncdhhs.gov/app.htm">https://teenpregnancy.dph.ncdhhs.gov/app.htm</a></td>
</tr>
<tr>
<td>NCDHHS Personal Responsibility Education Program (PREPare) for Success</td>
<td><a href="https://teenpregnancy.dph.ncdhhs.gov/prep.htm">https://teenpregnancy.dph.ncdhhs.gov/prep.htm</a></td>
</tr>
<tr>
<td>NC Obstetrical and Gynecological Society</td>
<td><a href="https://www2.ncmedsoc.org/nc-obstetrical-and-gynecological-society">https://www2.ncmedsoc.org/nc-obstetrical-and-gynecological-society</a></td>
</tr>
<tr>
<td>NC Pediatric Society</td>
<td><a href="https://www.ncped.org/">https://www.ncped.org/</a></td>
</tr>
<tr>
<td>North Carolina Area Health Education Centers (NC AHEC)</td>
<td><a href="https://www.ncahec.net">https://www.ncahec.net</a></td>
</tr>
<tr>
<td>North Carolina School Health Training Center (NCSHTC) - ECU</td>
<td><a href="https://hhp.ecu.edu/nchtc/">https://hhp.ecu.edu/nchtc/</a></td>
</tr>
<tr>
<td>Nurse-Family Partnership</td>
<td><a href="https://www.nursefamilypartnership.org/">https://www.nursefamilypartnership.org/</a></td>
</tr>
<tr>
<td>Parents As Teachers</td>
<td><a href="https://parentsteachers.org/">https://parentsteachers.org/</a></td>
</tr>
<tr>
<td>Teen Health Connection</td>
<td><a href="https://teenhealthconnection.org/">https://teenhealthconnection.org/</a></td>
</tr>
</tbody>
</table>
HNC 2030 Indicators

CLINICAL CARE FACTORS

Uninsured...........................................................106-111
Primary Care Clinicians......................................112-115
Early Prenatal Care.............................................116-119
Suicide Rate......................................................120-122
HEALTH INDICATOR 16: UNINSURED

WHAT RESULT DO WE WANT?
All people in North Carolina have access to comprehensive, high quality, affordable health 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 HEADLINE INDICATOR:
Percent of the population under age 65 without health insurance

WHAT DOES THIS INDICATOR MEASURE?
- Uses Small Area Health Insurance Estimates (SAHIE), reported annually by the U.S. Census Bureau
- Combines data from the American Community Survey (ACS), Demographic population estimates, aggregated federal tax returns, participation records for the Supplemental Nutrition Assistance Program (SNAP), county Business Patterns, Medicaid, Children’s Health Insurance Program (CHIP) participation records, and the US Census
- Consistent estimates are available from 2008-2019
- Disaggregated by race, gender, income level, age group, and county
- Not all cross classifications are available

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th></th>
<th>BASELINE 2017</th>
<th>RECENT 2021</th>
<th>TARGET 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12.6%</td>
<td>12.5%</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

HOW ARE WE DOING?

- The percent of people uninsured may have increased for White/Caucasian and Black/African American race/ethnicities during the pandemic. This increase may be related to job loss and loss of employer-sponsored insurance.
- Hispanic/LatinX had the highest rate of uninsured compared to Black/African American and White/Caucasian. The percentage of Hispanic/LatinX reporting being uninsured dropped from 2019 to 2020 but then increased 2020 to 2021.
- People at or below 200% of the Federal Poverty Level are four to five times more likely to not have health insurance than people at 400% and above the Federal Poverty Level.
CURRENT DATA TRENDED OVER TIME

Figure 61. Percent of population under 65 with no insurance in North Carolina (2014-2021)

Data source: Small Area Health Insurance Estimate (SAHIE)

Figure 62. Percent of population under 65 with no insurance in North Carolina by race/ethnicity (2014-2021)

Data source: Small Area Health Insurance Estimate (SAHIE)
Figure 63. Percent of population under 65 with no insurance in North Carolina by gender (2014-2021)

Figure 64. Percent of people under 65 with no insurance in North Carolina by poverty level (2014-2021)
THE STORY BEHIND THE CURVE

The 2021 NC State Health Improvement Plan Community Council Meeting and Stakeholder Symposia stimulated dialogue among attendees. Questions that the participants posed included:

- Is healthcare a right?
- What is the standard for high quality health care? Is there a living document?
- What does high quality mean? Standards of care have been established.
- Who shares the responsibility?
- Who benefits from high quality healthcare?
- Does the government bail out insurance companies by giving a certain amount of care, but doesn't address root causes or families getting the care that they need?
- Who owns this issue in the state?
- Who were the community care givers? Are there enough of the other groups to meet the unmet need?
- Did the care of people fall to the community when we did not have health insurance 100 years ago?
- Does shared responsibility bring out the opportunity to do nothing?

The same attendees expanded the story about uninsured people with these collective statements:

- “People need information about the different levels of insurance within plans.”
- “Many people do not qualify for the subsidies and fall into a coverage gap.”
- “Because North Carolina has a robust safety net, there is a philosophical and political bias against support for Medicaid expansion.”
- “The safety net is an excuse not to expand Medicaid.”
- “We may need new words to describe the problems and the solutions to avoid the pitfalls of bias in our public discourse.”
- “The terminology we use for the uninsured can be stigmatizing.”
- “The undocumented population doesn’t qualify for these services.”
- “Implicit bias needs to be addressed to create change.”
- “Paternal leave/care not offered by some employers.”
- “Family care excludes father.”

WHAT OTHER DATA DO WE NEED?

- Data on the capacity of health centers, shared resources, and mobile unit utilization
- Characteristics of the uninsured population in North Carolina and at the county level, including the numbers of uninsured remaining if/when Medicaid is expanded, their demographic information and employment status
- Measurable and reliable data about the uninsured
WHAT COULD WORK TO TURN THE CURVE?

The Uninsured Work Group identified the following priorities for action planning. Work group members engaged in discussions and review of best practices related to Medicaid eligibility criteria, financial support for community health workers, health clinic sustainability, and opportunities to leverage savings from Medicaid transformation.

The work group also acknowledged the need to designate “ownership” of the uninsured problem in North Carolina. Responsibility for the uninsured is fragmented in the state and not focused on a single agency. Additional future considerations could include expanding Medicaid, appointing a safety-net provider collaboration, a public-private coalition, or a state agency to own and address issues affecting care for the state’s uninsured population, including improving data collection about the uninsured and addressing social drivers of health services for the uninsured.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Medicaid, including expanding recipient eligibility criteria</td>
<td>Medicaid expansion will benefit an estimated 600,000 North Carolinians (NC Justice Center, 2023). Expanding recipient eligibility criteria would increase access to health coverage for those that make too much money to qualify for Medicaid, but too little to qualify for a subsidy on the health insurance marketplace.</td>
</tr>
<tr>
<td>Determine the need for expanding and sustaining financial support for Community Health Workers</td>
<td>Community health workers (CHWs) empower communities to ensure all individuals can access health care. Cessation of federal and state funding for CHWs on December 31, 2022, resulted in immediate layoffs for hundreds of CHWs across North Carolina. For the CHW workforce to be expanded or sustained, exploration into other funding models is needed.</td>
</tr>
<tr>
<td>Determine the need for sustaining health clinics for the uninsured</td>
<td>Sustainability of current safety-net clinics ensures continued access to care. Evaluating sustainability provides an opportunity to understand funding and resource needs, consider additional partnerships, and explore alternative ways to address access to care.</td>
</tr>
<tr>
<td>Repurpose savings and surpluses created by Medicaid transformation and expansion and leverage the community benefit programs of health systems to fund programs for the uninsured</td>
<td>There may be opportunities to utilize new funds invested through Medicaid Transformation and community benefit programs to benefit the uninsured.</td>
</tr>
</tbody>
</table>

RECOMMENDED READING/LISTENING


The UCITY Family Zone: A Community Health Science Approach: [https://www.unityfamilyzone.com/](https://www.unityfamilyzone.com/)

ACTION PLAN

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at [https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm](https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm).
ONCE ENACTED, IT WILL BE CRITICAL THAT NORTH CAROLINA’S MEDICAID EXPANSION PROGRAM IS AVAILABLE TO AS MANY OF THE 600,000 NORTH CAROLINIANS IN THE HEALTH INSURANCE COVERAGE GAP AS POSSIBLE. THIS IS ESPECIALLY CRITICAL TO THE NORTH CAROLINIANS THAT GAINED MEDICAID COVERAGE DURING THE PUBLIC HEALTH EMERGENCY AND WHOSE ELIGIBILITY WILL HAVE TO BE REDETERMINED WHEN THE PUBLIC HEALTH EMERGENCY ENDS.

- Abby Carter Emanuelson, Executive Director, Care4Carolina

---

**NC PARTNERS WHO CAN HELP US**

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Heart Association</td>
<td><a href="https://www.heart.org/">https://www.heart.org/</a></td>
</tr>
<tr>
<td>Anesthesiology Consultants of North Carolina, PLLC</td>
<td><a href="https://www.acnchealth.com/">https://www.acnchealth.com/</a></td>
</tr>
<tr>
<td>Benson Health</td>
<td><a href="https://bensonhealth.org/">https://bensonhealth.org/</a></td>
</tr>
<tr>
<td>Blue Ridge Health</td>
<td><a href="https://www.brchs.com/">https://www.brchs.com/</a></td>
</tr>
<tr>
<td>Care4Carolina</td>
<td><a href="https://care4carolina.com/">https://care4carolina.com/</a></td>
</tr>
<tr>
<td>Down Home North Carolina</td>
<td><a href="https://downthomenc.org/">https://downthomenc.org/</a></td>
</tr>
<tr>
<td>Equality North Carolina</td>
<td><a href="https://equalitync.org/">https://equalitync.org/</a></td>
</tr>
<tr>
<td>Foundation for Health Leadership &amp; Innovation (FHLI)- NC Rural Health Leadership Alliance (NCRHLA)</td>
<td><a href="https://foundationhli.org/nrchla/">https://foundationhli.org/nrchla/</a></td>
</tr>
<tr>
<td>Legal Aid of North Carolina</td>
<td><a href="https://legalaidnc.org/project/medical-legal-partnership/">https://legalaidnc.org/project/medical-legal-partnership/</a></td>
</tr>
<tr>
<td>MDC</td>
<td><a href="https://www.mdcinc.org/">https://www.mdcinc.org/</a></td>
</tr>
<tr>
<td>NC Child</td>
<td><a href="https://ncchild.org/">https://ncchild.org/</a></td>
</tr>
<tr>
<td>NCDHHS Office of Rural Health</td>
<td><a href="https://www.ncdhhs.gov/divisions/orh">https://www.ncdhhs.gov/divisions/orh</a></td>
</tr>
<tr>
<td>NC Rural Center</td>
<td><a href="https://www.ncruralcenter.org/">https://www.ncruralcenter.org/</a></td>
</tr>
<tr>
<td>Next Stage</td>
<td><a href="https://nextstage-consulting.com/">https://nextstage-consulting.com/</a></td>
</tr>
<tr>
<td>North Carolina Area Health Education Centers (NC AHEC)</td>
<td><a href="https://www.ncahec.net/">https://www.ncahec.net/</a></td>
</tr>
<tr>
<td>North Carolina Association of Local Health Directors (NCALHD)</td>
<td><a href="https://www.ncalhd.org/">https://www.ncalhd.org/</a></td>
</tr>
<tr>
<td>North Carolina Community Health Center Association (NCCHCA)</td>
<td><a href="https://ncchwa.org/">https://ncchwa.org/</a></td>
</tr>
<tr>
<td>North Carolina Community Health Worker Association</td>
<td><a href="https://ncchwa.org/en/">https://ncchwa.org/en/</a></td>
</tr>
<tr>
<td>NCCHWA – North Carolina Community Health Workers Association – Advancing Community Health Workers (CHWs)</td>
<td><a href="https://ncchwa.org/">https://ncchwa.org/</a></td>
</tr>
<tr>
<td>North Carolina Justice Center</td>
<td><a href="https://www.ncjustice.org/">https://www.ncjustice.org/</a></td>
</tr>
<tr>
<td>Old North State Medical Society</td>
<td><a href="https://onsms.org/">https://onsms.org/</a></td>
</tr>
<tr>
<td>Project Access of Durham County</td>
<td><a href="https://projectaccessdurham.org/">https://projectaccessdurham.org/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 17: PRIMARY CARE CLINICIANS

WHAT RESULT DO WE WANT?
All people in North Carolina have access to comprehensive, high quality, affordable health care provided by clinicians who identify with the culture of people they serve.

