Durham County

CCPT/CFPT

2016-2017

Annual Reports

PROMOTING THE DEVELOPMENT OF A COMMUNITY-WIDE APPROACH TO ISSUES OF CHILD ABUSE AND NEGLECT

SEEKING TO RECOGNIZE SYSTEMS' BARRIERS AND MAKING RECOMMENDATIONS TO PROTECT OUR COMMUNITY'S CHILDREN FROM PREVENTABLE DEATHS

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Section One

Community Child Protection Team

(CCPT)

2016

Annual Report

PROMOTING THE DEVELOPMENT OF A COMMUNITY-WIDE APPROACH TO ISSUES OF CHILD ABUSE AND NEGLECT

Community Child Protection Team

Durham County

2016 Annual Report

I. Introduction

a. Background

The Child Fatality Task Force, within the Department of Health and Human Services, was created in 1991 through General Statute 7-B-Article-14 of the North Carolina Juvenile Code. Local Community Child Protection Teams (CCPTs) were established in each county to identify deficiencies in the community child protection system and review all cases in which a child died as a result of suspected abuse and neglect. In 1993 the legislature added local Child Fatality Prevention Teams (CFPTs) to review all child deaths in each county that were not already under review by the local CCPT. Because the purposes of each team are so similar, the teams were given the option of joining together or operating independently.

The Durham County teams operated jointly for a number of years, with meetings including information relating to both CCPT and CFPT purposes. However, in 2015 it was noted that the statutory requirements for CCPT meetings were no longer being met and had not been for several years. The group meetings were related to the CFPT only, and the current team did not function as a CCPT or receive cases related to child abuse and neglect. In September 2015, the Durham CCPT began meeting separately from the CFPT with Christy Malott serving as chairperson. The team meets the fourth Thursday of every other month at the Durham County Health and Human Services Building. The CFPT meets on the fourth Thursday of alternating months.

Under §7B-1406, CCPTs review selected active cases in which children are being served by child protective services, and cases in which a child died as a result of suspected abuse or neglect. They are required to then submit recommendations annually to the board of county commissioners, advocating for system improvements and needed resources, and identifying gaps and deficiencies. Per §7B-1413, the team shall have access to all necessary records maintained by the state, county, and local agencies to carry out the aforementioned purposes, including medical records, hospital records, police investigations data, medical examiner investigative data, health records, mental health records, and social services records. In an official meeting, any member of the team may share any information that is needed for the team to carry out its duties. However, the team is not permitted to contact, question, or interview the child whose record is being reviewed, or any other family member.

The CCPT operates under strict confidentiality requirements and thus meetings are not subject to the Open Meetings Law. §7B-1408 – 1411 outline specific duties of those assisting the local teams, including the Team Coordinator, the director of the county department of social services, and the director of the local department of health. DSS is expected to develop and offer, on an ongoing basis, training materials for local teams that address their role and function, confidentiality requirements, child protective services law and policy, and team record keeping.

b. Relevant Statistical Information

- 62,274 child abuse and neglect hearings in NC from 2014-2015[1]
- 16,698 abused and neglected children received legal representation in NC from 2014- 2015[2]
- 235 juvenile appellate cases filed in NC from 2014-2015[3]
- 1,900 children in need of volunteer advocate services in NC in the fiscal year 2014-2015[4]
- 25 children in NC died as a result of abuse or neglect in the fiscal year 2013-14 [5]

c. Composition of the local CCPT (§7B-1407)

- DSS director, DSS staff member, and DSS board member
- Law enforcement officer
- Attorney from district attorney's office
- Executive director of the local community action agency (as defined by DHHS) or designee
- School superintendent or designee
- Mental health professional
- Guardian ad-litem coordinator or designee
- Department of Health director
- Health care provider
- Community appointees

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[1] Guardian Ad Litem Program Facts, NC Administrative Office of the courts statewide program data, 2014–15, available at http://www.nccourts.org/Citizens/JData/Documents/Guardian_ad_Litem_Facts.pdf

[2] Id.

[3] Id.

[4] Id.

[5] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2016). Child Maltreatment 2014: Reports from the States to the National Child Abuse and Neglect Data System: Table 4-1: Child Fatalities by Submission Type, 2014. Retrieved November 8, 2016 from http://www.acf.hhs.gov/sites/default/files/cb/cm2014.pdf#page=65.

