NORTH CAROLINA
STATE HEALTH
IMPROVEMENT PLAN

A companion report to Healthy North Carolina 2030: A Path Toward Health (NCIOM) and the 2019 North Carolina State Health Assessment
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A JOINT LETTER OF INTRODUCTION FOR THE 2020 NC STATE HEALTH IMPROVEMENT PLAN

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

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

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

- The Foundation for Health Leadership and Innovation (FHLI) for its financial support of Clear Impact Scorecard statewide with funds from The Duke Endowment. This web-based technology visualizes accountability with local community health improvement plans and policy initiatives at the state level.

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

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

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

Sincerely,

Mark T. Benton
Assistant Secretary for Public Health
Division of Public Health
NC Department of Health and Human Services

Elizabeth Cuervo Tilson, MD, MPH, FAAP, FACPM
State Health Director
Chief Medical Officer
NC Department of Health and Human Services
The COVID-19 pandemic continues to be the number one public health priority in North Carolina public health and the HNC 2030 indicators are an integral part of the pandemic response – not just to the infection, but rather to the fabric of our culture. Covid-19 magnifies inequities and disparities that have too long been a part of our social and institutional biases.

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

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

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

With sincere appreciation,
Kathy Dail
North Carolina Division of Public Health
**WORK GROUP MEMBERS**

**INDIVIDUALS BELOW 200% FEDERAL POVERTY LEVEL (FPL) WORK GROUP**

Lariza Garzon  
Executive Director  
Episcopal Farmworker Ministry

Henry C McKoy, Jr., PhD  
Director of Entrepreneurship, School of Business  
North Carolina Central University

Candace Rashada Mujahid  
Program Coordinator  
Durham Technical Community College

Mikki Sager  
Vice President and Director, Resourceful Communities  
The Conservation Fund

Camryn Smith  
Executive Director  
Communities in Partnership

**UNEMPLOYMENT WORK GROUP**

DeWayne Barton  
Co-founder  
Green Opportunities

Reuben Blackwell  
President and CEO  
OIC, Inc.

William A. Darity, PhD  
Economist, Distinguished Professor  
Duke Sanford School of Public Policy

Jason Gray  
Senior Fellow for Research and Policy  
NC Rural Center

Ricky Hill  
Community Engagement and Volunteer Coordinator  
Hinton Rural Life Center

Jovonia Lewis, M.S.  
Licensed Professional Counselor  
Durham School Board

**SHORT-TERM SUSPENSION WORK GROUP**

Ronda Taylor Bullock, PhD  
Lead Curator/Executive Director  
we are (working to extend anti-racist education)

Ellen Essick, PhD  
Section Chief  
NC Healthy Schools  
North Carolina Department of Public Instruction

Sonja Frison, MPH, PhD  
Associate Director  
Center for Youth Family and Community  
Partnership UNC- Greensboro

William P. Jackson, PhD  
Founder  
Village of Wisdom

Les Spell, MA  
Data & Policy Consultant  
NC Healthy Schools  
North Carolina Department of Public Instruction

**INCARCERATION WORK GROUP**

Evan Ashkin, MD  
Professor, UNC School of Family Medicine  
Founder and Director, North Carolina Formerly Incarcerated Transition Program (NC FIT)

Michelle Gunn, BA  
Operations Director  
Leading Into New Communities, Inc.

Gudrun Parmer  
Director  
Criminal Justice Resource Center at Durham County

**INDIVIDUALS BELOW 200% FEDERAL POVERTY LEVEL (FPL) WORK GROUP**

Lariza Garzon  
Executive Director  
Episcopal Farmworker Ministry

Henry C McKoy, Jr., PhD  
Director of Entrepreneurship, School of Business  
North Carolina Central University

Candace Rashada Mujahid  
Program Coordinator  
Durham Technical Community College

Mikki Sager  
Vice President and Director, Resourceful Communities  
The Conservation Fund

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Communities in Partnership

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Green Opportunities

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OIC, Inc.

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NC Rural Center

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Community Engagement and Volunteer Coordinator  
Hinton Rural Life Center

Jovonia Lewis, M.S.  
Licensed Professional Counselor  
Durham School Board

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NC Healthy Schools  
North Carolina Department of Public Instruction

Sonja Frison, MPH, PhD  
Associate Director  
Center for Youth Family and Community  
Partnership UNC- Greensboro

William P. Jackson, PhD  
Founder  
Village of Wisdom

Les Spell, MA  
Data & Policy Consultant  
NC Healthy Schools  
North Carolina Department of Public Instruction

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Evan Ashkin, MD  
Professor, UNC School of Family Medicine  
Founder and Director, North Carolina Formerly Incarcerated Transition Program (NC FIT)

Michelle Gunn, BA  
Operations Director  
Leading Into New Communities, Inc.

Gudrun Parmer  
Director  
Criminal Justice Resource Center at Durham County

**STEERING COMMITTEE**

Dorothy Cilenti, DrPH  
Associate Professor Department of Maternal and Child Health  
Director Maternal and Child Health Workforce Development Center  
Gillings School of Global Public Health  
University of North Carolina at Chapel Hill

Candice DuVernois, BSN, RN, MPH, JD  
Program Director  
Division of Public Health  
Local and Community Support  
NC Department of Health and Human Services

Mikki Sager  
Vice President and Director, Resourceful Communities  
The Conservation Fund

Stephen Sills, PhD  
Professor and Director  
The Center for Housing and Community Studies  
University of North Carolina at Greensboro

Camryn Smith  
Executive Director  
Communities in Partnership

Charlene Wong, MD, MSPH  
Assistant Professor, Department of Pediatrics  
Marajpa Center for Health Policy  
Duke University

Cornell P. Wright, MPA  
Executive Director  
Office of Minority Health and Health Disparities  
NC Department of Health and Human Services

Kathryn Dail, PhD, RN  
Co-Project Director, 2020 NC SHIP  
State Center for Health Statistics  
Division of Public Health  
NC Department of Health and Human Services

Brieanne Lyda-McDonald, MSPH  
Co-Project Director, 2020 NC SHIP  
North Carolina Institute of Medicine

Adam J. Zolotor, MD, DrPH  
Former President and CEO  
North Carolina Institute of Medicine

Henry C McKoy, Jr., PhD  
Director of Entrepreneurship, School of Business  
North Carolina Central University

Candace Rashada Mujahid  
Program Coordinator  
Durham Technical Community College

Mikki Sager  
Vice President and Director, Resourceful Communities  
The Conservation Fund

Camryn Smith  
Executive Director  
Communities in Partnership

Weyling White, MBA, CAPPM  
Practice Administrator  
Roanoke-Chowan Community Health Center

**SHORT-TERM SUSPENSION WORK GROUP**

Ronda Taylor Bullock, PhD  
Lead Curator/Executive Director  
we are (working to extend anti-racist education)

Ellen Essick, PhD  
Section Chief  
NC Healthy Schools  
North Carolina Department of Public Instruction

Sonja Frison, MPH, PhD  
Associate Director  
Center for Youth Family and Community  
Partnership UNC- Greensboro

William P. Jackson, PhD  
Founder  
Village of Wisdom

Les Spell, MA  
Data & Policy Consultant  
NC Healthy Schools  
North Carolina Department of Public Instruction

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Evan Ashkin, MD  
Professor, UNC School of Family Medicine  
Founder and Director, North Carolina Formerly Incarcerated Transition Program (NC FIT)

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Operations Director  
Leading Into New Communities, Inc.

Gudrun Parmer  
Director  
Criminal Justice Resource Center at Durham County

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Dorothy Cilenti, DrPH  
Associate Professor Department of Maternal and Child Health  
Director Maternal and Child Health Workforce Development Center  
Gillings School of Global Public Health  
University of North Carolina at Chapel Hill

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Program Director  
Division of Public Health  
Local and Community Support  
NC Department of Health and Human Services

Mikki Sager  
Vice President and Director, Resourceful Communities  
The Conservation Fund

Stephen Sills, PhD  
Professor and Director  
The Center for Housing and Community Studies  
University of North Carolina at Greensboro

Camryn Smith  
Executive Director  
Communities in Partnership

Charlene Wong, MD, MSPH  
Assistant Professor, Department of Pediatrics  
Marajpa Center for Health Policy  
Duke University

Cornell P. Wright, MPA  
Executive Director  
Office of Minority Health and Health Disparities  
NC Department of Health and Human Services

Kathryn Dail, PhD, RN  
Co-Project Director, 2020 NC SHIP  
State Center for Health Statistics  
Division of Public Health  
NC Department of Health and Human Services

Brieanne Lyda-McDonald, MSPH  
Co-Project Director, 2020 NC SHIP  
North Carolina Institute of Medicine

Adam J. Zolotor, MD, DrPH  
Former President and CEO  
North Carolina Institute of Medicine

Henry C McKoy, Jr., PhD  
Director of Entrepreneurship, School of Business  
North Carolina Central University

Candace Rashada Mujahid  
Program Coordinator  
Durham Technical Community College

Mikki Sager  
Vice President and Director, Resourceful Communities  
The Conservation Fund

Camryn Smith  
Executive Director  
Communities in Partnership

Weyling White, MBA, CAPPM  
Practice Administrator  
Roanoke-Chowan Community Health Center

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Section Chief  
NC Healthy Schools  
North Carolina Department of Public Instruction

Sonja Frison, MPH, PhD  
Associate Director  
Center for Youth Family and Community  
Partnership UNC- Greensboro

William P. Jackson, PhD  
Founder  
Village of Wisdom

Les Spell, MA  
Data & Policy Consultant  
NC Healthy Schools  
North Carolina Department of Public Instruction

**INCARCERATION WORK GROUP**

Evan Ashkin, MD  
Professor, UNC School of Family Medicine  
Founder and Director, North Carolina Formerly Incarcerated Transition Program (NC FIT)

Michelle Gunn, BA  
Operations Director  
Leading Into New Communities, Inc.