WHY IS THIS IMPORTANT?
Having a primary care provider (PCP) is important for maintaining health and preventing and managing serious diseases. PCPs can develop long-term relationships with patients and coordinate care across health care providers. Strategies like team-based care and innovative payment methods are promising approaches for improving access to primary care.¹

WHAT DOES THIS INDICATOR MEASURE?
This indicator is a measurement of geographic access to health care expressed as a ratio of clinician to population. Lower is better: 1:2,000 is better than 1:4,000. The HNC 2030 target is 1:1,500. Clinicians include primary care physicians, physician assistants, nurse practitioners, and certified nurse midwives.

Licensure data for clinicians in North Carolina is the primary data source. Clinicians are assigned to a county based on primary practice location:
- A primary care clinician is a physician or physician assistant practicing family medicine, general internal medicine, pediatrics, or obstetrics and gynecology
- A nurse practitioner must be certified in a primary care specialty, e.g., a family nurse practitioner and working in a primary care setting, e.g., not a hospital
- A certified nurse midwife must be working in a primary care setting, e.g., not a hospital

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th>BASELINE</th>
<th>CURRENT</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>64 COUNTIES (2017)</td>
<td>78 COUNTIES (2021)</td>
<td>100 COUNTIES</td>
</tr>
<tr>
<td>1:1,500 primary care provider to population ratio</td>
<td>1:1,500</td>
<td>1:1,500</td>
</tr>
</tbody>
</table>

HOW ARE WE DOING?
- The number of counties meeting the HNC 2030 target ratio of at least one primary care provider per 1,500 population has increased from 64 counties in 2017 to 78 counties in 2021.
- Nurse practitioners have seen the greatest rate of increase among all types of primary care clinicians going from 3.8 (2010) to 8.1 (2020) per 10,000 population.
- Over the last decade, there has been an increase in the number of underrepresented minority clinicians (certified nurse midwives, nurse practitioners, and primary care physicians).

HNC 2030 HEADLINE INDICATOR:
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
THE STORY BEHIND THE CURVE

Access to health services means “the timely use of personal health services to achieve the best health outcomes.” A lack of access to care can impact overall physical, social, and mental health. It can also affect someone’s quality of life and livelihood. Barriers to access typically include the high cost of care, inadequate or no insurance coverage, and a lack of available services (geographically or remotely), especially to culturally competent care. These barriers can lead to unmet health needs, delays in receiving appropriate care, an inability to get preventive services, preventable hospitalizations, and financial burdens. Access to care often varies by race/ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location.

Source: Healthy People 2030 Access to Health Services Workgroup

Participants in the 2021 NC SHIP Community Council Meeting and Stakeholder Symposia elaborated on the story of primary care in North Carolina with these comments:

• “Surprising that certified nurse midwives (CNMs) are weighted at 0.75 in primary care when an obstetrician (OB) is weighted at 0.25 and most CNMs work in OB.”
• “To the point regarding CNM vs OBs time splitting: CNMs do mostly deliveries, OB visits, and prescribing birth control, and annual exams are all primary care activities. OBs are mostly surgical so actually, we under-valued CNMs in this regard.”
• “The correlation of good health outcomes in quality primary care is the level of continuity and comprehensiveness – it’s the longitudinal relationship and the understanding of all of the indicators and factors putting the puzzle together.”
• “We have a data problem in counting population per primary care practitioner – example in Chatham County most of the physicians that work in Northern Chatham County, have a primary practice in Orange County, but their ambulatory office may be in Chatham County.”
• “There are primary care physicians that have practices in one county, but they may go out to surrounding counties three days per week but are not counted in those counties.”
• “I am willing to accept that the data are not perfect and that this is all that we have, but it is bothersome that there is no sense of ‘part-time-edness.’ Most physicians in academic health settings are going to be less than one half clinical. In addition, you have people in various stages of retirement or family life cycle. This is a big impact on access that we have no way to estimate.”
• “This is also a FANTASTIC measure because it now includes advanced practice providers whereas previously it only captured primary care physicians. This is a huge advance and is really appreciated. No doubt it can still be refined but it is still a great advance from what we had been using.”
WHAT OTHER DATA DO WE NEED?

- Availability of conditional acceptance programs for primary care clinicians
- Availability of financial support for rural preceptors
- Economic investments in primary care
- Independent primary care practices
- Primary care workforce needs in underserved geographic areas

WHAT COULD WORK TO TURN THE CURVE?

The Primary Care Clinicians Work Group identified the following priorities for action planning. Work group members engaged in discussions and review of best practices related to leveraging Medicaid to support the viability of primary care clinicians in rural settings, provider loan repayment programs, and the need for provider trainings within rural communities.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand healthcare provider training onsite in rural communities</td>
<td>Primary care clinicians are more likely to practice in rural and underserved communities if they are trained there and have exposure to rural settings. Alignment of community development, provider training, and provider recruitment programs in rural and underserved communities increases primary care clinician retention.</td>
</tr>
<tr>
<td>Increase funding for provider loan repayment programs</td>
<td>There is a growing number of conditional acceptance programs for primary care clinicians that align with and incentivize providing primary care in rural and underserved communities. Intentional recruitment is needed to match health care providers with the demographics and diversity of the communities they serve.</td>
</tr>
<tr>
<td>Leverage Medicaid, including Medicaid Expansion, to support the viability of all primary care clinicians in rural settings</td>
<td>Making primary care economically viable for prospective providers results in communities becoming more economically viable. Lack of success in primary care provider recruitment can be considered an economic issue and investments should be made accordingly, similar to attracting new industry to North Carolina through economic incentives.</td>
</tr>
</tbody>
</table>

RECOMMENDED READING/LISTENING

American Academy of Family Physicians: Primary Care Spend (October 2021):
https://www.aafp.org/dam/AAFP/documents/advocacy/payment/apms/BKG-PrimaryCareSpend.pdf

Human Services Department: Graduate Medical Education Expansion in New Mexico Five Year Strategic Plan (January 2022):
https://www.hsd.state.nm.us/gme-expansion/

NCDHHS Office of Rural Health- Health Professional Shortage Area 2022 Profile (June 2023):
https://www.ncdhhs.gov/nc-dhhs-orh-hpsa-one-pager/open

ACTION PLAN

Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm.
ENHANCING RURAL ROTATIONS AND PRECEPTORS FOR ALL HEALTH PROFESSIONAL STUDENTS IS A KEY PART OF THE PATHWAY TO RURAL PRACTICE.

- Adam Zolotor, MD, DrPH, NC AHEC

## NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology Consultants of North Carolina, PLLC</td>
<td><a href="https://www.acnchealth.com/">https://www.acnchealth.com/</a></td>
</tr>
<tr>
<td>Carolina Complete Health Network</td>
<td><a href="https://network.carolinacompletehealth.com/">https://network.carolinacompletehealth.com/</a></td>
</tr>
<tr>
<td>Carolina Family Health Centers, Inc.</td>
<td><a href="https://www.cfnc.org/">https://www.cfnc.org/</a></td>
</tr>
<tr>
<td>College Foundation of North Carolina (CFNC)</td>
<td><a href="https://www.communitycarenc.org/">https://www.communitycarenc.org/</a></td>
</tr>
<tr>
<td>Community Care of North Carolina (CCNC)</td>
<td></td>
</tr>
<tr>
<td>CommWell Health</td>
<td></td>
</tr>
<tr>
<td>Duke Health’s Primary Care Preceptor Development Mini-Fellowship Program</td>
<td><a href="https://www.highcountrycommunityhealth.com/">https://www.highcountrycommunityhealth.com/</a></td>
</tr>
<tr>
<td>High Country Community Health</td>
<td></td>
</tr>
<tr>
<td>Mountain Community Health Partnership (MCHP)</td>
<td></td>
</tr>
<tr>
<td>NCDHHS Office of Rural Health</td>
<td><a href="https://www.ornette.com/">https://www.ornette.com/</a></td>
</tr>
<tr>
<td>NC Medical Society</td>
<td></td>
</tr>
<tr>
<td>Next Stage</td>
<td></td>
</tr>
<tr>
<td>North Carolina Academy of Family Physicians</td>
<td><a href="https://www.ncafp.com/">https://www.ncafp.com/</a></td>
</tr>
<tr>
<td>North Carolina Academy of Physician Assistants (NCAPA)</td>
<td><a href="http://ncapa.org/">http://ncapa.org/</a></td>
</tr>
<tr>
<td>North Carolina Alliance for Health Professions Diversity (NCAHPD)</td>
<td><a href="https://ncahp.org/">https://ncahp.org/</a></td>
</tr>
<tr>
<td>North Carolina Area Health Education Centers (NC AHEC)</td>
<td><a href="https://www.ncahec.net/">https://www.ncahec.net/</a></td>
</tr>
<tr>
<td>North Carolina Association of Local Health Directors (NCALHD)</td>
<td><a href="https://www.ncalhd.org/">https://www.ncalhd.org/</a></td>
</tr>
<tr>
<td>North Carolina Community Health Center Association (NCCHCA)</td>
<td><a href="https://www.ncccha.org/">https://www.ncccha.org/</a></td>
</tr>
<tr>
<td>North Carolina Institute of Medicine (NCiOM)</td>
<td><a href="https://nciom.org/">https://nciom.org/</a></td>
</tr>
<tr>
<td>North Carolina Medical Board</td>
<td><a href="https://www.ncmedboard.org/">https://www.ncmedboard.org/</a></td>
</tr>
<tr>
<td>North Carolina Nurses Association (NCNA)</td>
<td><a href="https://www.ncnurses.org/">https://www.ncnurses.org/</a></td>
</tr>
<tr>
<td>North Carolina Public Health Association (NCPHA)</td>
<td><a href="https://ncpha.memberclicks.net/">https://ncpha.memberclicks.net/</a></td>
</tr>
<tr>
<td>Office of Rural Initiatives at UNC</td>
<td><a href="https://www.med.unc.edu/inclusion/ori/">https://www.med.unc.edu/inclusion/ori/</a></td>
</tr>
<tr>
<td>Piedmont HealthCare</td>
<td><a href="https://piedmonthealthcare.com/">https://piedmonthealthcare.com/</a></td>
</tr>
<tr>
<td>The Cecil G. Sheps Center for Health Services Research at UNC</td>
<td><a href="https://www.shepscenter.unc.edu/">https://www.shepscenter.unc.edu/</a></td>
</tr>
<tr>
<td>UNC Family Medicine</td>
<td><a href="https://www.med.unc.edu/fammed/">https://www.med.unc.edu/fammed/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 18: EARLY PRENATAL CARE

WHAT RESULT DO WE WANT?
All birthing people have healthy pregnancies and maternal birth outcomes.

WHY IS THIS IMPORTANT?
Prenatal or antepartum care is care given to pregnant women by an obstetrician or midwife and increases the likelihood of a safe and healthy delivery. Components of prenatal care recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) include determination of gestational age, fetal ultrasound imaging, routine laboratory testing, immunizations, genetic screening, psychosocial risk screening and patient education. According to the National Institute of Health, engaging in prenatal care early and consistently in pregnancy is an essential preventative factor in reducing adverse pregnancy outcomes such as low birth weight.¹ By addressing chronic diseases such as diabetes and hypertension associated with preterm birth, prenatal care has been found to reduce adverse birth outcomes. Assessment of prenatal care utilization is considered a critical step in improving prenatal care access and birth outcomes.²,³

HNC 2030 HEADLINE INDICATOR:
Percent of women who receive pregnancy-related health care services during the first trimester of a pregnancy

WHAT DOES THIS INDICATOR MEASURE?
This is a calculated variable based on the difference between the date of last menses and prenatal care initiation. The indicator uses vital records birth certificate data, providing both frequencies and percentages.

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th></th>
<th>Baseline 2018</th>
<th>Recent 2021</th>
<th>Target 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>73.9%</td>
<td>73.8%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

HOW ARE WE DOING?