d. 2015-2016 Durham CCPT Members

CCPT/CFPT Members			
Name	**Position**	**Membership**	**Appointed by:**
Ameshia A Cooper	Attorney from DA's office	CCPT/CFPT	Statute/District Attorney
Ann Granby	CCPT Review Coordinator	CCPT/CFPT	Statute/DSS Director
Beth Herold	Local Health Care Provider	CCPT/CFPT	Statute/BOH
Cheryl Scott	CFPT Review Coordinator	CCPT/CFPT	Ex-Officio
Christy Hamilton Malott	At Large-Chair CCPT	CCPT/CFPT	Statute/BOCC
Gayle Harris	Director Local Health Department	CCPT/CFPT	Statute
James Hill	District Court Judge	CCPT/CFPT	Chief District Court Judge
Jane Volland	Member DSS Board	CCPT/CFPT	Statute/DSS Board
Jovetta Whitfield	DSS Staff Member	CCPT/CFPT	Statute/DSS Director
Judy Mack	At Large	CCPT/CFPT	Statute/BOCC
Michael Becketts	DSS Director	CCPT/CFPT	Statute
Michael Page	County Commissioner	CCPT/CFPT	BOCC
Milicia Tedder	At Large	CCPT/CFPT	Statute/BOCC
James F. Key II	Durham Public Schools Designee	CCPT/CFPT	Statute/Superintendent
Rick Pendergrass	Local Law Enforcement	CCPT/CFPT	Statute/BOCC
Shirley Harley-Smith	Local GAL Coordinator	CCPT/CFPT	Statute
Zakilya Taylor-Thompson	Local Mental Health Professional	CCPT/CFPT	Statute/Director LME
Position not filled	Local Community Action Agency	CCPT/CFPT	Exec director or designee

II. Actions

- The CCPT met five times in 2016 (January 28, March 24, May 26, July 23, and October 27)
- During these meetings, the team discussed various cases that the Durham Department of Social Services presented. For each case the team reviewed, they analyzed the involvement of DSS with families receiving services in child welfare to identify strengths and needs of the community, including systemic barriers that may delay and/or affect care and services recommended for families.
- The team received one training in June – The Racial Equity Training by the Public Health Department

III. Findings

a. Systemic Strengths related to Child Abuse and Neglect Prevention:

i. Strong community network and collaboration
ii. Broad network of mental health and family-strengthening resources, including but not limited to the Exchange Club, the Center for Child & Family Health, El Futuro, Carolina Outreach, etc.
iii. Access to major university hospitals is a great asset in dealing with cases involving

medical conditions, and identifying medical neglect

iv. Interstate collaboration between neighboring Departments of Social Services
v. Local agency crosses program lines to meet the needs of families that have been assessed globally by the agency, such as families receiving services from both the Adult Protective Services Unit and the Child Protective Services Unit
vi. Access to several law schools, which provide both direct client services and relevant research through clinics that address pertinent social justice issues
vii. Close follow-up and proactive planning by DSS to protect the health and wellbeing of newborns who are otherwise at high risk for neglect
viii. Durham County Detention Facility employs two teachers onsite to assist youth in juvenile detention to continue their education
ix. Overall, the community in Durham is passionate and dedicated when it comes to helping children and working to keep them safe

b. Systemic Problems related to Child Abuse and Neglect Prevention:

i. Limited ability to deal with children and youth who have aggression issues
    1. Very few mental health providers will accept physically aggressive clients
    2. Disagreements between providers and agencies regarding the core causes of aggression (i.e. mental health or behavior) – at times, this results in insufficient documentation available to support a mental health diagnosis
ii. Lack of preventive resources:
    1. A resource void has been identified for childcare coordination services for pre-school-aged children (to ensure their social, mental, and physical needs are properly addressed)
    2. Insufficient support services in place to assist autistic children and their families
    3. Underfunded public schools: lack of sufficient mental health and social workers in schools, lack of sufficient autistic services in schools, faculty and staff working to do more with less resources
    4. Truancy an on-going issue that is not adequately addressed in the earliest years of a child's education and leads to poor educational performance and higher likelihood of school dropout
iii. North Carolina State Law Issues:
    1. North Carolina state laws only require children to attend school between the ages of 7 and 16 years
    2. Youth 16 years of age and older (13 and older for certain felonies) are treated as adults in the criminal justice system despite their lack of adult-like brain development
    3. Lack of affordable health insurance for parents who are at or above 45% of the federal poverty rate, reducing their ability to access mental health treatment and medical care, thereby increasing risk factors for the

potential abuse and neglect of children

iv. Recommendations:
    a. Encourage a change in state laws that allow 16 year olds to be charged as adults and encourage corresponding increases funding to support the court system and DJJDP to address the increased cases in juvenile court
    b. Increase funding to allow for more social workers or counselors in each school to assist with truancy issues and other issues that cause students to miss school (such as homelessness, lack of transportation, etc.)
    c. Encourage the state to accept federal Medicaid expansion or find another way to address the number of poor people (particularly parents) who have inadequate access to health care and mental health care
    d. Provide technical support for the use social media and the internet to target Durham's youth and their parents:
        i. to channel community volunteers (especially retirees) into supporting school aged-children through reading programs and other educational programs
        ii. to publicize the strengths of Durham Public Schools to the community as a whole
        iii. to emphasize community messages to school aged-children
    e. Provide adequate funding and broaden early education/HeadStart programs
        i. By making it possible for more children to go to school earlier, those children are given an advantage in the classroom, thereby increasing their likelihood of academic success. Additionally, their parents are able to go to work without having to pay for expensive childcare.
v. Conclusion
    a. The CCPT appreciates the opportunity to meet regularly to review and discuss the issues surrounding child abuse and neglect prevention. Durham County has much to offer children, and the CCPT looks forward to on-going advocacy in the year ahead.