Gudrun Parmer  
Director  
Criminal Justice Resource Center at Durham County
**WORK GROUP MEMBERS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corey Purdie</td>
<td>Executive Director, Wash Away Unemployment, Inc.</td>
</tr>
<tr>
<td>Melissa Raddiff, BA</td>
<td>Program Director, Our Children’s Place of Coastal Horizons Center, Inc.</td>
</tr>
<tr>
<td>Frankie Roberts</td>
<td>Executive Director, Leading Into New Communities, Inc.</td>
</tr>
<tr>
<td>Lauren Brinkley-Rubinstein, PhD</td>
<td>Assistant Professor of Social Medicine, The University of North Carolina at Chapel Hill</td>
</tr>
<tr>
<td>Mikki Sager</td>
<td>Vice President and Director, Resourceful Communities, The Conservation Fund</td>
</tr>
<tr>
<td>Noran Sanford, MSW, LCSW</td>
<td>Sara Jose Fellow Founder, Board Chair, Growing Change, Inc.</td>
</tr>
<tr>
<td>Kristie Puckett Williams, MA</td>
<td>Statewide Campaign for Smart Justice Manager, ACLU of NC Chair, Women in Incarceration Workgroup, State Reentry Coalition Collaborative</td>
</tr>
<tr>
<td>Wanda Boone, PhD</td>
<td>Founder, Executive Director, Together for Resilient Youth</td>
</tr>
<tr>
<td>Elizabeth Byrum MSW, MPH</td>
<td>Resilient Communities Officer, North Carolina Partnership for Children</td>
</tr>
<tr>
<td>Elaine Cabinon-Feorder, MD, FAAP</td>
<td>Associate Professor/Department of Pediatrics, East Carolina University</td>
</tr>
<tr>
<td>Joshua Gettiner, MD</td>
<td>Family Medicine, MAHEC Family Health Center Bilmore</td>
</tr>
<tr>
<td>Lisa Amaya-Jackson, MD, MPH</td>
<td>Professor of Psychiatry and Behavioral Sciences, Associate Director, Duke School of Medicine, National Child Traumatic Stress Network</td>
</tr>
<tr>
<td>Safiyah Jackson</td>
<td>Early Childhood Systems Director, North Carolina Partnership for Children</td>
</tr>
<tr>
<td>Jasmin Jones</td>
<td>System of Care Coordinator, Sandhills Center</td>
</tr>
<tr>
<td>Sharon E. Lez, PhD</td>
<td>President, North Carolina Infant and Young Child Mental Health Association, and Early Intervention Branch Head, Women and Children’s Health Section Division of Public Health, North Carolina Department of Health and Human Services</td>
</tr>
<tr>
<td>Lisa Phillips, BS, MA</td>
<td>State Coordinator for the Education of Homeless Children and Youth Office of the Deputy State Superintendent of Innovation, Federal Program Monitoring and Support Division, NC Department of Public Instruction</td>
</tr>
<tr>
<td>Lisa Salo</td>
<td>System of Care Coordinator, Sandhills Center</td>
</tr>
<tr>
<td>Meghan Shanahan, PhD</td>
<td>Assistant Professor, Research Scientist, Department of Maternal and Child Health, UNC Injury Prevention Research Center</td>
</tr>
<tr>
<td>Mandy Ableidingter, BA, MPA</td>
<td>Deputy Director, North Carolina Early Childhood Foundation</td>
</tr>
<tr>
<td>Callie Boulware</td>
<td>Regional Executive Director, Reach Out and Read Carolina</td>
</tr>
<tr>
<td>Heriberto Corral, Ed.D.</td>
<td>Migrant Education Program Administrator, North Carolina Department of Public Instruction</td>
</tr>
<tr>
<td>Dawn Baldwin Gibson, PhD</td>
<td>Superintendent, Peleiah Academic Center for Excellence</td>
</tr>
<tr>
<td>Emily M. D’Agostino, DrPH, MS, MEd, MA</td>
<td>Assistant Professor, Department of Family Medicine &amp; Community Health, Department of Population Health Sciences, Duke University School of Medicine</td>
</tr>
<tr>
<td>Laura Fenn, M.S. Ed.</td>
<td>Co-Founder, Chief Executive Officer, The Waking Classroom Institute</td>
</tr>
<tr>
<td>Ed Johnson, RLA, ASLA</td>
<td>School Resource Officer, Integrated Mobility Division, North Carolina Department of Transportation</td>
</tr>
<tr>
<td>Kelly Kavanaugh, MPH, CHES</td>
<td>Built Environment and Early Care and Education Coordinator, Division of Public Health, North Carolina Department of Health and Human Services, Community and Clinical Connections for Prevention and Health Branch, North Carolina Department of Health and Human Services, Kids in Parks</td>
</tr>
<tr>
<td>Adam Roades</td>
<td>Associate Director, Kids in Parks, North Carolina Department of Health and Human Services</td>
</tr>
<tr>
<td>Alice Ammerman, DrPH</td>
<td>Director, Center for Health Promotion and Disease Prevention/CDC Prevention Research Center, The University of North Carolina at Chapel Hill</td>
</tr>
<tr>
<td>Mary Anne Burghardt, MS, RD, LDN</td>
<td>Head, Nutrition Services Branch, Division of Public Health, North Carolina Department of Health and Human Services</td>
</tr>
<tr>
<td>Mary Davis</td>
<td>Director, Healthy Food, Blue Cross Blue Shield of NC Foundation</td>
</tr>
<tr>
<td>Raven King-Edwards, MPH</td>
<td>Public Health Program Coordinator, Office of Minority Health and Health Disparities, North Carolina Department of Health and Human Services</td>
</tr>
<tr>
<td>Morgan Wittman Gramann</td>
<td>Executive Director, North Carolina Alliance for Health</td>
</tr>
<tr>
<td>Archie Hart</td>
<td>Director, Small Farms Policy Office, North Carolina Department of Agriculture</td>
</tr>
<tr>
<td>Marianne LeGreco</td>
<td>Associate Professor, Communication Studies, University of North Carolina at Greensboro</td>
</tr>
<tr>
<td>Jen Zuckerman</td>
<td>Director of Strategic Initiatives, World Food Policy Center, Sanford School of Public Policy, Duke University</td>
</tr>
<tr>
<td>Lariza Garzon</td>
<td>Executive Director, Episcopal Farmworker Ministry</td>
</tr>
<tr>
<td>Neasha Graves, MPA</td>
<td>Environmental Health Outreach Manager, Center for Public Engagement with Science, UNC Institute for the Environment, The University of North Carolina at Chapel Hill</td>
</tr>
<tr>
<td>Kay Jawors, J.D.</td>
<td>Senior Policy Associate, State Policy Program, Nicholas Institute, Duke University</td>
</tr>
<tr>
<td>Ed Norman, MPH</td>
<td>Head, Children’s Environmental Health, North Carolina Department of Health and Human Services, Environmental Section, North Carolina Department of Health and Human Services</td>
</tr>
<tr>
<td>Stephen Sills, PhD</td>
<td>Professor and Director, The Center for Housing and Community Studies, The University of North Carolina at Greensboro</td>
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<td>Assistant Professor, Department of City and Regional Planning, The University of North Carolina at Chapel Hill</td>
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<td>Evan Ashkin, MD</td>
<td>Professor, UNC School of Medicine, Founder and Director, North Carolina Formerly Incarcerated Transition Program, NC FIT</td>
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<tr>
<td>Alan Dellapenna, RS, MPH</td>
<td>Branch Head, Injury and Violence Prevention Branch, North Carolina Department of Health and Human Services, Division of Public Health</td>
</tr>
<tr>
<td>E. Blake Fagan, MD</td>
<td>Chief Education Officer, Mountain Area Health Education Center, MAHEC, Professor Department of Family Medicine, UNC-Chapel School of Medicine</td>
</tr>
<tr>
<td>Chase Holleman, LCSW, LCAS</td>
<td>Program Director, Guilford County Solution to the Opioid Problem</td>
</tr>
</tbody>
</table>

**ACCESS TO EXERCISE OPPORTUNITIES WORK GROUP**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Sills, PhD</td>
<td>Professor and Director, The Center for Housing and Community Studies, The University of North Carolina at Greensboro</td>
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<td>Assistant Professor, Department of City and Regional Planning, The University of North Carolina at Chapel Hill</td>
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<td>Branch Head, Injury and Violence Prevention Branch, North Carolina Department of Health and Human Services, Division of Public Health</td>
</tr>
<tr>
<td>E. Blake Fagan, MD</td>
<td>Chief Education Officer, Mountain Area Health Education Center, MAHEC, Professor Department of Family Medicine, UNC-Chapel School of Medicine</td>
</tr>
<tr>
<td>Chase Holleman, LCSW, LCAS</td>
<td>Program Director, Guilford County Solution to the Opioid Problem</td>
</tr>
</tbody>
</table>
WORK GROUP MEMBERS

TONIA LOCKLEAR, BSW, MSW, LCSWA
Mobile Crisis Professional Team Lead
Monarch

ELYSE POWELL, PhD
State Opioid Coordinator
North Carolina Department of Health and Human Services

SCOTT PREOSCHOLDBILL, MPH
Injury Epidemiologist and Surveillance Unit Manager
Division of Public Health
North Carolina Department of Health and Human Services

NIDHI SACHDEVA, MPH, CHES
Senior Research Program Leader
Division of Public Health
North Carolina Department of Health and Human Services

KINNA STRICHARTZ
Communications and Media Coordinator
North Carolina Urban Survivors Union

SALVATION ARMS
COMMUNICATIONS AND MEDIA COORDINATOR
North Carolina Urban Survivors Union

JIM MARTIN, MS
Director of Policy and Prevention
Tobacco Prevention and Control Branch
Division of Public Health
North Carolina Department of Health and Human Services