• The HNC 2030 target is 80.0% of women will receive care in the first trimester of pregnancy.
• The percent of women receiving care in the first trimester of pregnancy has varied little in the last seven years (73.2% in 2014 to 73.8% in 2021).
CURRENT DATA TRENDED OVER TIME

Figure 66. Early prenatal care use across populations in North Carolina (2014-2021)

Figure 67. Early prenatal care use in North Carolina by race/ethnicity (2014-2021)

THE STORY BEHIND THE CURVE

Racial discrimination is a significant risk factor for adverse birth outcomes. To best understand the mechanisms by which racial discrimination impacts birth outcomes, and to inform the development of effective interventions that eliminate its harmful effects on health, longitudinal research that incorporates comprehensive measures of racial discrimination is needed. Health care providers must fully acknowledge and address the psychosocial factors that impact health outcomes in minority racial/ethnic women.4

WHAT OTHER DATA DO WE NEED?

- Availability of Pregnancy Risk Assessment Monitoring System (PRAMS) survey-related data and trends
- Availability of public transportation to prenatal appointments
- Data on barriers to timely prenatal care
- Employer policies related to pregnancy care
- Entry into prenatal care pre- and post-Medicaid expansion
- Number of community health care workers providing outreach and education
- Number of high-risk pregnancy care providers in the community
- Number of pregnancy care providers in the community
- Percentage of providers who accept Medicaid-pending status
- Rate of pregnancies reported as intended
- Time to enroll in Medicaid for Pregnant Women by county
EARLY PREGNATAL CARE

WHAT COULD WORK TO TURN THE CURVE?

The NC Perinatal Health Strategic Plan (PHSP) serves as a statewide guide to improve maternal and infant health and the health of all people of reproductive age. The PHSP includes three primary goals and beneath each goal are the four points to move that goal forward, and beneath each point are strategies to carry out the work that will improve health and health equity across the state. Refer to the PHSP for points and strategies. [PHSP, page 1].

• Goal 1 - Address Economic and Social Inequities
• Goal 2 - Strengthen Families and Communities
• Goal 3 - Improve Health Care for All People of Reproductive Age

The Perinatal Health Equity Collective Policy Workgroup prioritized the following PHSP strategy that aligns with the 2022 NC SHIP. The numbers included with the prioritized policies refer to the strategy numbers in the PHSP.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1E. Perinatal health care providers should participate in training around health equity, implicit bias, and cultural competency</td>
<td>Culturally competent perinatal health care is essential to undoing racism. The effects of structural racism impede the ability of Black, Indigenous, and People of Color (BIPOC) to achieve the best possible health (PHSP, 2022). Training perinatal health care providers can improve health care for all people of childbearing age.</td>
</tr>
<tr>
<td>7E. Increase the number of Prepaid Health Plans (PHPs) that cover doula services</td>
<td>Coverage of doula services by Prepaid Health Plans increases access and strengthens families and communities. Doula services have a positive impact on the well-being of the entire family by improving the physical and psychological outcomes for both pregnant, birthing, and postpartum people and their babies. Doulas also provide services in the postpartum and interconception period to support mom and infant outcomes and assist with provider connection for future pregnancies.</td>
</tr>
<tr>
<td>7G. Elevate the role of community health workers in addressing the social drivers of health</td>
<td>Community health workers are trusted members of and have a unique understanding of the community served. Their trusting relationship enables them to facilitate access to services and address the social drivers of health (NCDHHS, 2018).</td>
</tr>
<tr>
<td>9A. Expand Medicaid to provide affordable, comprehensive health, behavioral health, and dental insurance coverage, including mobile health and telehealth for all</td>
<td>Affordable insurance coverage increases a person's access to health care. Access to comprehensive health, behavioral health, and dental service can help birthing persons begin pregnancies as healthy as possible (NCDHHS, 2023). Mobile health and telehealth services can increase access to health care within rural and underserved communities.</td>
</tr>
<tr>
<td>9I. Implement the NC Area Health Education Centers (AHEC) Scholars Program to recruit and train students of color and students from rural backgrounds to become providers in underserved areas</td>
<td>Culturally competent and/or congruent care impacts individuals who are seeking access to healthcare, including prenatal care services. The NC AHEC Scholars Program has an emphasis on individuals from underrepresented minorities, disadvantaged/rural backgrounds, and first-generation college students. Intentional recruitment and training improve the diversity and distribution of all health professions and supports health system transformation across the state (NC AHEC, 2023).</td>
</tr>
<tr>
<td>10A. Expand the use of evidence-based and evidence-informed models of perinatal care highlighted in the Maternal Health Innovation Program, including doula services, group prenatal care, group child visits, and community health workers</td>
<td>The North Carolina Maternal Health Innovation (MHI) Program augments and strengthens the state's perinatal system of care (NCDHHS, 2023). MHI works with providers through the Statewide Provider Support Network, including family medicine and obstetrician champions, to increase access to healthcare services. MHI also funds several CHW programs in supporting outreach and education with individuals with lived experience and the broader community.</td>
</tr>
</tbody>
</table>

RECOMMENDED READING/LISTENING

2022-2026: NC Perinatal Health Strategic Plan: https://wicws.dph.ncdhhs.gov/phsp/
Critical Term: Why Are Black Mothers and Babies Dying: https://www.youtube.com/watch?v=rN1vtYICJWM&t=4s
Improving Maternal Health Outcomes in North Carolina, NCMJ: https://ncmedicaljournal.com/issue/5393
NC AHEC Scholars Program: https://www.ncahec.net/health-careers/ahec-scholars/
**ACTION PLAN**

The Perinatal Health Equity Collective (PHEC) Data and Evaluation Work Group compiles data annually for the Perinatal Health Equity Strategic Plan's data indicators and monitors new data sources. In addition, they promote data quality improvement and assist other PHEC work groups to move data to action, focusing on a research action plan and providing technical assistance for the environmental scanning process.

Progress on the Perinatal Health Equity Strategic Plan is also being tracked internally by the North Carolina Division of Public Health; the most recent plan is available on the Division of Public Health’s website at [https://wicws.dph.ncdhhs.gov/phsp/](https://wicws.dph.ncdhhs.gov/phsp/).

**NC PARTNERS WHO CAN HELP US**

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Parenting Program</td>
<td><a href="https://teenpregnancy.dph.ncdhhs.gov/">https://teenpregnancy.dph.ncdhhs.gov/</a></td>
</tr>
<tr>
<td>Alliance of Black Doulas for Black Mamas</td>
<td><a href="https://www.alliance-bdbm.com/">https://www.alliance-bdbm.com/</a></td>
</tr>
<tr>
<td>Count the Kicks</td>
<td><a href="https://countthekicks.org/">https://countthekicks.org/</a></td>
</tr>
<tr>
<td>Equity Before Birth</td>
<td><a href="https://www.equitybeforebirth.com/">https://www.equitybeforebirth.com/</a></td>
</tr>
<tr>
<td>Federally Qualified Health Centers (FQHC)</td>
<td>[<a href="https://medicaid.ncdhhs.gov/providers/programs-services/medical/">https://medicaid.ncdhhs.gov/providers/programs-services/medical/</a></td>
</tr>
<tr>
<td>Health Equity and Racism (H.E.R.) LAB</td>
<td><a href="https://www.herlab.org/">https://www.herlab.org/</a></td>
</tr>
<tr>
<td>Healthy Beginnings</td>
<td><a href="https://wicws.dph.ncdhhs.gov/phsp/">https://wicws.dph.ncdhhs.gov/phsp/</a></td>
</tr>
<tr>
<td>Healthy Blue- Cityblock Health</td>
<td><a href="https://wicws.dph.ncdhhs.gov/phsp/">https://wicws.dph.ncdhhs.gov/phsp/</a></td>
</tr>
<tr>
<td>March of Dimes</td>
<td><a href="https://www.marchofdimes.org/">https://www.marchofdimes.org/</a></td>
</tr>
<tr>
<td>MomsRising</td>
<td><a href="https://www.momsrising.org/">https://www.momsrising.org/</a></td>
</tr>
<tr>
<td>NC Baby Love Plus</td>
<td><a href="https://wicws.dph.ncdhhs.gov/phsp/">https://wicws.dph.ncdhhs.gov/phsp/</a></td>
</tr>
<tr>
<td>NC Child</td>
<td><a href="https://ncchild.org/">https://ncchild.org/</a></td>
</tr>
<tr>
<td>NCDHHS Healthy Opportunities</td>
<td><a href="https://www.ncdhhs.gov/about/department-initiatives/health-opportunities">https://www.ncdhhs.gov/about/department-initiatives/health-opportunities</a></td>
</tr>
<tr>
<td>NC Maternal Mental Health MATTERS (Making Access to Treatment, Evaluation,</td>
<td><a href="https://www.med.unc.edu/ncmatters/">https://www.med.unc.edu/ncmatters/</a></td>
</tr>
<tr>
<td>Resources, and Screening Better)</td>
<td></td>
</tr>
<tr>
<td>North Carolina Association of Local Health Directors (NCALHD)</td>
<td><a href="https://www.ncahec.net/">https://www.ncahec.net/</a></td>
</tr>
<tr>
<td>North Carolina Association of Local Health Directors</td>
<td><a href="https://www.ncalhd.org/">https://www.ncalhd.org/</a></td>
</tr>
<tr>
<td>North Carolina Community Health Center Association (NCCHCA)</td>
<td><a href="https://www.ncchca.org">https://www.ncchca.org</a></td>
</tr>
<tr>
<td>North Carolina Perinatal Health Equity Collective and Perinatal Health</td>
<td><a href="https://wicws.dph.ncdhhs.gov/phsp/">https://wicws.dph.ncdhhs.gov/phsp/</a></td>
</tr>
<tr>
<td>Strategic Plan</td>
<td></td>
</tr>
<tr>
<td>Perinatal Quality Collaborative of North Carolina (PQCNC)</td>
<td><a href="https://www.pqcnc.org/">https://www.pqcnc.org/</a></td>
</tr>
<tr>
<td>Planned Parenthood</td>
<td><a href="https://www.plannedparenthood.org/health-center?location=27603">https://www.plannedparenthood.org/health-center?location=27603</a></td>
</tr>
<tr>
<td>Postpartum Support International - North Carolina Chapter</td>
<td><a href="https://psychapters.com/nc/">https://psychapters.com/nc/</a></td>
</tr>
<tr>
<td>The UNC Center of Excellence in Maternal and Child Health Education,</td>
<td><a href="https://sph.unc.edu/mch/center-of-excellence/">https://sph.unc.edu/mch/center-of-excellence/</a></td>
</tr>
<tr>
<td>Science, and Practice</td>
<td></td>
</tr>
<tr>
<td>UNC Collaborative for Maternal and Infant Health</td>
<td><a href="https://www.mommbaby.org/">https://www.mommbaby.org/</a></td>
</tr>
</tbody>
</table>

**HAVING HEALTH INSURANCE INCREASES A PERSON’S ACCESS TO HEALTH CARE- INCLUDING MENTAL HEALTH, SUBSTANCE USE SERVICES, AND PRECONCEPTION HEALTH SERVICES - WHICH CAN HELP A BIRTHING PERSON BEGIN PREGNANCY AS HEALTHY AS POSSIBLE.**

- 2022-2026 NC Perinatal Health Strategic Plan
HEALTH INDICATOR 19: SUICIDE

WHAT RESULT DO WE WANT?
All people in North Carolina receive culturally appropriate mental health care without fear of stigma, have a positive sense of self-worth, and feel supported by the community at large regardless of ability, age, gender-identity, income, lived experience, nationality, neighborhood, or race.

WHY IS THIS IMPORTANT?
Suicide rates increased 30% from 2000 to 2018 and declined in 2019 and 2020. Suicide is a leading cause of death in the United States, with 45,979 deaths in 2020. This is about one death every 11 minutes. The number of people who think about or attempt suicide is even higher. In 2020, an estimated 12.2 million American adults seriously thought about suicide, 3.2 million planned a suicide attempt, and 1.2 million attempted suicide. In 2020, suicide was among the top nine leading causes of death for people ages 10-64. Suicide was the second leading cause of death for people ages 10-14 and 25-34.1,2

WHAT DOES THIS INDICATOR MEASURE?
N.C. Vital Records receives and files death certificates. The State Center for Health Statistics compiles, cleans, and publishes the death data. Finalized death data are not available until 9-18 months after a year has ended. Accuracy of the underlying cause of death depends, to some extent, on the person making the determination and filing the death certificate.

The U.S. Census Bureau conducts a decennial population census of the country, as well as yearly bridged population updates that estimate yearly population changes.