INGRID MORRIS
Senior Healthcare Program Director
Blue Cross and Blue Shield of North Carolina

KURT RIBISI, PhD
Distinguished Professor & Program Leader
Cancer Prevention and Control; UNC Lineberger Comprehensive Cancer Center

CARRIE ROSARIO, DrPH, MPH, CHES
Associate Professor
Department of Public Health Education
The University of North Carolina at Greensboro

MICHAEL SCOTT, BS, CHES
Program Director
The Center for Black Health and Equity

RONDA DOWARD, MHA
Director of Tobacco Prevention
Division of Public Health
North Carolina Department of Health and Human Services

EXCESSIVE DRINKING WORK GROUP

MINA COOK
Project Coordinator
NC Preventing Underage Drinking Initiative
The University of North Carolina at Greensboro

DYLAN ELLERBEE
Project Coordinator
The University of North Carolina at Greensboro

TERRI SHELTON, PhD
Project Director, North Carolina Preventing Underage Drinking Initiative
Vice Chancellor for Research and Engagement
The University of North Carolina at Greensboro

MIKE YOW
President & CEO
Fellowship Hall

SUGAR SWEETENED BEVERAGE CONSUMPTION WORK GROUP

ALICE AMMERMANN, DrPH
Director
Center for Health Promotion and Disease Prevention/CDC Prevention Research Center
The University of North Carolina at Chapel Hill

ZACHARY BRIAN, DMD, MHA
Director, North Carolina Oral Health Collaborative Foundation for Health Leadership and Innovation

KELLY BROWNELL, PhD
Director
Duke World Food Policy Center

NEAL CURRAN
Director of Food Programs
Reinvestment Partners

MERRY DAVIS
Director
Healthy Food at Blue Cross NC Foundation

ELLEN ESZICK, PhD
Section Chief
NC Healthy Schools
North Carolina Department of Public Instruction

SAM HOFFELLER, MS
Program Manager
Reinvestment Partners

LORELEI JONES, M.Ed.
Expanded Food and Nutrition Education Program (EFNEP) Coordinator
Department of Agricultural and Human Sciences
NC State Extension
North Carolina State University

SUSAN KANSAGRA, MD, MBA
Section Chief
Chronic Disease and Injury Section
Division of Public Health
North Carolina Department of Health and Human Services

MEGAN LOTT, MPH, RDN
Deputy Director
Healthy Eating Research
Duke Global Health Institute

LES SPELL, MA
Data & Policy Consultant
NC Healthy Schools
North Carolina Department of Public Instruction

MARY STORY, PhD, RD
Professor, Global Health and Community and Family Medicine
Duke Global Health Institute
Duke University

LAURA THOMASON, MPH
Health Policy Coordinator
Active Living & Youth Injury Prevention at Mecklenburg County

KELLY WARNock
Communications and Health Promotion Program Manager
Durham County Health Department

HIV DIAGNOSIS WORK GROUP

GIBBIE HARRIS, MSPH, BSN
Associate Professor
The University of North Carolina at Greensboro

J. DONTÉ PRAYAR
Prevention Coordinator
North Carolina AIDS Action Network

BLANKA REESE, PhD, MSPH
Research and Evaluation Manager
Sexual Health Initiatives for Teens (SHIFT NC)

LEE STORROW
Executive Director
North Carolina AIDS Action Network

J. WESLEY THOMPSON, MHS, PA-C, AAHIVS, DFAAPA
HIV Medical Director
Amity Medical Group

VICTORIA MOBLEY, MD, MPH
Medical Epidemiologist
Communicable Disease Branch
Division of Public Health
North Carolina Department of Health and Human Services

TAMEKA S. BROWN
Founder and Executive Director
Helping Each Adolescent Reach Their Spark (H.E.A.R.T.S.)

KRISTEN CARROLL, MPH
Family Planning & Reproductive Health Unit Manager
Women’s Health Branch/Women’s and Children’s Health Section
Division of Public Health
North Carolina Department of Health and Human Services

CATHY DEMASON
Director
Buckingham County Student Health Centers

CAROLYN T. HALPERN, PhD
Professor and Department Chair
Department of Maternal and Child Health (MCH)
UNC Gillings School of Global Public Health
The University of North Carolina at Chapel Hill

DANA MANGUM, MA
Chief Executive Officer
Sexual Health Initiatives for Teens (SHIFT NC)

ASHLEY STEWART, MS, CHES
Director of Clinic Improvement Services
Sexual Health Initiatives for Teens (SHIFT NC)

KIA THACKER, MPH
Chief Program Officer
SHIFT NC (Sexual Health Initiatives for Teens)

JUANELLA TYLER
Teen Pregnancy Prevention Initiative (TPPI)
Women’s Health Branch/Women’s and Children’s Health Section
Division of Public Health
North Carolina Department of Health and Human Services

UNINSURED WORK GROUP

NORTH CAROLINA ASSOCIATION OF FREE & CHARITABLE CLINICS
Chief Executive Officer
North Carolina Association of Free & Charitable Clinics

APRIL MORGAN, MA
Outreach and Enrollment Manager
North Carolina Community Health Center Association

12 NORTH CAROLINA STATE HEALTH IMPROVEMENT PLAN

NC Department of Health and Human Services 13
WORK GROUP MEMBERS

Pam Silberman, JD, DrPH  
Professor and Director  
Gillings School of Global Public Health  
The University of North Carolina at Chapel Hill

Erica Palmer Smith  
Executive Director  
CareCarolina

Willona Stallings, MPH  
NC Get Covered (former Director)  
Care Share Health Alliance

Mark Van Arnam  
Director Navigator Consortium  
Legal Aid of North Carolina

EARLY PRENATAL CARE WORK GROUP

Kimberly DeBerry, BSN, RN, CCM  
Director, Maternal Child Health  
Community Care of North Carolina

Tammera Hilton  
United Health Care

Claudia Richardson, MD, MPH  
Chief Medical Officer  
Roanoke Chowan Community Health Center

Peter Roethling, MD  
OB/GYN  
Wayne Women’s Clinic

Tara Schuler  
Perinatal Health Unit Manager  
Women’s Health Branch/Children’s Health Section  
Division of Public Health  
North Carolina Department of Health and Human Services

Tina Sherman  
Campaign Director  
MomsRising

SUICIDE RATE WORK GROUP

Garry J. Crites, PhD  
Executive Director  
National Alliance on Mental Illness, North Carolina

David B. Goldston, PhD  
Associate Professor and Clinical Psychologist  
Duke University School of Medicine

Amanda McGough, PhD  
Clinical Psychologist  
Southwest Psych

Jane Miller  
Public Health Program Consultant  
Injury and Violence Prevention Branch  
Division of Public Health  
North Carolina Department of Health and Human Services

Susan Robinson, M.Ed.  
Mental Health Program Manager  
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services  
North Carolina Department of Health and Human Services

PRIMARY CARE WORKFORCE WORK GROUP

Emily Adams, MPA  
Executive Director  
North Carolina Academy of Physician Assistants

Brandy Bynum Dawson, MPA  
Director of Advocacy  
North Carolina Rural Center

Tina Gordon  
Chief Executive Officer  
North Carolina Nurses Association

Gregory K. Griggs, MPA, CAE  
Executive Vice President and CEO  
North Carolina Academy of Family Physicians

Emily Roland, BA  
Senior Director, Community Health  
North Carolina Healthcare Association

STATE HEALTH IMPROVEMENT PLAN

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

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

The NC SHIP consists of three phases (Figure 1).

**Figure 1. The State Health Improvement Process**

**The State Health Improvement Process has Three Phases:**

**Development Phase:** January 2020 – November 2020

**Implementation Phase:** December 2020 – July 2021

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

### OVERVIEW

#### Development Phase

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

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

#### HEALTH FACTORS (19)

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

#### HEALTH OUTCOMES (2)

- Infant Mortality
- Life Expectancy

### TIMELINE

#### 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 2020 workgroup.

#### Step 2.

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

#### Step 3.

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

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

#### Step 4.

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

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

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

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

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

- System
- Organizations
- Agencies
- Institutions
- Policies

**We seek to identify successful practices as evidenced by:**

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

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

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

#### Implementation Phase

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

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

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

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

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

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

**Step 4.** Convene learning collaboratives for stakeholders addressing the HNC 2020 Indicators.

### Monitoring Progress

**Step 1.** Establish and convene the Community Council

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

- The first meeting will occur in July 2021.
PROCESS

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

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

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

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

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

LEARNING COLLABORATIVES

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

PUBLIC COMMENT AND REVIEW

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

POPULATION HEALTH MODEL

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

RESULTS–BASED ACCOUNTABILITY FRAMEWORK

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

CLEAR IMPACT SCORECARD

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

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

HEALTH OUTCOMES
- Length of Life (50%)
- Quality of Life (50%)

HEALTH BEHAVIORS (30%)
- Tobacco Use
- Diet and Exercise
- Alcohol and Drug Use
- Sexual Activity

CLINICAL CARE (20%)
- Access to Care
- Quality of Care

SOCIAL AND ECONOMIC FACTORS (40%)
- Education
- Employment
- Income
- Family and Social Support
- Community Safety