BASELINE DATA FROM HNC 2030

BASELINE 2018 13.8
RECENT 2021 13.3
TARGET 2030 11.1

HOW ARE WE DOING?
• Suicide rate is highest among White/Caucasian population
• In 2021, the suicide rate is approximately four-and-a-half times higher in males than females.
• Overall, the suicide rate is trending upwards (11.8 in 2010 to 13.3 in 2021).

"SUICIDES CAN BE PREVENTED BY RECOGNIZING SIGNS AND SYMPTOMS, LEARNING HOW TO HELP, AND TAKING STEPS TO PROVIDE THAT HELP TO PEOPLE OF ALL AGES AND ABILITIES WHO ARE IN NEED."

- North Carolina Suicide Prevention Action Plan, 2021-2025
CURRENT DATA TRENDED OVER TIME

Figure 68. Suicide rate in North Carolina (2014-2021)

Figure 69. Suicide rate in North Carolina by race/ethnicity (2014-2021)

Figure 70. Suicide rate in North Carolina by gender (2014-2021)
SUICIDE

THE STORY BEHIND THE CURVE

Some groups have higher suicide rates than others. Suicide rates vary by race/ethnicity, age, and other factors, such as where someone lives. By race/ethnicity, the groups with the highest rates were non-Hispanic American Indian/Alaska Native and non-Hispanic White populations. Other Americans with higher than average rates of suicide are veterans, people who live in rural areas, and workers in certain industries and occupations like mining and construction. Young people who identify as lesbian, gay, or bisexual have higher rates of suicidal thoughts and behavior compared to their peers who identify as heterosexual.\(^3,4,5\)

WHAT OTHER DATA DO WE NEED?

- Coding proficiency among physicians, funeral home directors, medical examiners, and coroners
- Effectiveness of crisis response
- Occupations associated with higher risks of suicide
- Self-harm data
- Suicide ideation/attempts
- Undiagnosed, untreated, mental health needs

WHAT COULD WORK TO TURN THE CURVE?

The North Carolina Suicide Prevention Action Plan (NC SPAP) acknowledges that suicide prevention is complex, and the plan is structured to implement comprehensive strategies in the following focus areas to reduce injury and death by suicide. Refer to the NC Suicide Prevention Action Plan for additional information about this plan, data and justification, strategies, and related actions. The policies included below are the focus areas for the NC SPAP. For additional information refer to https://injuryfreenc.dph.ncdhhs.gov/preventionResources/docs/CSP-ActionPlanFinal.pdf.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Create a coordinated infrastructure</td>
<td>To reduce duplication of efforts and enhance efforts through collaboration.</td>
</tr>
<tr>
<td>2. Reduce access to lethal means</td>
<td>The reduction of lethal means is an evidence-based strategy to reduce suicide.</td>
</tr>
<tr>
<td>3. Increase community awareness and prevention</td>
<td>To increase participation in suicide prevention efforts and decrease stigma.</td>
</tr>
<tr>
<td>4. Identify populations at risk</td>
<td>Direct interventions to highest risk groups to have the greatest impact on suicide rates.</td>
</tr>
<tr>
<td>5. Provide crisis intervention with a specific focus on people with increased risk</td>
<td>Provide crisis intervention with populations at risk to have the greatest impact on suicide rates.</td>
</tr>
<tr>
<td>6. Provide access to and delivery of suicide care</td>
<td>Suicide care supports life.</td>
</tr>
<tr>
<td>7. Measure our impact and revise strategies based on results</td>
<td>Evaluation of effectiveness allows for pivoting to the best strategies.</td>
</tr>
</tbody>
</table>

RECOMMENDED READING/LISTENING

- CALM Training: https://zerosuicide.edc.org/resources/resource-database/counseling-access-lethal-means-calm
- Suicide Prevention Resource for Action: https://www.cdc.gov/suicide/resources/prevention.html
- Workplace Policies and Supports: https://injuryfreenc.org/resources/workplace-policies-and-supports/

ACTION PLAN


NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carolinas CARE Partnership</td>
<td><a href="https://www.carolinascare.org/what-we-do/mental-health/">https://www.carolinascare.org/what-we-do/mental-health/</a></td>
</tr>
<tr>
<td>Faith Connections on Mental Illness</td>
<td><a href="https://www.fcmi-nc.org/">https://www.fcmi-nc.org/</a></td>
</tr>
<tr>
<td>National Alliance on Mental Illness - North Carolina Chapter</td>
<td><a href="https://naminc.org/">https://naminc.org/</a></td>
</tr>
<tr>
<td>North Carolina Area Health Education Centers (NC AHEC)</td>
<td><a href="https://www.ncahec.net/">https://www.ncahec.net/</a></td>
</tr>
<tr>
<td>North Carolina Coalition Against Domestic Violence (NCCADV)</td>
<td><a href="https://nccadv.org/">https://nccadv.org/</a></td>
</tr>
<tr>
<td>North Carolina Coalition Against Sexual Assault (NCCASA)</td>
<td><a href="http://www.nccasa.org/">http://www.nccasa.org/</a></td>
</tr>
<tr>
<td>North Carolina Governor’s Challenge to Prevent Suicide</td>
<td><a href="https://challenge.ncgwg.org/">https://challenge.ncgwg.org/</a></td>
</tr>
<tr>
<td>North Carolina Harm Reduction Coalition</td>
<td><a href="http://www.nchrc.org/">http://www.nchrc.org/</a></td>
</tr>
<tr>
<td>Southeastern and Southwestern Injury Prevention Network (SE&amp;SW IPN)</td>
<td><a href="https://iprc.unc.edu/see-sw-ipn/">https://iprc.unc.edu/see-sw-ipn/</a></td>
</tr>
<tr>
<td>UCLA-Duke Center for Trauma-Informed Suicide, Self-Harm &amp; Substance Abuse Treatment &amp; Prevention ASAP Center</td>
<td><a href="https://asapncrtn.org/">https://asapncrtn.org/</a></td>
</tr>
<tr>
<td>UNC-Chapel Hill Suicide Prevention Institute</td>
<td><a href="https://www.med.unc.edu/psych/research/unc-suicide-prevention-institute/">https://www.med.unc.edu/psych/research/unc-suicide-prevention-institute/</a></td>
</tr>
</tbody>
</table>
STATE HEALTH IMPROVEMENT PLAN

HNC 2030 Indicators

HEALTH OUTCOMES

Infant Mortality.......................................................124-128

Life Expectancy.......................................................130-134
WHAT RESULT DO WE WANT?
All babies in North Carolina are born healthy, thrive in caring and healthy homes, and see their first birthday.

WHY IS THIS IMPORTANT?
Infant mortality is considered a key indicator of the overall health of the population, and both infant and maternal mortality are multifaceted problems impacted by factors such as access to care, poverty, systemic racism, and housing.1

Racial disparities have long plagued the state’s infant mortality rate and many other health indicators, now including those associated with the current pandemic. And at the same time, as with COVID-19, we know how to prevent many infant deaths. Other states have prioritized addressing racial gaps in infant deaths and have moved to expand Medicaid, address the impacts of racism on birth outcomes, and implement a number of policies that improve family economic security. Here in North Carolina, it is beyond time to implement critical policy interventions that we already know will work to prevent unnecessary infant deaths.2

WHAT DOES THIS INDICATOR MEASURE?
• The data are produced annually using counts of resident birth certificate data and death certificate data.
• The disparity ratio indicator is a ratio of the non-Hispanic Black to the non-Hispanic White infant mortality rates, calculated by aggregating five years of data.

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th></th>
<th>BASELINE 2015</th>
<th>RECENT 2021</th>
<th>TARGET 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality rate</td>
<td>2.4</td>
<td>2.4</td>
<td>6.0</td>
</tr>
<tr>
<td>Black/White disparity</td>
<td>1.5 or lower</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HNC 2030 HEADLINE INDICATOR:
Rate of infant births per 1,000 live births

HOW ARE WE DOING?
• The HNC 2030 target for infant mortality rate is 6.0 per 1,000 live births.
• Black/African Americans experience over two-and-a-half times more infant deaths than White/Caucasians.
• Infant mortality rates have been relatively stable for the last decade.
CURRENT DATA TRENDED OVER TIME

Figure 71. Infant mortality rate in North Carolina (2014-2021)


Figure 72. Infant mortality rate in North Carolina by race/ethnicity (2014-2021)


Figure 73. Infant mortality disparity ratio between Black/African Americans and White/Caucasians in North Carolina (2014-2021)

THE STORY BEHIND THE CURVE

Participants in the 2021 NC SHIP Community Council Meeting and Symposia expressed the following thoughts about infant mortality:

• “It’s hard to understand the root causes.”
• “Physiological stress due to racism, adverse childhood experiences, and social determinants play a huge role.”
• “Many children who died in the first year of life had no father listed on the birth certificate.”
• “The father’s name not being on the birth certificate may be an important predictor of risk – what does it mean? Is there economic, emotional stress?”
• “There are barriers to getting the father added: access to notary, transportation, affidavit of parentage is not easily found, cost of DNA test.”
• “Indicator rates for fertility suffer from small counts. Rates are sensitive with small counts and should be interpreted with caution. How do we navigate issues of equity if we can’t measure with small numbers?”
• “We need attorneys that understand statutes for adding father to the birth certificate.”

WHAT OTHER DATA DO WE NEED?

• Availability of Pregnancy Risk Assessment Monitoring System (PRAMS) survey-related data and trends
• Availability/utilization of services adjusted by the demographic rates
• Complete and timely fetal death registration
• Confirmation of pregnancy checkbox on death certificates and checkbox where one can choose location of where delivery services were initiated: home, birthing center, birthing facility (safety data when intrapartum transfers occur)
• Data on risk-appropriate neonatal and maternal levels of care
• Data quality for vital statistics
• Estimate of number of pregnancies prevented
• Inventory of issues/challenges affecting access to services
• Location of contraceptive health services (public and private)
• Number/map of organizations in community that have similar interests in reproductive health
• Rate of pregnancies reported as intended
• Timely and expanded data linkages, such as BabyLove file (Medicaid and births, etc.)
• Timely hospital discharge data to link with other sources
**WHAT COULD WORK TO TURN THE CURVE?**

The NC Perinatal Health Strategic Plan (PHSP) serves as a statewide guide to improve maternal and infant health and the health of all people of reproductive age. The PHSP includes three primary goals. Beneath each goal are the four points to move that goal forward, and beneath each point are strategies to carry out the work that will improve health and health equity across the state. Refer to the PHSP for points and strategies. [PHSP, page 1].

- **Goal 1- Address Economic and Social Inequities**
- **Goal 2- Strengthen Families and Communities**
- **Goal 3- Improve Health Care for All People of Reproductive Age**