PHYSICAL ENVIRONMENT (10%)
- Air and Water Quality
- Housing and Transit

PROPOSED POLICY CHANGES
PROPOSED POLICY CHANGES

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

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

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>POLICY INITIATIVE</th>
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<tbody>
<tr>
<td><strong>POVERTY</strong></td>
<td>• Expand Medicaid eligibility</td>
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<td></td>
<td>• Advocate for paid medical leave among employers</td>
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<td>• Expand subsidized childcare</td>
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<td></td>
<td>• Increase the state earned income tax credit</td>
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<td></td>
<td>• Raise the minimum wage to $15.00 per hour</td>
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<tr>
<td><strong>UNEMPLOYMENT</strong></td>
<td>• Increase access to broadband internet</td>
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<td></td>
<td>• Expand transit options in rural and low-income communities</td>
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<td></td>
<td>• Increase percentage of jobs that pay a living wage</td>
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<tr>
<td></td>
<td>• Increase access to affordable childcare</td>
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<td></td>
<td>• Seek a national health insurance/service program: An Economic Bill of Rights for the 21st Century</td>
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<tr>
<td><strong>SHORT-TERM SUSPENSIONS</strong></td>
<td>• Develop statewide system of restorative justice programs</td>
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<tr>
<td><strong>INCARCERATION RATE</strong></td>
<td>• Implement Medication Assisted Treatment (MAT) programs in correctional settings</td>
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<tr>
<td></td>
<td>• Review current criminal justice policies to reduce the rates of incarceration</td>
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<tr>
<td><strong>ADVERSE CHILDHOOD EXPERIENCES</strong></td>
<td>• Increase access to behavioral health treatment</td>
</tr>
<tr>
<td></td>
<td>• Increase access to evidence-based parenting, early intervention, and home visiting programs</td>
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<tr>
<td></td>
<td>• Increase minimum wage and employment opportunities</td>
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<tr>
<td><strong>THIRD GRADE READING PROFICIENCY</strong></td>
<td>• Expand access to NC Pre-K, 4, and 5-star early learning programs and other high-quality early childhood programs</td>
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<td></td>
<td>• Increase access to home visiting programs for young children</td>
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<td></td>
<td>• Increase funding to public schools and early childhood programs that serve children with the highest barriers to success, including children from low-income families and people of color</td>
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<td>• Raise wages to attract, recruit, and retain highly qualified teachers, birth - third grade</td>
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<tr>
<td><strong>ACCESS TO EXERCISE OPPORTUNITIES</strong></td>
<td>• Adopt “Complete Streets” policies</td>
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<td></td>
<td>• Expand transit services to provide access to parks for physical activity</td>
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<tr>
<td></td>
<td>• Increase number of biking trails and lanes, walking trails, and greenways</td>
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<td></td>
<td>• Increase number of and access to community parks, particularly in rural areas</td>
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<td></td>
<td>• Increase the number of joint use/open use policy agreements for school playground facilities</td>
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<td></td>
<td>• Maintain safe and walkable sidewalks</td>
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<td></td>
<td>• Provide public access to municipal recreation facilities</td>
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<tr>
<td><strong>LIMITED ACCESS TO HEALTHY FOOD</strong></td>
<td>• Continue, expand, and institutionalize the SNAP online purchasing pilot</td>
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<td>• Establish a public-private financing fund to stimulate the development/innovation/expansion of new and existing community-supported venues</td>
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<td></td>
<td>• Expand transit options in rural and low-income communities</td>
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<td></td>
<td>• Provide additional funding and support to School Nutrition Programs to expand healthy, locally-sourced food options and reduce financial barriers for students.</td>
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<td></td>
<td>• Provide financial incentives like “double bucks” for SNAP/FNS recipients for the purchase of fruits and vegetables in grocery stores and farmers markets</td>
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<tr>
<td><strong>SEVERE HOUSING PROBLEMS</strong></td>
<td>• Consider regulatory change allowing trailers to be registered as homes, not vehicles.</td>
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<td></td>
<td>• Enforce fair housing laws</td>
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<td></td>
<td>• Implement “right-to-counsel” policies for tenants need to take their landlord to court</td>
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<tr>
<td></td>
<td>• Increase living wage employment opportunities</td>
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<tr>
<td></td>
<td>• Support programs designed to increase home ownership for people of color</td>
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<td></td>
<td>• Update housing standards (H2A housing) required by OSHA</td>
</tr>
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<td></td>
<td>• Update the NC Migrant Housing Act</td>
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</tbody>
</table>

Table Continued

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>POLICY INITIATIVE</th>
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<tbody>
<tr>
<td><strong>DRUG OVERDOSE DEATHS</strong></td>
<td>• Increase the use of agonist therapies (naltrexone and buprenorphine)</td>
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<tr>
<td></td>
<td>• Encourage insurance companies to expand access to treatment and recovery supports by piloting alternative pain management models</td>
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<td></td>
<td>• Expand peer support specialist programs</td>
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<tr>
<td></td>
<td>• Implement broader use of NC Controlled Substance Reporting System by health care providers and pharmacies</td>
</tr>
<tr>
<td></td>
<td>• Implement Medication-Assisted Treatment (MAT) programs in correctional settings</td>
</tr>
<tr>
<td></td>
<td>• Implement needle exchange programs</td>
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<tr>
<td></td>
<td>• Improve access to drug treatment programs, including medication-assisted treatment</td>
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<tr>
<td></td>
<td>• Increase distribution of naloxone</td>
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<tr>
<td></td>
<td>• Increase training for health care providers on buprenorphine prescribing</td>
</tr>
<tr>
<td></td>
<td>• Increase training for health care providers on safe prescribing practices</td>
</tr>
<tr>
<td></td>
<td>• Support policies that discriminate and prevent treatment of substance use disorder</td>
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<tr>
<td><strong>TOBACCO USE</strong></td>
<td>• Fund comprehensive state tobacco control programs to levels recommended by the CDC</td>
</tr>
<tr>
<td></td>
<td>• Implement state and local tobacco-free and smoke-free air policies that include e-cigarettes</td>
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<td>• Implement strategies to curb tobacco product advertising and marketing that are appealing to young people</td>
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<tr>
<td></td>
<td>• Increase access to standards of care tobacco use treatment</td>
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<td></td>
<td>• License tobacco retailers to enforce youth access to tobacco laws</td>
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<td></td>
<td>• Raise the age of tobacco product sales to 21 to comply with federal law</td>
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<td></td>
<td>• Raise the price of tobacco products through a tobacco tax</td>
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<tr>
<td></td>
<td>• Remove state preemption of local government regulations on the sale, promotion, distribution, and display of tobacco products</td>
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<tr>
<td></td>
<td>• Restrict the sales of flavored tobacco products</td>
</tr>
<tr>
<td><strong>EXCESSIVE DRINKING</strong></td>
<td>• Consider laws around beer and wine consumption</td>
</tr>
<tr>
<td></td>
<td>• Expand access to treatment through Medicaid eligibility</td>
</tr>
<tr>
<td></td>
<td>• Hold alcohol retailers liable for intoxicated or underage customers who cause injury to others</td>
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<td></td>
<td>• Increase alcohol excise taxes</td>
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<tr>
<td></td>
<td>• Increase funding for compliance checks</td>
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<td></td>
<td>• Increase number and access to programs like Fellowship Hall</td>
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<td></td>
<td>• Integrate Screening, Brief Intervention, and Referral to Treatment (SBIRT) into medical settings</td>
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<td></td>
<td>• Reduce density of alcohol retailers</td>
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<td>• Reduce the days and hours of alcohol sales</td>
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<td>• Support and maintain state-controlled alcohol sales</td>
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<tr>
<td><strong>SUGAR-SWEETENED BEVERAGE (SSB) CONSUMPTION</strong></td>
<td>• Limit sugary drinks through government and private sector procurement policies</td>
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<tr>
<td></td>
<td>• Limit the default beverages served with kids meals to milk, 100% fruit juice, or water</td>
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<td>• Use SSB taxes and generated revenues to address equity issues</td>
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<td></td>
<td>• Work with clinicians, medical practices, and insurance providers to add SSB screening questions to the electronic health record</td>
</tr>
<tr>
<td><strong>HIV DIAGNOSIS</strong></td>
<td>• Allow pharmacists to provide post-exposure prophylaxis</td>
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<td></td>
<td>• Increase harm reduction, such as needle exchange programs, housing programs</td>
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<tr>
<td></td>
<td>• Implement interventions that improve access to HIV treatment</td>
</tr>
<tr>
<td></td>
<td>• Increase access to PrEP for individuals at high risk for HIV transmission</td>
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<tr>
<td></td>
<td>• Increase education and access for formerly incarcerated populations.</td>
</tr>
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<td></td>
<td>• Increase Medicaid eligibility</td>
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<tr>
<td><strong>TEEN BIRTH RATE</strong></td>
<td>• Examine school-based education policies to ensure they include information on how to avoid teen pregnancy and sexually transmitted infections</td>
</tr>
<tr>
<td></td>
<td>• Increase access to educational programs for youth in juvenile justice and foster care systems on pregnancy and STIs</td>
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<tr>
<td></td>
<td>• Make contraceptives available on-site in schools</td>
</tr>
<tr>
<td></td>
<td>• Require medically accurate sex education</td>
</tr>
<tr>
<td><strong>UNINSURED</strong></td>
<td>• Expand Medicaid eligibility criteria</td>
</tr>
<tr>
<td></td>
<td>• Increase publicity and navigator funding for open enrollment</td>
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<td></td>
<td>• Support bans or limitations on short-term health plans</td>
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<tr>
<td></td>
<td>• Increase rural health clinical rotations for physician assistants (PAs) and Advanced Practice Nurses (DNPs)</td>
</tr>
<tr>
<td></td>
<td>• Increase telehealth primary care initiatives in rural areas</td>
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<tr>
<td></td>
<td>• Invest in rural economies</td>
</tr>
<tr>
<td></td>
<td>• Support increased funding for provider loan repayment programs that incentivize primary care providers to practice in medically underserved areas</td>
</tr>
<tr>
<td></td>
<td>• Support pipeline programs in rural areas to encourage high school and college students to pursue careers in medicine/primary care</td>
</tr>
</tbody>
</table>

NC Department of Health and Human Services
ROLES AND RESPONSIBILITIES
ROLE OF STATE HEALTH DEPARTMENT AND PARTNERS

- The NC DPH is responsible for conducting a state health assessment every five years. At the beginning of each decade, DPH partners with a larger group of stakeholders to set decennial objectives. In 2019-20, DPH partnered with the NC Institute of Medicine to produce its 2019 SHA/HNC 2030 report. NC DPH also produces a state health improvement plan based upon the state health assessment (2020 NC SHIP).