The Perinatal Health Equity Collective Policy Workgroup prioritized the following PHSP strategy that aligns with the 2022 NC SHIP. The numbers included with the prioritized policies refer to the strategy numbers in the PHSP.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1D. Provide training to all NCDHHS staff and ongoing professional development on equity that builds understanding of and competencies to advance health equity</td>
<td>Understanding and competency of equity is essential to advancing health equity to eliminate disparities and infant mortality across the state.</td>
</tr>
<tr>
<td>1E. Perinatal health care providers should participate in training around health equity, implicit bias, and cultural competency</td>
<td>Culturally competent perinatal health care is essential to undoing racism. The effects of structural racism impede the ability of Black, Indigenous, and People of Color (BIPOC) to achieve the best possible health (PHSP, 2022). Training perinatal health care providers can improve health care for all people of childbearing age.</td>
</tr>
<tr>
<td>7E. Increase the number of Prepaid Health Plans (PHPs) that cover doula services</td>
<td>Studies suggest that increased access to doula care, especially in under-resourced communities, can improve a range of health outcomes for mothers and babies while lowering healthcare costs and could play a role in reducing persistent racial and ethnic disparities.</td>
</tr>
<tr>
<td>7G. Elevate the role of community health workers in addressing the social drivers of health</td>
<td>Community health workers are trusted members of and have a unique understanding of the community served. Their trusting relationship enables them to facilitate access to services and address the social drivers of health (NCDHHS, 2018). Infant mortality is an indicator of societal health and requires a comprehensive response that supports individuals and families, including addressing the non-medical drivers of health (racism, transportation, hunger, poverty, housing, interpersonal violence, etc.).</td>
</tr>
<tr>
<td>7J. Expand efforts to prevent infant deaths related to unsafe sleep environments</td>
<td>Expanded prevention efforts strengthen the education of safe sleep practices. In North Carolina over 100 babies die suddenly and unexpectedly every year while sleeping. Many of these deaths are associated with unsafe sleep environments (for example, blankets in a crib, sleeping on an adult bed, or sleeping with another person in a bed or couch, etc.) (Safe Sleep NC, 2023).</td>
</tr>
<tr>
<td>9A. Expand Medicaid to provide affordable, comprehensive health, behavioral health, and dental insurance coverage, including mobile health and telehealth for all</td>
<td>Affordable insurance coverage increases a person’s access to health care. Access to comprehensive health, behavioral health, and dental service can help birthing persons begin pregnancies as healthy as possible (NCDHHS, 2023).</td>
</tr>
<tr>
<td>10A. Expand the use of evidence-based and evidence-informed models of perinatal care highlighted in the Maternal Health Innovation Program, including doula services, group prenatal care, group child visits, and community health workers</td>
<td>The North Carolina Maternal Health Innovation Program augments and strengthens the state’s perinatal system of care (NCDHHS, 2023). Evidence-based and evidence-informed models of perinatal care can result in improvements in maternal and infant health outcomes.</td>
</tr>
<tr>
<td>10F. Adopt maternal and neonatal risk-appropriate levels of care that align with national standards</td>
<td>Alignment with national standards of care improves equitable access to high quality risk-appropriate maternal and neonatal care.</td>
</tr>
<tr>
<td>10Q. Support the creation of a statewide 24-hour breastfeeding support hotline</td>
<td>Breastfeeding can help moms recover more quickly from childbirth and provides critical nutrients to support baby’s growth and development.</td>
</tr>
<tr>
<td>12F. Increase same-day access to all methods of contraception</td>
<td>Same-day access to all methods of contraception improves health care for all people of reproductive age. Increased access to contraception can reduce unintended pregnancy and achieve healthy birth spacing.</td>
</tr>
</tbody>
</table>
INFANT MORTALITY

INFANT MORTALITY IS AN INDICATOR OF SOCIETAL HEALTH AND REQUIRES A COMPREHENSIVE RESPONSE THAT SUPPORTS INDIVIDUALS AND FAMILIES, INCLUDING ADDRESSING THE NON-MEDICAL DRIVERS OF HEALTH (RACISM, TRANSPORTATION, HUNGER, POVERTY, HOUSING, INTERPERSONAL VIOLENCE, ETC.)

-2022-2026 NC Perinatal Health Strategic Plan

RECOMMENDED READING/LISTENING

2022-2026: NC Perinatal Health Strategic Plan: https://wicws.dph.ncdhhs.gov/phsp/
Critical Term: Why Are Black Mothers and Babies Dying: https://www.youtube.com/watch?v=rN1vtYICJWM&t=4s

ACTION PLAN

The Perinatal Health Equity Collective (PHEC) Data and Evaluation Work Group compiles data annually for the Perinatal Health Equity Strategic Plan’s data indicators and monitors new data sources. In addition, they promote data quality improvement and assist other PHEC work groups to move data to action, focusing on a research action plan and providing technical assistance for the environmental scanning process.

Progress on the Perinatal Health Equity Strategic Plan is also being tracked internally by the North Carolina Division of Public Health; the most recent plan is available on the Division of Public Health’s website at https://wicws.dph.ncdhhs.gov/phsp/.

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Connects International</td>
<td><a href="https://familyconnects.org/">https://familyconnects.org/</a></td>
</tr>
<tr>
<td>Frank Porter Graham Child Development Institute</td>
<td><a href="https://fpg.unc.edu/">https://fpg.unc.edu/</a></td>
</tr>
<tr>
<td>March of Dimes</td>
<td><a href="https://www.marchofdimes.org/">https://www.marchofdimes.org/</a></td>
</tr>
<tr>
<td>MomsRising</td>
<td><a href="https://www.momsrising.org/">https://www.momsrising.org/</a></td>
</tr>
<tr>
<td>National Birth Equity Collaborative (NBEC)</td>
<td><a href="https://birthequity.org/">https://birthequity.org/</a></td>
</tr>
<tr>
<td>NC Breastfeeding Coalition</td>
<td><a href="https://www.ncbifc.org/">https://www.ncbifc.org/</a></td>
</tr>
<tr>
<td>NC Child</td>
<td><a href="https://ncchild.org/">https://ncchild.org/</a></td>
</tr>
<tr>
<td>NCDHHS Office of Health Equity</td>
<td><a href="https://www.ncdhhs.gov/divisions/office-health-equity">https://www.ncdhhs.gov/divisions/office-health-equity</a></td>
</tr>
<tr>
<td>NC Obstetrical and Gynecological Society</td>
<td><a href="https://www2.ncmedsoc.org/nc-obstetrical-and-gynecological-society">https://www2.ncmedsoc.org/nc-obstetrical-and-gynecological-society</a></td>
</tr>
<tr>
<td>NC Reproductive Life Planning Stakeholders Group</td>
<td>N/A</td>
</tr>
<tr>
<td>North Carolina Midwifery Education, Regulation, and Association (MERA)</td>
<td><a href="https://www.ncmera.org/">https://www.ncmera.org/</a></td>
</tr>
<tr>
<td>Smart Start- Home Visiting &amp; Parenting Education System-Building</td>
<td><a href="https://www.smartstart.org/about-smart-start/">https://www.smartstart.org/about-smart-start/</a></td>
</tr>
<tr>
<td>The UNC Center of Excellence in Maternal and Child Health Education, Science and Practice</td>
<td><a href="https://sph.unc.edu/mch/center-of-excellence/">https://sph.unc.edu/mch/center-of-excellence/</a></td>
</tr>
<tr>
<td>UNC Collaborative for Maternal and Infant Health</td>
<td><a href="https://www.mombaby.org/">https://www.mombaby.org/</a></td>
</tr>
</tbody>
</table>
HEALTH INDICATOR 21: LIFE EXPECTANCY

WHAT RESULT DO WE WANT?
All people in North Carolina have long and healthy lives.

WHY IS THIS IMPORTANT?
Well-being is a complex, multifaceted, and multilayered concept. There are many different approaches to defining and measuring well-being, and the focus and terminology used to describe these measures vary. Concepts that fall within the category of well-being include psychological well-being, emotional well-being, quality of life, health-related quality of life, psychosocial functioning, thriving, flourishing, happiness, satisfaction, and others. Life expectancy is one of those measures. It is also a proxy measure for the total health of a population. Disparities in life expectancy between populations point to areas where issues of health equity must be addressed.

WHAT DOES THIS INDICATOR MEASURE?
Life Expectancy (LE) is the average number of additional years that someone at a given age would be expected to live if he/she were to experience throughout life the age-specific death rates observed in a specified reference period (2016-2018, 2017-2019...). At the state level, the LEs are provided for each age interval (1) in total and by (2) gender, (3) race (white and African American), and (4) race by gender. At the county level, the LEs are provided for each age interval (1) in total and by (2) gender and (3) by race (white and African American). In counties with (1) a total African American population estimate of less than 1,000 or (2) any age interval African American population estimate less than 10, the LEs for African Americans are suppressed due to potential instability of the data. Race-specific county-level LEs are limited to white and African American due to issues with small numbers for other racial and ethnic categories, such as American Indians and Hispanics.

Population estimates are revised annually by the U.S. Census Bureau and may result in small differences in rates when comparing data in historical reports to a current report.

BASELINE DATA FROM HNC 2030

<table>
<thead>
<tr>
<th></th>
<th>BASELINE 2018</th>
<th>RECENT 2021</th>
<th>TARGET 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>78.1</td>
<td>76.5</td>
<td>82.0</td>
</tr>
</tbody>
</table>

HOW ARE WE DOING?

- The target for HNC 2030 is 82 years.
- The three-year average for life expectancy decreased across all races/ethnicities in 2019-2021.
- Females continue to have a life expectancy that is about six years longer than males.

HNC 2030 HEADLINE INDICATOR:
Average number of years of life remaining for people who have attained a given age

“EVERYONE, ESPECIALLY THOSE WORKING WITH OLDER ADULTS, HAS A ROLE TO PLAY IN FALLS PREVENTION. THE MULTIFACTORIAL ELEMENTS OF FALLS RISK ARE SO VERY IMPORTANT TO UNDERSTAND. WE CONTINUE TO FIND NEWFACTORS CONTRIBUTING TO FALLS RISK EVERY YEAR AND ARE SURPRISED THAT SO MANY THINGS CAN LEAD TO FALLS.”

-Martha Zimmerman, NC Falls Prevention Coalition
CURRENT DATA TRENDED OVER TIME

Figure 74. Life expectancy across populations in North Carolina in years (2016-2021)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>AVERAGE LIFE EXPECTANCY AT BIRTH (YEARS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>78.2</td>
</tr>
<tr>
<td>2017</td>
<td>78.5</td>
</tr>
<tr>
<td>2018</td>
<td>78.3</td>
</tr>
<tr>
<td>2019</td>
<td>77.8</td>
</tr>
<tr>
<td>2020</td>
<td>76.9</td>
</tr>
<tr>
<td>2021</td>
<td>76.5</td>
</tr>
</tbody>
</table>

Data source: N.C. State Center for Health Statistics, Vital Statistics, 3-year estimates

Figure 75. Life expectancy in North Carolina by race/ethnicity (2016-2021)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>AVERAGE LIFE EXPECTANCY AT BIRTH (YEARS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>White: 87.9</td>
</tr>
<tr>
<td>2017</td>
<td>White: 84.1</td>
</tr>
<tr>
<td>2018</td>
<td>White: 81.0</td>
</tr>
<tr>
<td>2019</td>
<td>White: 77.9</td>
</tr>
<tr>
<td>2020</td>
<td>White: 76.9</td>
</tr>
<tr>
<td>2021</td>
<td>White: 76.8</td>
</tr>
</tbody>
</table>

Data Source: N.C. State Center for Health Statistics, Vital Statistics, 3 year estimates

Figure 76. Life expectancy in North Carolina by gender in years (2016 - 2021)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>AVERAGE LIFE EXPECTANCY AT BIRTH (YEARS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Male: 80.5</td>
</tr>
<tr>
<td>2017</td>
<td>Male: 80.1</td>
</tr>
<tr>
<td>2018</td>
<td>Male: 79.7</td>
</tr>
<tr>
<td>2019</td>
<td>Male: 79.3</td>
</tr>
<tr>
<td>2020</td>
<td>Male: 78.9</td>
</tr>
<tr>
<td>2021</td>
<td>Male: 78.5</td>
</tr>
</tbody>
</table>

Data Source: N.C. State Center for Health Statistics, Vital Statistics, 3 year estimates
**THE STORY BEHIND THE CURVE**

Participants in the 2021 NC SHIP Community Council Meeting and Symposia discussed the following:

- “It is difficult to focus on just a few programs because many programs/initiatives/policies impact the result we want. Life expectancy is just one measure.”
- “We should examine the way we look at this measure. Living a long time and being healthy can be quite independent of each other.”
- “We need help in figuring out how to deal with small numbers.”
- “We should consider bringing in statisticians who can assist with data modeling and impute data to get more precise estimates.”
- “We need to streamline the process of obtaining data.”

Several participants recognized this indicator as an opportunity to focus on community priorities identified by partnering agencies and organizations. Two areas of interest were brain health and radon exposure. Brain health was further linked to hearing loss and falls prevention.

**WHAT OTHER DATA DO WE NEED?**

- Availability of existing training and resource opportunities for individuals, caregivers, and healthcare providers addressing brain health and cognitive decline
- Continuing impact of infant mortality on life expectancy
- Continuing impact of opioid epidemic on life expectancy
- County and regional availability of community falls prevention programs and resources
- County and regional level demographic and inventory of accessible older adult health care services
- Fall-related injuries and socioeconomic factors related to falls
- Impact of COVID-19 pandemic on life expectancy
- Impact of radon exposure in schools and other public places on lung cancer deaths in North Carolina
WHAT COULD WORK TO TURN THE CURVE?

The Life Expectancy Work Group identified the following priorities for action planning. Work group members engaged in discussions and review of best practices related to falls prevention, brain health and dementia, and radon. The Life Expectancy Work Group acknowledges that many factors have and will impact Life Expectancy as an indicator that are not addressed by these three policy areas. Some key factors include maternal and infant mortality, substance misuse, chronic disease prevention and management, and the COVID-19 pandemic. The work group suggests using some related secondary population level indicators to measure whether North Carolinians are better off.