- NC DPH is responsible for creating and maintaining the state level HNC 2030 Scorecard. This includes training and technical assistance to local health departments and their partners in linking local scorecards to the state scorecard.

- NC DPH is responsible for convening annual meetings of the NC SHIP Community Council. DPH ensures that all Council members receive training in the use of Scorecard to monitor progress on the HNC 2030 indicators.

- NC DPH and partners are responsible for promoting and supporting local health department participation in Community Council meetings.

- NC DPH and partners are responsible for promoting and supporting local health department participation in Community Council meetings.

NC SHIP COMMUNITY COUNCIL

- The NC SHIP Community Council provides oversight on “turning the curve” for the 21 HNC 2030 indicators (Figure 7). Community Council members were recruited initially from the pool of over 150 work group participants that created the initial plan. Each agency/institutional representative then actively recruits a community representative and addresses potential barriers to participation in Community Council meetings.

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

- NC DPH convenes the NC SHIP Community Council meeting and provides staff support for their annual report.

ROLE OF LOCAL HEALTH DEPARTMENTS AND PARTNERS

- Local health departments and their partners contribute to the state plan by implementing best practice programs, timely interventions, and promising new activities to address complex social, economic, educational, environmental, and health needs. Performance accountability is transparent and captured in local scorecards that can be linked in local community health improvement plans and to the state level HNC 2030 Scorecard.

- Local health departments are responsible for ensuring that staff are trained in Results-Based Accountability (RBA).

MONITORING EFFORT AND EFFECT USING CLEAR IMPACT SCORECARD

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

STRATEGY 1

Use data to improve accountability for community health improvement

STRATEGY 2

Implement RBA/CI Scorecard statewide on a voluntary basis

- Positive experience with 16 counties and hospitals in western NC

STRATEGY 3

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

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

STRATEGY 4

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

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

STRATEGY 5

Continue research identifying factors associated with accountability of community health improvement

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

STRATEGY 6

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

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

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

<table>
<thead>
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<th>Not Achieved</th>
<th>Partially Achieved</th>
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<td>59%</td>
<td>24%</td>
<td>12%</td>
<td>4%</td>
<td>~2%</td>
</tr>
</tbody>
</table>

STATE HEALTH IMPROVEMENT PLAN

INDICATORS

SOCIAL AND ECONOMIC FACTORS

- Individuals Below 200% Federal Poverty Level (FPL)......30-31
- Unemployment ...............................................................32-33
- Short-term Suspensions.................................................34-35
- Incarceration Rate...........................................................36-37
- Adverse Childhood Experiences....................................38-39
- Third Grade Reading Proficiency ..................................40-41
**PERCENT OF INDIVIDUALS WITH INCOMES AT OR BELOW 200% OF THE FPL**

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

- NC SHIP Work Session May 2020

**WHAT OTHER DATA DO WE NEED?**

- Economic Mobility: Job market (income); Savings rate; Ownership (home, business, investment)
- Study Economic Mobility - [https://scholar.harvard.edu/files/hendren/files/mobility_geo.pdf](https://scholar.harvard.edu/files/hendren/files/mobility_geo.pdf)
- DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of Social Determinants of Health (SDOH) screening questions.
  - Food insecurity
  - Housing instability
  - Lack of transportation
  - Interverbal violence

[https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions](https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions)

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

**WHAT WORKS?**

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

**NC PARTNERS WHO CAN HELP US:**

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

**WHAT RESULT DO WE WANT?**

All people in North Carolina are economically self-sufficient.

**POVERTY**

**WHY IS THIS IMPORTANT?**

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

**HOW ARE WE DOING?**

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

**WHAT WORKS?**

• Advocate for universal basic income
• Advocate for universal health insurance/Expand Medicaid eligibility
• Bring back the infrastructure to support community & economic development at the state and federal level
• Focus economic development on well-paying jobs
• Improve third grade reading proficiency and high school graduation rates
• Increase paid medical leave
• Increase subsidized childcare
• Increase the state earned income tax credit
• Launch funds for minority businesses
• Raise the minimum wage to $15 per hour
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• Z. Smith Reynolds Foundation making racial equity a priority - [https://www.zsr.org/](https://www.zsr.org/)
**PERCENT OF POPULATION AGED 16 AND OLDER WHO ARE UNEMPLOYED BUT SEEKING WORK**

**UNEMPLOYMENT DISPARITY RATIO BETWEEN WHITE AND OTHER POPULATIONS**

**WHAT RESULT DO WE WANT?**

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

**WHY IS THIS IMPORTANT?**

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

**HOW ARE WE DOING?**

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

**WHAT WORKS?**

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

**NC PARTNERS WHO CAN HELP US:**

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

**WHAT OTHER DATA DO WE NEED?**

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

Information about the data source can be found in Appendix C: American Community Survey
**Number of Out-of-School Short-Term Suspensions in Educational Facilities for All Grades**

“Punishment must be student-centered; Consequences should be just and appropriate.”

- NC SHIP Work Session May 2020

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

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

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**WHAT OTHER DATA DO WE NEED?**

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

---

**WHAT WORKS?**

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

---

**WHAT RESULT DO WE WANT?**

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

**WHY IS THIS IMPORTANT?**

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

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**HOW ARE WE DOING?**

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

---

**NC Partners Who Can Help Us:**

- Color of Education - https://colorofeducation.org/about/
- Duke Center for Research to Advance Healthcare Equity - https://sites.duke.edu/reachequity/
- Made in Durham A community partnership of engaged educators, business, government, nonprofits, youth and young adults aligning their resources and initiatives to create an education-to-career system that better equips Durham’s youth for career and life success and builds a stronger local workforce - https://madeindurham.org/
- Racial Equity Institute - https://www.racialequityinstitute.com/
- Southern Coalition for Social Justice A project of the (SCS) that works to ensure equity, fairness, and justice for youth in high-quality education, juvenile, and criminal systems - https://southerncoalition.org/
- University of North Carolina at Greensboro Center for Youth Family and Community Partnership - https://cyfcp.uncg.edu/
- Village of Wisdom - https://www.villageofwisdom.org/
- we are - https://www.weare-nc.org/
**INDICATOR 4**

**INCARCERATION RATE IN NORTH CAROLINA PRISONS PER 100,000 POPULATION**

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

- NC SHIP Work Session May 2020

**WHAT OTHER DATA DO WE NEED?**

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

**WHAT WORKS?**

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

**NC PARTNERS WHO CAN HELP US:**

- Durham County Criminal Justice Resource Center - https://www.ncmedicaljournal.com/content/80/6/369
- Leading Into New Communities, Inc. - https://lincnc.org/
- Wash Away Unemployment, Inc. - https://www.facebook.com/WashAwayUnemployment

**WHAT RESULT DO WE WANT?**

North Carolina has a fair and equitable criminal justice system.

**WHY IS THIS IMPORTANT?**

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

**HOW ARE WE DOING?**

North Carolina has the 21st lowest incarceration rate among US states with a rate of 341 people incarcerated in prison per 100,000 people in the population. Mental illness affects 17% of inmates in North Carolina. African Americans account for only 22% of the state population, yet make up 52% of the total incarcerated population. African Americans are 6.5 times more likely to be incarcerated for drug-related offenses although drug use among African Americans is lower than other racial and ethnic groups.

Rates of trafficking are similar. Explicit targeting of people of color by law enforcement and harsher sentencing leads to jail and prison time. The 2030 state goal is to decrease the incarceration rate to 150 people incarcerated per 100,000 in the population or increase the rate of decline. Reducing the disproportionate incarceration of African Americans and American Indians will largely affect the success in meeting this goal. **HNC 2030 pp. 44-45**

**WHAT WORKS?**

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

**NC PARTNERS WHO CAN HELP US:**

- Durham County Criminal Justice Resource Center - https://www.ncmedicaljournal.com/content/80/6/369
- Leading Into New Communities, Inc. - https://lincnc.org/
- Wash Away Unemployment, Inc. - https://www.facebook.com/WashAwayUnemployment
PERCENT OF CHILDREN WITH TWO OR MORE ADVERSE CHILDHOOD EXPERIENCES

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

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

WHAT OTHER DATA DO WE NEED?

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

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

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

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

WHAT WORKS?

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

WHAT RESULT DO WE WANT?

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

WHY IS THIS IMPORTANT?

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

HOW ARE WE DOING?

North Carolina is ranked 32rd among US states for the number of children with two or more Adverse Childhood Experiences (ACEs) and is ranked 1st for the lowest percent of children with 2+ ACEs at 23.6% of children ages 0-17 (2016-17). In NC 18% of children ages 0-5 have experienced 2+ ACEs. A child’s living arrangements, household income level, care needs, and race and ethnicity can all affect the risk of ACEs. The statewide goal is to decrease the percentage of children with 2+ ACEs to 18.0% by 2030. Current work involves increasing trauma-informed practices and programs that support families and children to decrease their exposure to trauma and overcome the impact of ACEs. [HNC 2030, p. 48-47]

WHAT PARTNERS CAN HELP US:

- Center for Child & Family Health - https://www.ccflhn.org/about-ccfh/
- Working to define, practice, and teach the highest standards of care in treating and preventing childhood trauma
- North Carolina Child Treatment Program - https://www.nchltreatmentprogram.org/- Offers training to mental health providers in evidence-based treatment models addressing childhood trauma, behavior, and attachment
- North Carolina Homeless Education Program - https://hepnc.uncg.edu/
- North Carolina Infant and Young Child Mental Health Association - http://www.ncimha.org/- Offers a professional network and community of early childhood mental health professionals to promote, educate, and advocate for the reduction of ACEs.
- Our Children's Place of Coastal Horizons Center - https://www.ourchildrensplace.com/- Committed to the well-being of children experiencing parental incarceration, through advocacy, education, and outreach
- Parenting Inside Out - http://www.parentinginsideout.org/- Evidence-based parenting skills training program for criminal justice-involved parents
- The Impact of Racism on Child and Adolescent Health - https://pediatrics.aappublications.org/content/144/2/e20191765
- Wellness Action Recovery Plan (WARP) - https://mentalhealthrecovery.com/- Addresses physical, mental health, and life issues to help people get well and stay well

The target goal for this indicator was set based upon 2016-2017 data. Now data in 2019 show that we are doing better across all categories.
PERCENT OF CHILDREN WHO ARE PROFICIENT IN READING AT THE END OF THIRD GRADE

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

- NC SHIP Work Session May 2020

WHAT OTHER DATA DO WE NEED?