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>WHY IS THIS IMPORTANT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>FALLS PREVENTION</td>
<td>Falls risks factors are individually based on both intrinsic or extrinsic and modifiable or non-modifiable for the individual. The presence of multiple risk factors increases the likelihood of falling. By reducing or minimizing these risk factors, an individual’s risk of falling can be significantly decreased. To prevent falls and related deaths from falls, those modifiable individual risk factors must be identified and addressed with appropriate intervention. Therefore, it is crucial to foster partnerships that aim to raise awareness of the complexities of falls risk management.</td>
</tr>
<tr>
<td>Advance access to fall prevention interventions</td>
<td>Appropriate screening and assessment during Medicare annual wellness visits for all older adults (65 years and older). To effectively reduce falls, it is also crucial to establish clear communication and foster cooperation among various stakeholders involved in fall prevention interventions and educate about different co-morbidities associated with falls, such as mental health issues. Ensuring that fall prevention interventions are accessible and available to older adults throughout North Carolina is vital. This involves promoting the integration of falls prevention services into primary care settings, community centers, senior housing facilities, and home care services and offers various programs, such as community modifications.</td>
</tr>
<tr>
<td>Cultivate strategic partnerships with traditional and nontraditional agencies and organizations addressing falls</td>
<td>The multifactorial nature of falls necessitates the involvement of various disciplines to effectively address falls prevention and reduce fall-related injuries. By cultivating strategic partnerships with both traditional and nontraditional agencies and organizations, we can leverage a diverse range of expertise and resources and promote effective referral pathways to all health care providers, rehab care providers, and evidence-based falls prevention programs throughout North Carolina. Recognizing that falls prevention is a collective responsibility, involving multiple stakeholders enhances the effectiveness of interventions and maximizes the impact on reducing falls and promoting safety for North Carolina individuals of all ages.</td>
</tr>
<tr>
<td>BRAIN HEALTH AND DEMENTIA CARE</td>
<td>Evidence is strong that people can reduce their risk of cognitive decline by making key lifestyle changes, including participating in regular physical activity, staying socially engaged, and maintaining good heart health (Alzheimer’s Association, 2023).</td>
</tr>
<tr>
<td>Increase use of screening and diagnostic assessment to identify early signs of cognitive decline risk factors and dementia to reduce risk, slow decline and manage symptoms</td>
<td>Early detection and diagnosis of cognitive decline and dementia provides an opportunity to slow decline and manage symptoms through treatment options and/or lifestyle changes.</td>
</tr>
<tr>
<td>Improve access to and use of clinical and community services for people with Alzheimer’s disease and related dementias (ADRD)</td>
<td>The incidence of Alzheimer’s disease and related dementias in North Carolina is increasing as are health care costs and the costs of both formal and informal care. Numerous studies have documented the disproportionately higher costs of caring for a person with dementia compared with other conditions and the wider array of challenges that are unique to caregiving for someone with dementia. As the state continues its efforts to address ADRD, consideration should be given to the undue costs and additional challenges which may be encountered by those with dementia and their families and caregivers (BOLD NC2023 Dementia Caregiver Data Brief).</td>
</tr>
<tr>
<td>RADON TESTING AND MITIGATION</td>
<td>Radon-induced lung cancer is a predictor of health disparities and instances of restricted access to resources and opportunities for healthy living conditions (DHHS, 2023). Mitigation resources are needed to follow up with screening. Ethnic and racial minorities as well as those with lower incomes are disproportionately affected as they are least likely to know about radon gas and its impacts and may not have the resources to mitigate elevated indoor radon levels (DHHS, 2023). The risk of lung cancer in children resulting from exposure to radon may be almost twice as high as the risk to adults exposed to the same amount of radon. If children are also exposed to tobacco smoke, the risk of getting lung cancer increases at least 20 times. Due to lung shape and size differences, children receive higher estimated radiation doses than do adults because of their differences in lung shape, lung size and faster breathing rates than those of adults (ATSDR 2023).</td>
</tr>
</tbody>
</table>
LIFE EXPECTANCY

RECOMMENDED READING/LISTENING
Alzheimer’s Association - Brain Health: https://www.alz.org/help-support/brain_health
CDC - A CDC Compendium of Effective Fall Interventions: What Works for Community-Dwelling Older Adults: https://cdc.gov/falls/pdf/Steady_Compendium_2023_508.pdf
CDC- STEADI- Older Adult Fall Prevention: https://www.cdc.gov/steadi/
NC DHHS- Dementia-Capable North Carolina: 2022 Update- A Strategic Plan for Addressing Alzheimer’s Disease & Related Dementias: https://www.ncdhhs.gov/dementiacapablestateplan112322/download?attachment#:~:text=NCDHHS%20s%20BOLD%20NC%20work%20focuses,decline%20as%20well%20as%20their
NC DHHS Housing and Home Improvement Assistance: https://www.ncdhhs.gov/divisions/aging-and-adult-services/housing-and-home-improvement-assistance
NC DHHS- North Carolina Dementia Friendly Communities: https://www.ncdhhs.gov/nc-dementia-friendly-communities-standards/open

ACTION PLAN
Action plans evolve continuously as priorities move from talk to action. For the current action plan, refer to the 2023-2024 NC SHIP Community Council Scorecard at https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm.

NC PARTNERS WHO CAN HELP US

<table>
<thead>
<tr>
<th>PARTNER/POTENTIAL PARTNER</th>
<th>WEBSITE LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s Association</td>
<td><a href="https://www.alz.org/">https://www.alz.org/</a></td>
</tr>
<tr>
<td>Andrea Harris Equity Task Force</td>
<td><a href="https://ncadmin.nc.gov/boards-commissions/andrea-harris-equity-task-force">https://ncadmin.nc.gov/boards-commissions/andrea-harris-equity-task-force</a></td>
</tr>
<tr>
<td>APTA North Carolina- Falls Prevention Special Interest Group</td>
<td><a href="https://epsig.my.canva.site/falls-prevention-sig">https://epsig.my.canva.site/falls-prevention-sig</a></td>
</tr>
<tr>
<td>Community Health And Mobility Partnership (CHAMP)</td>
<td><a href="http://ncchamp.org/">http://ncchamp.org/</a></td>
</tr>
<tr>
<td>Dementia Alliance of North Carolina</td>
<td><a href="https://dementianc.org/">https://dementianc.org/</a></td>
</tr>
<tr>
<td>NCDHHS Older Adult Mental Health</td>
<td><a href="https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/older-adult-mental-health">https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/older-adult-mental-health</a></td>
</tr>
<tr>
<td>Lung Cancer Initiative</td>
<td><a href="https://lungcancerinitiative.org/">https://lungcancerinitiative.org/</a></td>
</tr>
<tr>
<td>Mountain Area Health Education Center (MAHEC)- Center for Healthy Aging</td>
<td><a href="https://mahec.net/regional-initiatives/center-for-healthy-aging">https://mahec.net/regional-initiatives/center-for-healthy-aging</a></td>
</tr>
<tr>
<td>NCDHHS Area Agencies on Aging</td>
<td><a href="https://www.ncdhhs.gov/divisions/aging-and-adult-services/area-agencies-aging">https://www.ncdhhs.gov/divisions/aging-and-adult-services/area-agencies-aging</a></td>
</tr>
<tr>
<td>North Carolina Area Health Education Centers (NC AHEC)</td>
<td><a href="https://www.ncahec.net/">https://www.ncahec.net/</a></td>
</tr>
<tr>
<td>NC Audiology Project</td>
<td><a href="https://www.theaudiologyproject.com/">https://www.theaudiologyproject.com/</a></td>
</tr>
<tr>
<td>NC BAM</td>
<td><a href="https://ncbam.org/programs-and-services/#rampin">https://ncbam.org/programs-and-services/#rampin</a></td>
</tr>
<tr>
<td>NC Caregiver Portal powered by Trualta</td>
<td><a href="https://nc-caregivers.com/login">https://nc-caregivers.com/login</a></td>
</tr>
<tr>
<td>NCDHHS Cancer Control Branch</td>
<td><a href="https://www.dph.ncdhhs.gov/chronicdiseaseandinjury/cancerpreventionandcontrol/lungcancer.htm">https://www.dph.ncdhhs.gov/chronicdiseaseandinjury/cancerpreventionandcontrol/lungcancer.htm</a></td>
</tr>
<tr>
<td>NCDHHS LME-MCO Directory</td>
<td><a href="https://www.ncdhhs.gov/providers/lme-mco-directory">https://www.ncdhhs.gov/providers/lme-mco-directory</a></td>
</tr>
<tr>
<td>NCDHHS DPH Tobacco Prevention and Control Branch</td>
<td><a href="https://tobacco.preventionandcontrol.dph.ncdhhs.gov/">https://tobacco.preventionandcontrol.dph.ncdhhs.gov/</a></td>
</tr>
<tr>
<td>NCDHHS Aging and Adult Services</td>
<td><a href="https://www.ncdhhs.gov/assistance/aging-and-adult-services">https://www.ncdhhs.gov/assistance/aging-and-adult-services</a></td>
</tr>
<tr>
<td>NC Falls Prevention Coalition</td>
<td><a href="https://ncfallsprevention.org/">https://ncfallsprevention.org/</a></td>
</tr>
<tr>
<td>NC Regional Falls Prevention Coalitions</td>
<td><a href="https://ncfallsprevention.org/about-us/local-regional-nc-coalitions/">https://ncfallsprevention.org/about-us/local-regional-nc-coalitions/</a></td>
</tr>
<tr>
<td>NC State Cooperative Extension—Healthy Homes</td>
<td><a href="https://healthyhomes.ces.ncsu.edu/">https://healthyhomes.ces.ncsu.edu/</a></td>
</tr>
<tr>
<td>North Carolina Institute of Medicine (NCIOM) Task Force on Healthy Aging</td>
<td><a href="https://nciom.org/task-force-on-healthy-aging/">https://nciom.org/task-force-on-healthy-aging/</a></td>
</tr>
<tr>
<td>North Carolina Coalition on Aging</td>
<td><a href="https://nccoalitiononaging.org/">https://nccoalitiononaging.org/</a></td>
</tr>
<tr>
<td>UNC Asheville- NC Center for Health &amp; Wellness</td>
<td><a href="https://ncchhw.unca.edu/">https://ncchhw.unca.edu/</a></td>
</tr>
<tr>
<td>UNC Chapel Hill- Center for Aging and Health</td>
<td><a href="https://www.med.unc.edu/aging/">https://www.med.unc.edu/aging/</a></td>
</tr>
</tbody>
</table>
SECTION IV
References & Appendices

Works Cited...............................................................136-141
Appendix A: Acronyms..................................................142
Appendix B: List of Tables and Figures..............................143-145
Appendix C: HNC 2030 Indicator Table.............................146-147
Appendix D: Local Health Department and Tribal Community Priorities........................................148
Appendix E: Photography Sources.................................149
Appendix F: HNC 2030 Artistic Sketch Activity.............151-154
INDICATOR #1: POVERTY


INDICATOR #2: UNEMPLOYMENT


INDICATOR #3: SHORT-TERM SUSPENSIONS


INDICATOR #4: INCARCERATION


INDICATOR #5: ADVERSE CHILDHOOD EXPERIENCES


**INDICATOR #6: THIRD GRADE READING PROFICIENCY**


2. EducationNC. (2021, October). *Reading proficiency has tumbled in the early grades.*

https://www.dpi.nc.gov/media/12854/download?attachment


**INDICATOR #7: ACCESS TO EXERCISE OPPORTUNITIES**

**Healthy People 2030** - https://health.gov/healthypeople/objectives-and-data/browse-objectives/physical-activity


https://fpg.unc.edu/sites/fpg.unc.edu/files/resources/other-resources/NCODH_RemovingBarriersToHealthClubs.pdf
INDICATOR #8: LIMITED ACCESS TO HEALTHY FOODS


INDICATOR #9: SEVERE HOUSING PROBLEMS


INDICATOR #10: DRUG OVERDOSE


INDICATOR #11: TOBACCO USE


INDICATOR #12: EXCESSIVE DRINKING


INDICATOR #13: SUGAR-SWEETENED BEVERAGE CONSUMPTION

2. NC SHIP 2020 – SSB
   Source: CDC/Nutrition/Data and Statistics

INDICATOR #14: HIV DIAGNOSIS

2. Healthy People 2030 - Reduce the number of new HIV diagnoses – HIV-03

INDICATOR #15: TEEN BIRTHS


INDICATOR #16: UNINSURED

The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act

The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020
INDICATOR #17: PRIMARY CARE CLINICIANS

1 Healthy People 2030 - Increase the proportion of people with a usual primary care provider — AHS-07

Healthy People 2030


INDICATOR #18: EARLY PRENATAL CARE


INDICATOR #19: SUICIDE


INDICATOR #20: INFANT MORTALITY


2 Vittaglione, T. (2021, January). NC’s outrageous racial gap in infant deaths persists. NCCHILD. https://ncchild.org/2021-infant-mortality/#:~:text=Tom%20Vittaglione,-Senior%20Fellow%2C%20Health&text=But%20it%20may%20also%20be,5.7%20deaths%20per%201%2000%20births

INDICATOR #21: LIFE EXPECTANCY

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAP</td>
<td>American Academy of Pediatrics</td>
<td></td>
</tr>
<tr>
<td>ACC</td>
<td>Accountable Care Community</td>
<td></td>
</tr>
<tr>
<td>ACEs</td>
<td>Adverse Childhood Experiences</td>
<td></td>
</tr>
<tr>
<td>ACOG</td>
<td>American College of Obstetricians and Gynecologists</td>
<td></td>
</tr>
<tr>
<td>BRFSS</td>
<td>Behavioral Risk Factor Surveillance System</td>
<td></td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
<td></td>
</tr>
<tr>
<td>CNW</td>
<td>certified nurse midwife</td>
<td></td>
</tr>
<tr>
<td>EBCI</td>
<td>Eastern Band of Cherokee Indians</td>
<td></td>
</tr>
<tr>
<td>FHLL</td>
<td>The Foundation for Health Leadership &amp; Innovation</td>
<td></td>
</tr>
<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
<td></td>
</tr>
<tr>
<td>HNC</td>
<td>Healthy North Carolina</td>
<td></td>
</tr>
<tr>
<td>HPV</td>
<td>human papillomavirus</td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>intrauterine device</td>
<td></td>
</tr>
<tr>
<td>KEA</td>
<td>Kindergarten Entry Assessment</td>
<td></td>
</tr>
<tr>
<td>LARC</td>
<td>long-acting reversible contraceptives</td>
<td></td>
</tr>
<tr>
<td>LE</td>
<td>life expectancy</td>
<td></td>
</tr>
<tr>
<td>LEA</td>
<td>Local Education Agency</td>
<td></td>
</tr>
<tr>
<td>LGBTQ</td>
<td>lesbian, gay, bisexual, transgender, and queer</td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>men who have sex with men</td>
<td></td>
</tr>
<tr>
<td>NC AHEC</td>
<td>NC Area Health Education Centers</td>
<td></td>
</tr>
<tr>
<td>NC DHHS</td>
<td>North Carolina Department of Health and Human Services</td>
<td></td>
</tr>
<tr>
<td>NC DPH</td>
<td>North Carolina Division of Public Health</td>
<td></td>
</tr>
<tr>
<td>NC DPI</td>
<td>North Carolina Department of Public Instruction</td>
<td></td>
</tr>
<tr>
<td>NC EDSS</td>
<td>North Carolina Electronic Disease Surveillance System</td>
<td></td>
</tr>
<tr>
<td>NCHA</td>
<td>North Carolina Healthcare Association</td>
<td></td>
</tr>
<tr>
<td>NCIOM</td>
<td>North Carolina Institute of Medicine</td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>physician assistant</td>
<td></td>
</tr>
<tr>
<td>PrEP</td>
<td>pre-exposure prophylaxis</td>
<td></td>
</tr>
<tr>
<td>SBIRT</td>
<td>Screening, Brief Intervention, and Referral to Treatment</td>
<td></td>
</tr>
<tr>
<td>SDOH</td>
<td>Social determinants of health</td>
<td></td>
</tr>
<tr>
<td>SHA</td>
<td>State Health Assessment</td>
<td></td>
</tr>
<tr>
<td>SNAP/EBT</td>
<td>Supplemental Nutrition Assistance Program/Electronic Benefits Transfer</td>
<td></td>
</tr>
<tr>
<td>SSB</td>
<td>sugar-sweetened beverage</td>
<td></td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
<td></td>
</tr>
<tr>
<td>SUD</td>
<td>substance use disorder</td>
<td></td>
</tr>
<tr>
<td>VA</td>
<td>Veterans Affairs</td>
<td></td>
</tr>
<tr>
<td>YRBS</td>
<td>Youth Risk Behavior Surveillance</td>
<td></td>
</tr>
</tbody>
</table>
LIST OF TABLES AND FIGURES

Page 18 ....... Figure 1. The County Health Rankings Model
Page 19 ....... Figure 2. Clear Impact Scorecard Icons that Align with Results-Based Accountability
Page 20 ....... Figure 3. Results-Based Accountability
Page 21 ....... Figure 4. Snapshot of a HNC 2030 Scorecard: Social and Economic Factors
Page 21 ....... Figure 5. Five phases of the NC SHIP
Page 21 ....... Figure 6. HNC 2030 indicators categorized according to a population health framework (Health Factors/Health Outcomes)
Page 22 ....... Figure 7. Characteristics of best practices selected for the NC SHIP
Page 23 ....... Figure 8. Roles and responsibilities of state and local health departments and their partners in the NC SHIP
Page 26 ....... Table 1. 2022-2023 NC SHIP Community Council Working Groups
Page 20 ....... Figure 9. Figure 9. Snapshot of 2022 NC SHIP Policy/Program Scorecard
Pages 29-32 .. Table 2. Priorities identified by the 2022-2023 NC SHIP Community Council
Page 33 ....... Figure 10. Major milestones in the NC State Health Improvement Plan
Page 37 ....... Figure 11. Percent of individuals below 200% Federal Poverty Level in North Carolina (2014-2021)
Page 37 ....... Figure 12. Percent of individuals below Federal Poverty Level in North Carolina by race/ethnicity (2016-2021)
Page 38 ....... Figure 13. Percent of individuals below Federal Poverty Level in North Carolina by gender (2016-2021)
Page 41 ....... Figure 14. Percent of population aged 16 and older who are unemployed but seeking work in North Carolina (2014-2021)
Page 41 ....... Figure 15. Percent of population aged 16 and older who are unemployed but seeking work in North Carolina by race/ethnicity (2014-2021)
Page 41 ....... Figure 16. Percent of population aged 20 and older who are unemployed but seeking work in North Carolina by gender (2014-2021)
Page 42 ....... Figure 17. Disparity ratio between white and other races/ethnicities for percent of population aged 16 and older in North Carolina who are unemployed but seeking work (2014-2021)
Page 44 ....... Figure 18. Short-term suspension rate for all acts reported in (2016-2021)
Page 45 ....... Figure 19. Short-term suspension rate for all acts reported by gender
Page 45 ....... Figure 20. Short-term suspension rate by race/ethnicity
Page 46 ....... Figure 21. Short-term suspensions by exceptional children (EC) status
Page 49 ....... Figure 22. Incarceration rate in North Carolina prisons (2014-2021)
Page 49 ....... Figure 23. Incarceration rate in North Carolina prisons by race/ethnicity (2014-2021)
Page 49 ....... Figure 24. Incarceration rate in North Carolina prisons by gender (2014-2021)
Page 53 ....... Figure 25. Percent of children with two or more adverse childhood experiences in North Carolina (2016-2021)
Page 53 Figure 26. Percent of children with two or more adverse childhood experiences in North Carolina by gender (2016 - 2021)

Page 53 Figure 27. Percent of children with two or more adverse childhood experiences in North Carolina by race/ethnicity (2016 - 2021)

Page 54 Figure 28. Percent of children with two or more adverse childhood experiences in North Carolina by poverty level (2016 - 2021)

Page 56 Figure 29. Percent of children who are proficient in reading at the end of third grade across populations in North Carolina

Page 57 Figure 30. Percent of children who are proficient in reading at the end of third grade in North Carolina by select subgroups

Page 57 Figure 31. Percent of children who are proficient in reading at the end of third grade by gender in North Carolina

Page 61 Figure 32. Percent of people with access to exercise opportunities in North Carolina (2022)

Page 65 Figure 33. Percent of people with limited access to healthy foods (2019 data)

Page 65 Figure 34. Percent of people with food insecurity (2020 data)

Page 66 Table 3. People with limited access to healthy foods (2019)

Page 66 Table 4. People with food insecurity (2020)

Page 71 Figure 35. Percent of households with severe housing problems in North Carolina (2015-2019 data)

Page 71 Figure 36. Percent of households with housing cost burden 50% or more of household income (2017-2021 data)

Page 77 Figure 37. Drug overdose death rate in North Carolina (2014-2021)

Page 77 Figure 38. Drug overdose death rate in North Carolina by race/ethnicity (2014-2021)

Page 77 Figure 39. Drug overdose death rate in North Carolina by gender (2014-2021)

Page 81 Figure 40. Tobacco use among adults in North Carolina (2018-2021)

Page 81 Figure 41. Tobacco use among adults in North Carolina by gender (2018-2021)

Page 81 Figure 42. Tobacco use among adults in North Carolina by race/ethnicity (2018-2021)

Page 82 Figure 43. Tobacco use among youth in North Carolina by gender (2022)

Page 82 Figure 44. Tobacco use among youth in North Carolina by race/ethnicity (2022)

Page 87 Figure 45. Excessive drinking across populations in North Carolina (2019-2021)

Page 87 Figure 46. Excessive drinking in North Carolina by race/ethnicity (2019-2021)

Page 87 Figure 47. Excessive drinking across populations in North Carolina by gender (2019-2021)

Page 91 Figure 48. Sugar-sweetened beverage consumption across adult populations in North Carolina, 2021

Page 91 Figure 49. Youth sugar-sweetened beverage consumption in North Carolina, 2015-2021

Page 92 Figure 50. Youth sugar-sweetened beverage consumption by gender in North Carolina, 2015-2021

Page 92 Figure 51. Youth sugar-sweetened beverage consumption by race in North Carolina, 2015-2021

Page 92 Figure 52. Youth sugar-sweetened beverage consumption by grade level in North Carolina, 2015-2021
Figure 53. North Carolina newly diagnosed HIV rates (2010-2021*)

Figure 54. North Carolina newly diagnosed HIV rates by race/ethnicity (2010-2021*)

Figure 55. North Carolina newly diagnosed HIV by gender (2010-2021*)

Figure 56. North Carolina newly diagnosed HIV among men by race/ethnicity (2010-2021*)

Figure 57. North Carolina newly diagnosed HIV among women by race/ethnicity (2010-2021*)

Figure 58. North Carolina disparities in new HIV diagnoses among race/ethnicities (2010-2021*)

Figure 59. Teen birth rate for females aged 15 - 19 years in North Carolina (2014 - 2021)

Figure 60. Teen birth rate for females aged 15 - 19 years by race/ethnicity in North Carolina (2014-2021)

Figure 61. Percent of population under 65 with no insurance in North Carolina (2014-2021)

Figure 62. Percent of population under 65 with no insurance in North Carolina by race/ethnicity (2014-2021)

Figure 63. Percent of population under 65 with no insurance in North Carolina by gender (2014-2021)

Figure 64. Percent of people under 65 with no insurance in North Carolina by poverty level (2014-2021)

Figure 65. Population per primary care clinician in North Carolina (2021)

Figure 66. Early prenatal care use across populations in North Carolina (2014-2021)

Figure 67. Early prenatal care use in North Carolina by race/ethnicity (2014-2021)

Figure 68. Suicide rate in North Carolina (2014-2021)

Figure 69. Suicide rate in North Carolina by race/ethnicity (2014-2021)

Figure 70. Suicide rate in North Carolina by gender (2014-2021)

Figure 71. Infant mortality rate in North Carolina (2014-2021)

Figure 72. Infant mortality rate in North Carolina by race/ethnicity (2014-2021)

Figure 73. Infant mortality disparity ratio between Black/African Americans and White/Caucasians in North Carolina (2014-2021)

Figure 74. Life expectancy across populations in North Carolina in years (2016-2021)

Figure 75. Life expectancy in North Carolina by race/ethnicity (2016-2021)