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

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

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

WHAT WORKS?

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

NC PARTNERS WHO CAN HELP US:

- Book Harvest NC - https://bookharvestnc.org
- North Carolina Early Childhood Foundation - Pathways to Grade-Level Reading - https://buildthefoundation.org/initiative/pathways-to-grade-level-reading/
- Peletah Academic Center for Excellence (PACE) Ministry - https://www.peletahministries.com/pace/
- Reach Out & Read Carolinas - https://www.rorcarolinas.org/

WHAT RESULT DO WE WANT?

All children in North Carolina have early reading proficiency skills.

WHY IS THIS IMPORTANT?

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

HOW ARE WE DOING?

The third grade reading proficiency rate in North Carolina for the 2018-19 school year was 56.8%. This amounts to 53,000 students not meeting third grade reading requirements each year. Performance by school district varied greatly. Twenty-three percent of children with disabilities, 27.7% of English learners, 32.8% of students experiencing homelessness, and 40% of economically disadvantaged students and children in foster care were proficient in reading. From 2018-2019, only 40% of African American, American Indian, and Hispanic third graders were meeting proficiency requirements compared to 79% of white students and 76% of Asian students. The current goal is to accomplish 80% third grade reading proficiency by 2030. Achieving this goal is largely dependent upon eliminating disparities in proficiency rates for African American, Hispanic, and American Indian students. NC 2030, p. 48-49

WHAT WORKS?

- Expand access to NC Pre-K, 4-, and 5-star early learning programs and other high-quality early childhood programs, particularly for children who are homeless, in foster care, are from immigrant families, or who have disabilities or other special healthcare needs
- Expand use of evidence-based literacy programs connected to health care (e.g., Reach Out and Read)
- Improve the rigor and responsiveness of third grade teacher and administrator preparation programs
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STATE HEALTH IMPROVEMENT PLAN

INDICATORS

PHYSICAL ENVIRONMENT FACTORS

Access to Exercise Opportunities.................44-45
Limited Access to Healthy Foods.................46-47
Severe Housing Problems..........................48-49
**INDICATOR 7**

**PERCENT OF PEOPLE WITH ACCESS TO EXERCISE OPPORTUNITIES**

“Find a trail near your house!" Let us start by calling it physical activity, not exercise.” 
-NC SHIP Work Session May 2020

**WHAT OTHER DATA DO WE NEED?**

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

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

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

**WHAT WORKS?**

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

**NC PARTNERS WHO CAN HELP US:**

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

**HOW ARE WE DOING?**

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

**WHAT WORKS?**

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

**WHAT RESULT DO WE WANT?**

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

**WHY IS THIS IMPORTANT?**

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

**ACCESS TO EXERCISE OPPORTUNITIES**

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

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<th>Percent of People with Access</th>
<th>Counties</th>
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<td>0% - 29%</td>
<td>6 Counties</td>
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<td>50% - 69%</td>
<td>36 Counties</td>
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<td>70% - 89%</td>
<td>29 Counties</td>
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<td>90% - 100%</td>
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PERCENT OF PEOPLE WHO ARE LOW-INCOME THAT ARE NOT NEAR A GROCERY STORE

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

-NC SHIP Work Session May 2020

WHAT OTHER DATA DO WE NEED?

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

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

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

WHAT WORKS?

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

NC PARTNERS WHO CAN HELP US:

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

INDICATOR 8

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

WHY IS THIS IMPORTANT?

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

WHAT RESULT DO WE WANT?

North Carolina residents have equitable access to healthy foods.

HOW ARE WE DOING?

In North Carolina, 7% of people with low-income live more than one mile away from a grocery store in metropolitan areas or more than 10 miles away from a grocery store in rural areas (2015) making North Carolina ranked 26th among US states with limited access to healthy foods. More than 500,000 residents live in one of the 340+ “food deserts” or areas with limited access to healthy foods. Race and income level affect likelihood of living in a food desert and the grocery stores in those communities often have fewer options or higher prices for healthier foods compared to stores in wealthier areas. The current percent of the population with limited access to healthy food has remained steady at 7% for the last five years. The state goal is to reduce this to 5% within the next 10 years. HNC 2030 pp. 56-57

WHAT WORKS?

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

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

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

WHAT OTHER DATA DO WE NEED?

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

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

Information about the data source can be found in Appendix C: County Health Rankings and Roadmaps - United States Department of Agriculture (USDA).
PERCENT OF PEOPLE WITH SEVERE HOUSING PROBLEMS

“Our seasonal and migrant farmworkers often live in substandard housing.”

-NC SHIP Work Session May 2020

HOW ARE WE DOING?
With 16.1% of the population facing severe housing problems (2011-2016), North Carolina ranks at 28th among US states. One in six households in the state faces severe housing problems. This breaks down to 14,000 overcrowded households, 18,000 households with incomplete plumbing, 24,000 households with insufficient kitchen facilities, and severe cost burden affecting 500,000 households.

Geographic location, race and ethnicity, education level, and income level are all factors in determining likelihood for facing severe housing problems. People who rent their home face higher costs and lack the ability to improve their housing conditions. Only 43.9% of African American residents and 43% of Hispanic residents live in a home they own compared to 71.2% of white residents. The goal for 2030 is to reduce the percent of the population with severe housing problems to 14%.

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

WHAT OTHER DATA DO WE NEED?
DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of SDOH screening questions to address and acquire data on the following:
• Food insecurity
• Housing instability
• Lack of transportation
• Interpersonal violence

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

WHAT RESULT DO WE WANT?
All low-income families in North Carolina have sufficient, affordable, quality housing.

WHY IS THIS IMPORTANT?
Housing Quality is important for overall well-being affecting physical and mental health. Poor housing can increase risk of respiratory infections, psychological stressors, and other chronic conditions.

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

INDICATORS

HEALTH BEHAVIORS

Drug Overdose Deaths........................................52-53
Tobacco Use......................................................54-55
Excessive Drinking...........................................56-57
Sugar-Sweetened Beverage Consumption........58-59
HIV Diagnosis..................................................60-61
Teen Birth Rate...............................................62-63
**INDICATOR 10**

**NUMBER OF PEOPLE WHO DIE BECAUSE OF DRUG POISONING**

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

-NC SHIP Work Session May 2020

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**WHAT OTHER DATA DO WE NEED?**

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

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

[Link](https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions)

---

**WHAT WORKS?**

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

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**WHAT RESULT DO WE WANT?**

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

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**WHY IS THIS IMPORTANT?**

Drug overdose is the leading cause of death due to injury in the United States. Drug use affects relationships, employment, physical and mental health, and contributes to the spread of diseases. [HNC 2030, p. 66](https://www.ncdhhs.gov/about/department-initiatives/opioid-action-plan)

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**HOW ARE WE DOING?**

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

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**NC PARTNERS WHO CAN HELP US:**

- Monarch - [https://monarchnc.org/crisis-services/](https://monarchnc.org/crisis-services/)
- North Carolina Harm Reduction Coalition (NCHRC) - [https://www.nchrc.org/about/](https://www.nchrc.org/about/)
- Recovery Communities of North Carolina - [https://www.rcnc.org/about/](https://www.rcnc.org/about/)
- Safe Project: Stop the Addiction Fatality Epidemic - [https://www.safeproject.us/](https://www.safeproject.us/)
- Safe Project: Stop the Addiction Fatality Epidemic - [https://www.ncdhhs.gov/about/department-initiatives/opioid-action-plan](https://www.ncdhhs.gov/about/department-initiatives/opioid-action-plan)
- Safe Project: Stop the Addiction Fatality Epidemic - [https://www.nchrc.org/about/](https://www.nchrc.org/about/)
- Safe Project: Stop the Addiction Fatality Epidemic - [https://www.safeproject.us/](https://www.safeproject.us/)

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**DRUG OVERDOSE DEATHS**

**TABLE 1**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Current</th>
<th>Target</th>
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<td>18.0</td>
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<tr>
<td>Black (B/AA)</td>
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<td>Hispanic (H/LX)</td>
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<td>Other (O)</td>
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<td>American Indian (AI)</td>
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<tr>
<td>Asian/Pacific Islander (A/PI)</td>
<td>12.7</td>
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</tr>
</tbody>
</table>

**PRELIMINARY FIGURE 19**

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

**FIGURE 19**

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

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**INFOGRAPHIC**

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

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**INFOGRAPHIC**

Drug overdose death rates across populations in North Carolina and distance to 2030 target (2019)
PERCENT OF TOBACCO USE ACROSS THE POPULATION: Percent of Youth and Adults Reporting Current Use of E-Cigarettes, Cigarettes, Cigars, Smokeless Tobacco, Pipes, and/or Hookah

Current Use of E-Cigarettes, Cigarettes, Cigars, Smokeless Tobacco, Pipes, and/or Hookah

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

WHAT OTHER DATA DO WE NEED?