Figure 76. Life expectancy in North Carolina by gender in years (2016 - 2021)
<table>
<thead>
<tr>
<th>#</th>
<th>Short Title</th>
<th>2030 Target</th>
<th>Data Year</th>
<th>Baseline</th>
<th>Current</th>
<th>White/ Caucasian</th>
<th>Black/ African American</th>
<th>Hispanic/ Latino</th>
<th>Other 2 or more races</th>
<th>Asian</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>American Indian / Alaska Native</th>
<th>M</th>
<th>F</th>
<th>Below Poverty (&lt;100%)</th>
<th>200-399</th>
<th>400%+</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Individuals Below 200% Federal Poverty Level</td>
<td>27%</td>
<td>2021</td>
<td>36.5%</td>
<td>32.3%</td>
<td>(2017 - 2021)</td>
<td>10.4%</td>
<td>21.1%</td>
<td>23.4%</td>
<td>24.2%</td>
<td>18.6%</td>
<td>9.6%</td>
<td>24.1%</td>
<td>24%</td>
<td>12.3</td>
<td>15%</td>
<td>13.7%</td>
<td>32.3%</td>
</tr>
<tr>
<td>2</td>
<td>Unemployment</td>
<td>7%</td>
<td>2021</td>
<td>7.2%</td>
<td>5.3%</td>
<td>(2017 - 2021)</td>
<td>4.3%</td>
<td>8.3%</td>
<td>5.6%</td>
<td>5.3%</td>
<td>7.8%</td>
<td>4%</td>
<td>-</td>
<td>7.7%</td>
<td>4.9%</td>
<td>5%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>Short-Term Suspensions (Per 1,000)</td>
<td>80</td>
<td>2021-2022</td>
<td>139</td>
<td>146.6%</td>
<td>82.1</td>
<td>303.8</td>
<td>98.4</td>
<td>-</td>
<td>179</td>
<td>19.8%</td>
<td>119.5</td>
<td>242.8</td>
<td>196.7</td>
<td>90.7</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>Incarceration Rate (Per 100,000)</td>
<td>150</td>
<td>2021</td>
<td>341</td>
<td>167.3%</td>
<td>142.5</td>
<td>320.4</td>
<td>67.8</td>
<td>-</td>
<td>-</td>
<td>13.3</td>
<td>293.4</td>
<td>46.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5</td>
<td>Adverse Childhood Experiences</td>
<td>18%</td>
<td>2020-2021</td>
<td>23.6%</td>
<td>17.8%</td>
<td>12.4%</td>
<td>22.6%</td>
<td>24%</td>
<td>27.9%</td>
<td>-</td>
<td>12.6%</td>
<td>-</td>
<td>16.1%</td>
<td>19.5%</td>
<td>25.7%</td>
<td>12.3%</td>
<td>10.9%</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>Third grade Reading Proficiency</td>
<td>80%</td>
<td>2021-2022</td>
<td>56.8%</td>
<td>46.4%</td>
<td>60.0%</td>
<td>31%</td>
<td>33%</td>
<td>-</td>
<td>47%</td>
<td>71%</td>
<td>47%</td>
<td>31%</td>
<td>45%</td>
<td>48%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7</td>
<td>Access to Exercise Opportunities</td>
<td>92%</td>
<td>2022</td>
<td>73.4%</td>
<td>75%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>Limited Access to Healthy Foods</td>
<td>5%</td>
<td>2022</td>
<td>7%</td>
<td>8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9</td>
<td>Severe Housing Problems</td>
<td>14.0%</td>
<td>2021</td>
<td>16.1%</td>
<td>14%</td>
<td>(2019-2019)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10</td>
<td>Drug Overdose Death Rate, Age Adjusted (Per 100,000)</td>
<td>18</td>
<td>2021</td>
<td>20.4%</td>
<td>39.8%</td>
<td>45.8%</td>
<td>39.4</td>
<td>16.3</td>
<td>-</td>
<td>19.3</td>
<td>3.3</td>
<td>94.5</td>
<td>55.6</td>
<td>24.5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td>Tobacco Use – Youth (MS/HS)</td>
<td>9%</td>
<td>2021</td>
<td>11.6%</td>
<td>11.5%</td>
<td>(2015)</td>
<td>5.2%</td>
<td>2.4%</td>
<td>9.6%</td>
<td>4.9%</td>
<td>7%</td>
<td>-</td>
<td>5%</td>
<td>5.3%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>12</td>
<td>Tobacco Use - Adult</td>
<td>15.0%</td>
<td>2021</td>
<td>23.8%</td>
<td>20.7%</td>
<td>22.3%</td>
<td>19.6%</td>
<td>10%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25.2%</td>
<td>16.9%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>13</td>
<td>Excessive Drinking</td>
<td>12.0%</td>
<td>2021</td>
<td>16%</td>
<td>16.7%</td>
<td>18.4%</td>
<td>10.6%</td>
<td>18.5%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>21.1%</td>
<td>12.6%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>14</td>
<td>Sugar-Sweetened Beverage Consumption, Youth</td>
<td>17.0%</td>
<td>2021</td>
<td>33.6%</td>
<td>29.8%</td>
<td>35.8%</td>
<td>25.9%</td>
<td>20.5%</td>
<td>13.8%</td>
<td>38.4%</td>
<td>-</td>
<td>-</td>
<td>31.9%</td>
<td>27.4%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>15</td>
<td>Sugar-Sweetened Beverage Consumption, Adult</td>
<td>20.0%</td>
<td>2021</td>
<td>34.2%</td>
<td>29.8%</td>
<td>29.1%</td>
<td>30.2%</td>
<td>29.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>34.1%</td>
<td>26%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>16</td>
<td>HIV Diagnosis Rate</td>
<td>6.0</td>
<td>2021</td>
<td>13.9%</td>
<td>15.7%</td>
<td>5.3%</td>
<td>43.5</td>
<td>26.9</td>
<td>-</td>
<td>6.5</td>
<td>-</td>
<td>14.3</td>
<td>25.9</td>
<td>5.2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>17</td>
<td>Access to Primary Care</td>
<td>25% decrease for counties above 115,500 providers to population</td>
<td>2021</td>
<td>64</td>
<td>78%</td>
<td>73.9%</td>
<td>73.8%</td>
<td>79.5%</td>
<td>69.2%</td>
<td>62.2%</td>
<td>58.4%</td>
<td>70.7%</td>
<td>74.3%</td>
<td>70.4%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*Severe housing problems’ is a composite measure of inadequate kitchen and bathroom facilities, overcrowding and housing cost burden. The data source does not break down the contribution of each component at the state, but county level data does provide 3 separate percentages. 

The number of counties that meet the HNC 2030 target ratio of at least one primary care provider per 1500 population has increased from 64 counties in 2017 to 78 counties in 2021.

Cecil G. Sheps Center at UNC - CH
The state health assessment and improvement plan incorporates local community health and tribal priorities. In addition to 86 local health departments, North Carolina has eight state recognized tribes (the Coharie, the Eastern Band of Cherokee Indians, the Haliwa-Saponi, the Lumbee Tribe of North Carolina, the Meherrin, the Sappony, the Occaneechi Band of the Saponi Nation and the Waccamaw Siouan). The Eastern Band of Cherokee Indians (EBCI) is also a federally recognized tribe. The priorities are aligned with *HNC 2030* population indicators.

**Percent of community priorities by subcategories in the most recent North Carolina local health department/tribal health assessments (2019-2022)**

![Bar chart showing the percentage of community priorities by subcategories.]

**N=367 PRIORITIES**

**86 LOCAL HEALTH DEPARTMENTS**

**1 TRIBAL ASSESSMENT**

*Data source: Healthy North Carolina 2030 Resource Center, Local Community and Support Section, NC Division of Public Health*
PHOTOGRAPHY SOURCES

Housing Projects, By Jose Luis Stephens [Photograph] #471475326
Retrieved 2022, from: https://stock.adobe.com/471475326
Page 39

Focused diverse students discuss ideas studying in class together, By fizkes [Photograph] #281404840
Retrieved 2022, from: https://stock.adobe.com/281404840
Page 47

Barbed wire fence, By tomas [Photograph] #171240570
Retrieved 2022, from: https://stock.adobe.com/171240570
Page 51

The background of the outdoor exercise facility, By bangprik [Photograph] #345333799
Retrieved 2022, from: https://stock.adobe.com/345333799
Page 63

Page 69

Doctor hands holding Purple ribbons, By sewcream [Photograph] #221389347
Retrieved 2022, from: https://stock.adobe.com/221389347
Page 79

Collection of old glass bottles, toned, By Sergey [Photograph] #211995995
Page 89

Uninsured red circle, By zimmytws [Photograph] #83930875
Retrieved 2022, from: https://stock.adobe.com/83930875
Page 111

Hand turns dice and changes the expression “no care” to “health care”, By Fokusiert [Photograph] #1249188236
Page 115

Pregnant women in a class, By Rawpixel.com [Photograph] #203325337
Retrieved 2022, from: https://stock.adobe.com/203325337
Page 119

Young interracial family with little children at home, By Halfpoint [Photograph] #159330615
Retrieved 2022, from: https://stock.adobe.com/159330615
Page 128

Senior Couple Putting On In Line Skates In Park, By Monkey Business [Photograph] #119536342
Retrieved 2022, from: https://stock.adobe.com/19536342
Page 132
HEALTHY NORTH CAROLINA 2030

ARTISTIC SKETCH ACTIVITY

When helping partners come up with solutions for the wicked problems within our communities, we have found it helpful to use an activity where we imagine what a truly healthy North Carolina could look like!

We realize that it can be challenging to imagine the possibilities for a healthier world and to engage in positive thinking. The following activity is designed to help community partners to imagine a community in which they would like to live and work.

The activity is used in the RBA course taught by NC AHEC.

THE ACTIVITY

1. Spend a few minutes looking at the artwork on the next two pages.
2. Think of the artwork as a map of North Carolina.
3. Identify positive objects in the communities represented in the artwork.
4. Visit the last page for a Sketch Key list and compare your positive objects/ideas to imagine a healthier North Carolina!

The talented artist creating the original artwork for the course is:
Kim Ballentine of Kimberly Ballentine Fine Art
Raleigh/New Bern, North Carolina
NC ARTISTIC SKETCH KEY

TOP LEFT QUADRANT
- Accessibility
- Air Travel
- Apple Farm
- Bee Keeping
- Biking
- Community Park
- Education/School
- Faith Community
- Green Spaces
- Greensboro/Main Street
- Grocery Store/Market
- Highway Infrastructure
- Hiking
- Housing
- Mass Transit/City Bus
- Mixed Development Urban Area
- Museum - Indigenous People
- NC Zoo
- Playground
- Parkway
- Recreation Center/Gym
- River Rafting
- Skiing
- Solar Energy
- Tree Farm
- Walkable Community/Sidewalks
- Multigenerational communities

TOP RIGHT QUADRANT
- Academic Center/Research
- Bee Keeping
- Biking
- Camping
- Chicken Farm
- City Farm/Community Garden
- Crosswalks/Accessibility
- Emergency Services
- Ferry
- Fishing
- Golf Course
- Green Spaces
- Housing
- Mass Transit/City Bus/Train
- Medical Center/Hospital
- Pets
- Recreational Opportunities/Tourism
- Sailing/Canoeing
- State Capital/Government
- Walkable Community/Sidewalks
- Wind Energy

BOTTOM LEFT QUADRANT
- Biking
- Charlotte/NoDa District
- Clean Waterways
- Community Safety
- Crosswalks/Accessibility
- Education/School
- Electric Vehicles/Charging
- Station
- Emergency Services
- Green Spaces
- Highway Infrastructure
- Housing
- Industrial Warehouses
- Mass Transit/City Bus
- Military
- Mixed Development Urban Area
- Multicultural Communities
- Playground
- River Rafting
- Theater
- Walkable Community/Sidewalks

BOTTOM RIGHT QUADRANT
- Accessibility
- Agricultural Field/Community Garden
- Biking
- Child Care
- Clean Waterways
- Education/School
- Faith Center
- Green Spaces
- Health Center
- Housing
- Multicultural Communities
- Playground
- Recreational Opportunities/Tourism
- Swimming/Water Sports
- Transportation
- Walkable Community/Sidewalks
- Wilmington/Waterfront District
For more information about *Healthy North Carolina 2030*, the *North Carolina State Health Improvement Plan*, or the NC State Health Improvement Scorecard, please contact the *HNC 2030* Resource Center

HNC2030@dhhs.nc.gov

or visit

https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm
PREVIOUS PUBLICATIONS