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

WHAT WORKS?

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

WHAT RESULT DO WE WANT?

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

WHY IS THIS IMPORTANT?

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

HOW ARE WE DOING?

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

WHAT PARTNERS CAN HELP US?

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

INDICATOR 11

100% TOBACCO FREE ENVIRONMENTS HELP PEOPLE QUIT.

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

WHAT OTHER DATA DO WE NEED?

- PERCENT OF TOBACCO USE
- WHAT WORKS?
- WHAT RESULT DO WE WANT?
- NC PARTNERS WHO CAN HELP US:

INDICATOR 11

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

- NC SHIP Work Session May 2020

TOBACCO USE

12 weeks of varenicline (Chantix®)

Other pharmacotherapy includes bupropion, nicotine lozenge

12 weeks of combination therapy (nicotine gum or nicotine lozenge)

Evidenced-Based Counseling

In order of effectiveness:

- Face to face individual counseling
- Group counseling
- QuitlineNC – telephonic, texting, and web-based counseling

100% TOBACCO FREE ENVIRONMENTS HELP PEOPLE QUIT.

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

TOBACCO TREATMENT STANDARD OF CARE

FDA Approved Pharmacotherapy

12 weeks of varenicline (Chantix®) or 12 weeks of combination therapy (nicotine gum or nicotine lozenge)

Other pharmacotherapy includes bupropion, nicotine nasal spray and nicotine inhaler

Current Use of E-Cigarettes, Cigarettes, Cigars, Smokeless Tobacco, Pipes, and/or Hookah

Data to understand health disparities regarding tobacco use and exposure to hazardous secondhand smoke and e-cigarette emissions.

Data regarding sale and consumption of new and emerging tobacco products

Data to understand health disparities regarding tobacco use and exposure to hazardous secondhand smoke and e-cigarette emissions.

Data on the effectiveness of price policies to prevent initiation of e-cigarette use among young people

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

WHAT OTHER DATA DO WE NEED?

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

WHAT WORKS?

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

WHAT RESULT DO WE WANT?

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

WHY IS THIS IMPORTANT?

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

HOW ARE WE DOING?

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

WHAT PARTNERS CAN HELP US:

- Americans for Nonsmokers Rights
- ASTHO, NAACDD, and National Networks for Health Equity
- Campaign for Tobacco Free Kids
- Catch My Breath Program
- CDC’s 6/18 Initiative
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- NC Alliance for Health
- NC Association of Local Health Departments and NCPHA
- QuiltlineNC – 1-800-QuitNow (1-800-784-8669)
- The Center for Black Health and Equity - No Menthol Sunday
- The TRUTH initiative

IN NC PARTNERS WHO CAN HELP US:

- Americ
PERCENT OF ADULTS REPORTING BINGE OR HEAVY DRINKING

“By the time you reach treatment, systems have failed...look at the research around adverse childhood events.”
- NC SHIP Work Session June 2020

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

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

HOW ARE WE DOING?
In 2018, 16.9% of adults in North Carolina reported binge or heavy drinking. This placed North Carolina at 14th among US states. Men are twice as likely to report excessive drinking and it is most reported for adults 18-44, whites, Hispanics, and multiracial individuals. Individuals with higher income ($75,000+ annually) reported excessive drinking at 23% compared to 17.7% for lower income individuals ($25,000-$49,999 annually). Although the percentage of excessive drinking has been slowly increasing, the goal is to reduce this indicator to 12.0% over the next 10 years. Prioritizing reducing excessive drinking reported by men will help to reach this goal.
HNC 2030 pp. 70-71

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

NC PARTNERS WHO CAN HELP US:
• Centers for Disease Control's Community Guide on Preventing Excessive Alcohol Consumption - https://www.thecommunityguide.org/topic/excessive-alcohol-consumption
• NC-PUDI Collaborative Contacts - https://www.ncpudi.org/community-collaboratives/collaborative-contacts/
• North Carolina Preventing Underage Drinking Initiative (NC-PUDI) - https://www.ncpudi.org/about/
• Talk It Up. Lock It Up!™ - http://www.ncpudi.org/resources/talk-it-up-lock-it-up/
• Too Smart to Start - http://www.samhsa.gov/underage-drinking

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

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

Information about the data source can be found in Appendix C: NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)
PERCENT OF YOUTH AND ADULTS REPORTING CONSUMPTION OF ONE OR MORE SUGAR-SWEETENED BEVERAGES (SSBs) PER DAY

What Other Data Do We Need?

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

WHAT WORKS?

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

WHAT RESULT DO WE WANT?

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

WHY IS THIS IMPORTANT?

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

HOW ARE WE DOING?

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

NC PARTNERS WHO CAN HELP US:

- Duke University World Food Policy Center - https://wfpc.sanford.duke.edu/
- Durham’s Innovative Nutrition Education (DINE) - https://www.dcopublichealth.org/services/nutrition/dine
- Eat Smart, Move More NC - https://www.eatsmartmovemorenccom/
- Eat Smart, Move More, Prevent Diabetes - https://esmmpreventdiabetes.com/how-it-works/
- Go NAPSACC - https://gonapsacc.org/
- Healthy Eating Research Healthy Drinks Healthy Kids - https://healthydrinkshealthykids.org/
- I Heart Water - http://iheartwaternc.com/
- NC State Color Me Healthy - https://ncestepshealth.ces.ncsu.edu/color-me-healthy-for-steps-to-health/
- NC State Take Control - https://ncestepstohalth.ces.ncsu.edu/steps-to-health-eat-smart-move-more-take-control/
- North Carolina Expanded Food and Nutrition Education Program - https://ncfnapgov/

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

- Youth: NC Department of Public Instruction, Youth Risk Behavior Survey (YRBS)
- Adult: NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)
HIV RATE: NUMBER OF NEW HIV DIAGNOSES PER 100,000 POPULATION

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

WHAT WORKS?

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

WHAT RESULT DO WE WANT?

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

WHY IS THIS IMPORTANT?

HIV can cause lifelong physical and psychological consequences. When left untreated, HIV can also be transmitted to sexual partners and unborn children.

HOW ARE WE DOING?

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

WHAT OTHER DATA DO WE NEED?

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

Information about the data source can be found in Appendix C: NC Division of Public Health, Epidemiology Section
**WHAT OTHER DATA DO WE NEED?**

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

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

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**WHAT WORKS?**

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

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**NC PARTNERS WHO CAN HELP US:**

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

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**WHAT RESULT DO WE WANT?**

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

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**WHY IS THIS IMPORTANT?**

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

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**HOW ARE WE DOING?**

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

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**WHAT ELSE DO WE NEED TO KNOW?**

- Teenage pregnancy and birth are more common among girls from low income families and those with a history of adverse childhood experiences. African American, Hispanic, and American Indian girls give birth at rates 2-3 times higher than white girls and these girls are more likely to reside in under-resourced communities. Over the next 10 years, the goal is to reduce the number of teen births to 10 per 1,000, and to reduce racial disparities for this health indicator. [HNC 2030, pp. 78-79]
STATE HEALTH IMPROVEMENT PLAN

INDICATORS

CLINICAL CARE FACTORS

- Uninsured .................................. 66-67
- Primary Care Clinicians .............. 68-69
- Early Prenatal Care ..................... 70-71
- Suicide Rate ............................. 72-73
WHAT OTHER DATA DO WE NEED?

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

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

WHAT WORKS?

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

WHAT PARTNERS WHO CAN HELP US:

- Care4Carolina - https://care4carolina.com - statewide Coalition working to fill the coverage gap for low-income North Carolinians
- Equality NC - https://equalitync.org/ - Access to transition-related healthcare services under Medicaid
- NC Community Health Center Association - https://www.ncchca.org/ - Provides free or reduced cost health care to low income uninsured individuals
- NC Justice Center - https://www.ncjustice.org/projects/health-advocacy-project/ - advocates for access to health care and insurance coverage for low income North Carolinians
- NC Rural Center - https://www.ncruralcenter.org/ - working to build more vibrant rural communities, including filling the coverage gap

WHAT RESULT DO WE WANT?

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

WHY IS THIS IMPORTANT?

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

HOW ARE WE DOING?

In 2019, nearly 14% of North Carolina’s 8.4 million non-elderly lacked health insurance, ranking North Carolina 46th among US states. Approximately 55 percent of the population held employer-sponsored insurance. Another 8% had individual plans (primarily through the ACA Marketplace). More than one-in-five (21%) had public health insurance (Medicaid, NC Health Choice, or Medicare). Adults with low incomes who do not currently qualify for Medicaid fall into a coverage gap and have high rates of uninsured individuals. When viewed through an explicit race equity lens, conditions are more dire for people of color across the state. Of the nearly 1,845,000 non-elderly African Americans in North Carolina, almost 232,000 or 13% lacked health insurance. Hispanic-Americans are uninsured at higher rates among ethnic groups; about 270,000 (29%) of 937,000 non-elderly are without health insurance. This can likely be attributed to the ethnic group’s propensity to be locked into essential work that does not pay a living wage or offer health coverage. Comparatively, 10 percent or 509,000 (out of nearly 5,085,000) non-elderly white North Carolinians are uninsured. People in rural areas are less likely to have health insurance than their urban peers. The 80 rural counties (as defined by the NC Rural Center) make up 38 percent of the state’s non-elderly population but account for 42 percent of its uninsured. Expanding Medicaid in North Carolina would support the 2030 goal to decrease the uninsured rate for people under 65 to 8%, reaching more people of color and rural people all over the state. [HNC 2030 pp. 84-85, revised]

WHAT OTHER DATA DO WE NEED?

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

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

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- NC Rural Center - https://www.ncruralcenter.org/ - working to build more vibrant rural communities, including filling the coverage gap
The North Carolina State Health Improvement Plan (NC SHIP) is a comprehensive strategy aimed at improving the health of North Carolina residents. It focuses on primary care workforce challenges and solutions. The plan emphasizes the importance of ensuring that all residents have equitable access to high-quality, affordable primary care.

### PRIMARY CARE CLINICIANS

**INDICATOR 17**

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

Primary care workforce as a ratio of the number of full-time equivalent primary care clinicians.

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

**WHAT RESULT DO WE WANT?**

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

**WHY IS THIS IMPORTANT?**

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

**HOW ARE WE DOING?**

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

**WHAT WORKS?**

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

**WHAT OTHER DATA DO WE NEED?**

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

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

**WHAT OTHER DATA DO WE NEED?**

- Stories from consumers/residents and their experiences around access to primary care in their community
- Secondary and post-secondary opportunities to pursue careers in health care
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**Appendix C:**

WHAT OTHER DATA DO WE NEED?

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- Secondary and post-secondary opportunities to pursue careers in health care
- Telehealth availability
- Contact information for all health care providers serving residents

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

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

- NC SHIP Work Session June 2020

WHAT OTHER DATA DO WE NEED?

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

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

WHAT WORKS?

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

NC PARTNERS WHO CAN HELP US:

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

WHAT RESULT DO WE WANT?

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

WHY IS THIS IMPORTANT?

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

HOW ARE WE DOING?

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

WHAT OTHER DATA DO WE NEED?

- Number of pregnancy care providers in the community
- Number of High-risk pregnancy care providers in the community
- Employer policies related to pregnancy care
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**SUICIDE RATE PER 100,000 PEOPLE**  
(AGE-ADJUSTED NUMBER OF DEATHS ATTRIBUTABLE TO SELF-HARM PER 100,000)

**WHAT RESULT DO WE WANT?**  
All North Carolina residents live in communities that foster and support positive mental health.

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

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

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

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

**WHAT OTHER DATA DO WE NEED?**  
- Stories from survivors/families and their experiences with getting help for mental health/substance use disorders  
- Enhanced death certificate review  
- Inventory of all local/regional services for mental health care/substance use disorder

Information about the data source can be found in Appendix C: NC State Center for Health Statistics, Vital Statistics.
STATE HEALTH IMPROVEMENT PLAN

INDICATORS

HEALTH OUTCOMES

Infant Mortality ..................................76-77
Life Expectancy ..................................78-79
INDICATOR 20

RATE OF INFANT DEATHS PER 1,000 LIVE BIRTHS

“We see a disproportionately distribution of providers of color to the general population.”

- NC SHIP Work Session June 2020

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

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

WHAT OTHER DATA DO WE NEED?

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

WHAT RESULT DO WE WANT?

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

WHY IS THIS IMPORTANT?

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

HOW ARE WE DOING?

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

WHAT WORKS?

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

NC PARTNERS WHO CAN HELP US:

- March of Dimes, NC Chapter - Educates medical professionals and the public about best practices; Supports lifesaving research; Provides comfort and support to families in NICUs; Advocates for those moms and babies - https://www.marchofdimes.org/state-advocacy/state-advocacy-priorities-and-wins-NC.aspx
- NC Child Advocacy Network (CAN) - Brings together child advocates from across North Carolina to build power that can impact public policies and benefit children and families - https://ncchild.org/what-we-do/
- The UNC Center of Excellence in Maternal and Child Health Education, Science and Practice - https://sph.unc.edu/mch/center-of-excellence/
- UNC Collaborative for Maternal and Infant Health - Provides leadership in North Carolina to several important public health campaigns, including tobacco use cessation, preterm birth prevention, preconception health, postpartum care and inequities in birth outcomes - https://www.mombaby.org/
AVERAGE NUMBER OF YEARS OF LIFE REMAINING FOR PEOPLE WHO HAVE ATTAINED A GIVEN AGE

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

-Secretary Mandy Cohen, NC DHHS

INDICATOR 21

WHAT RESULT DO WE WANT?
All residents of North Carolina have long and healthy lives.

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

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

WHAT OTHER DATA DO WE NEED?
• Impact of Covid-19 pandemic on life expectancy
• Continuing impact of opioid epidemic on life expectancy
• Continuing impact of infant mortality on life expectancy

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


REFERENCES BY INDICATOR

INDIVIDUALS BELOW 200% FEDERAL POVERTY LEVEL (FPL)


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

UNEMPLOYMENT


SHORT-TERM SUSPENSION RATE


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

INCARCERATION RATE


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

THIRD GRADE READING PROFICIENCY

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

ACCESS TO EXERCISE OPPORTUNITIES

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

Carter WM, Morse WC, Broch RW, Streupler B. Improving Physical Activity and Outdoor Recreation in Rural Alabama Through Community Coalitions. Preventing Chronic Dis 2019;16:190062. DOI: http://dx.doi.org/10.5888/pchd.16.190062

- Increase number of community parks, particularly in rural areas


- Increase number of biking, walking trails, and greenways


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


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


- Provide public access to municipal recreational facilities

SEVERE HOUSING PROBLEMS

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

REFERENCES

DRUG OVERDOSE DEATHS

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


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

TOBACCO USE

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


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

EXCESSIVE DRINKING

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


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

SUGAR-SWEETENED BEVERAGE CONSUMPTION

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

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REFERENCES

HIV DIAGNOSIS RATE

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

TEEN BIRTH RATE

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

UNINSURED RATE

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

PRIMARY CARE WORKFORCE

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

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


- Invest in rural economies (Holmes, 2018)

- Increase telehealth primary care initiatives in rural areas

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

- Increase telehealth primary care initiatives in rural areas

INFANT MORTALITY RATE

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

REFERENCES APPENDIX A

WEIGHTED AVERAGES
We may not be able to find resources for all of your needs, but we will try and help as much as we can.

HEALTHY OPPORTUNITIES SOCIAL DETERMINANTS OF HEALTH SCREENING QUESTIONS

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

HEALTH SCREENING
We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation.

We may not be able to find resources for all of your needs, but we will try and help as much as we can.

HEALTHY OPPORTUNITIES SOCIAL DETERMINANTS OF HEALTH SCREENING QUESTIONS

<table>
<thead>
<tr>
<th>FOOD</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Within the past 12 months, did the food you bought just not last and you didn’t have money to get more?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOUSING/ UTILITIES</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent (other than recreational camping), in an overnight shelter, or temporarily in someone else’s home (i.e. couch-surfing)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Are you worried about losing your housing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRANSPORTATION</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERPERSONAL SAFETY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Do you feel physically or emotionally unsafe where you currently live?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPTIONAL: IMMEDIATE NEED</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Are any of your needs urgent? For example, you don’t have food for tonight, you don’t have a place to sleep tonight, you are afraid you will get hurt if you go home today.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Would you like help with any of the needs that you have identified?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACE – Adverse Childhood Experience

BRFSS - Behavioral Risk Factor Surveillance System

CDC – Centers for Disease Control and Prevention

CHA – Community Health Assessment

CI Scorecard – Clear Impact Scorecard

DPH – Division of Public Health

FHLI – Foundation for Health Leadership and Innovation

FPL – Federal Poverty Level

HIV – Human Immunodeficiency Virus

HNC – Healthy North Carolina

HPV – Human papillomavirus

IUD – Intrauterine device

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

NC AHEC – North Carolina Area Health Education Centers

NC DHHS – North Carolina Department of Health and Human Services

NC DPI – North Carolina Department of Public Instruction

NC IOM – North Carolina Institute of Medicine

NC SHA – North Carolina State Health Assessment

NC SHIP – North Carolina State Health Improvement Plan

NCHA – North Carolina Healthcare Association

PA – Physician Assistant

PreEP – Pre-exposure prophylaxis

RBA – Results-Based Accountability

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

SSB – Sugar-sweetened beverage

STI – Sexually transmitted infection

SUD – Substance use disorder

TDE – The Duke Endowment

YRBS – Youth Risk Behavior Surveillance

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

TABLE 2. Measurable Results in NC Community Health Improvement Plans 2011-2017

FIGURE 1. The State Health Improvement Process

FIGURE 2. NC 2030 indicators categorized according to a population health framework

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

FIGURE 6. The County Health Rankings Model

FIGURE 7. NC SHIP Implementation and Monitoring Plan

FIGURE 8. Percent of individuals below 200% Federal Poverty Level across populations in NC

FIGURE 9. Percent unemployed across populations in North Carolina

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

FIGURE 11. Short-term suspension rates across populations in NC

FIGURE 12. NC Student Population and Short-term Suspensions by Race

FIGURE 13. Incarceration rates across populations in NC

FIGURE 14. Percent children with two or more ACEs across populations in NC

FIGURE 15. Percent children who are proficient in reading at the end of 3rd grade

FIGURE 16. Percent of People with Access to Exercise Opportunities in NC Counties

FIGURE 17. Percent of People with Limited Access to Healthy Foods in NC Counties

FIGURE 18. Percent of People with Severe Housing Problems in NC Counties

FIGURE 19. Drug overdose death rates across populations in North Carolina

FIGURE 20. Tobacco use across populations in North Carolina

FIGURE 21. Excessive drinking across populations in NC

FIGURE 22. Sugar-sweetened beverage consumption across populations in NC

FIGURE 23. HIV rate across populations in North Carolina

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

FIGURE 25. Teen birth rate across populations in North Carolina

FIGURE 26. Teen Birth Rate in North Carolina, by Race/Ethnicity

FIGURE 27. Percent uninsured across populations in North Carolina


FIGURE 29. Early prenatal care use across populations in North Carolina

FIGURE 30. Suicide rate across populations in North Carolina

FIGURE 31. Infant mortality rates across populations in North Carolina

FIGURE 32. Teen Birth Rate Across Populations in North Carolina

FIGURE 33. Life expectancy across populations in North Carolina

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

### POPULATION ACCOUNTABILITY RESULTS

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

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