Durham County Child Welfare Data

Periods Covered: FY17 & FY18 thru February 2018

Total Number of CPS reports
FY17: 3,091
FY18: 2,053

Total Number # of CPS hotline calls
FY l7: 4,557
FY18: 2,627

Number of Reports Investigated
FYl7: 1,566
FY18: 967

Number or Investigative Assessments (Abuse cases)
FY17: 346
FY18: 181

Number of Family Assessments (Neglect)
FY17: 1,294
FY18:786

Number of children in foster care
FY17: 286
FY18: 283

Number of children who left foster care
FY17: 91
FY18: 47

****Reasons for reports or enter into foster care vary ****
(See NC Child Welfare Profile - Durham County FY l6/17).

March 22, 2018

North Carolina Child Welfare Profile - Durham County

Assessments for Child Maltreatment

Assessments SFY 16-17	
Total Child Assessments:	2,896
Unique children Assessed:	2,605
Avg. Days to Complete:	71
Annual Rate of Assessments (SFY 2016):	40.12
Annual Rate of Victimization (SFY 2016)	5.54
Estimated Population 2016 Ages 0-17 [1]	70560

Sex	*Children*	*%*
Female	1,307	50.17%
Male	1,298	49.83%
Total	2,605	100.00%

Race	*Children*	*%*
American Indian	2	0.08%
Asian or Pacific Islander	9	0.35%
Biracial/Multiracial	13	0.50%
Black	1,758	67.49%
Hispanic/Latino	420	16.12%
Other/Unable to Determine	73	2.80%
White	330	12.67%
Total	2,605	100.00%

Foster Care

Open Cases on 6/30/17	
Children in care on 6/30/17:	286
Average Days in Care:	565

Reason for Entering Care [2]	*Number*	*%*
Abandonment	15	5.24%
Physical Abuse	34	11.89%
Sexual Abuse	11	3.85%
Alcohol (Child)	1	0.35%
Alcohol (Parent)	15	5.24%
Child's Behavior	16	5.59%
Child's Disability	0	0.00%
Coping	22	7.69%
Death of Parent	3	1.05%
Domestic Violence	4	1.40%
Drug Use (Child)	2	0.70%
Drug Use (Parent)	50	17.48%
Inadequate Housing	8	2.80%
Incarceration	3	1.05%
Neglect	266	93.01%
Relinquishment	4	1.40%

Race	*Children*	*%*
Bi-Racial	13	4.55%
Black	195	68.18%
Hispanic/Latino	30	10.49%
Unable to Determine	1	0.35%
White	47	16.43%
Total	286	100.00%

Select Performance Measures SFY 16-17	
Children in Care SFY 16-17:	374
Discharged to Permanency in 12 months	9.77%
Re-entered within 12 months of Discharge	36.36%
Median Days to TPR Order Finalization [3]	1,040

Exits from Foster Care SFY 16-17		
Exit Type	*Children*	*%*
Adoption	40	40.00%
Other	7	7.00%
Relative (non-Guardian)	9	9.00%
Emancipation	15	15.00%
Guardianship with a Relative	7	7.00%
Guardianship with non-relative	1	1.00%
Reunification	21	21.00%
Total	100	100.00%

Exits by Race	*Children*	*%*
Biracial/Multiracial	1	1.00%
Black	65	65.00%
Hispanic/Latino	12	12.00%
Other/Unable to Determine	10	10.00%
White	12	12.00%
Total	100	100.00%

1 Population Estimates are from the NC Office of State Management Budgets (OSMB)
2 Children can have multiple reasons for entering care
3 Based on the 2016 Quarter 4 Reap Report in Management Assistance

North Carolina Child Welfare Profile - State of North Carolina

Assessments for Child Maltreatment

Assessments SFY 16-17	
Total Child Assessments:	146,394
Unique children Assessed:	125,751
Avg. Days to Complete:	50
Annual Rate of Assessments (SFY 2016):	54.36
Annual Rate of Victimization (SFY 2016)	10.24
Estimated Population 2016 Ages 0-17 [1]	2,313,403

Sex	*Children*	*%*
Female	62,019	49.32%
Male	63,732	50.68%
Total	125,751	100.00%

Race	*Children*	*%*
American Indian	1,871	1.49%
Asian or Pacific Islander	791	0.63%
Biracial/Multiracial	6,330	5.03%
Black	44,051	35.03%
Hispanic/Latino	14,339	11.40%
Other/Unable to Determine	2,367	1.88%
White	56,002	44.53%
Total	125,751	100.00%

Foster Care

Open Cases on 6/30/17	
Children in care on 6/30/17:	11,208
Average Days in Care:	572

Reason for Entering Care [2]	*Number*	*%*
Abandonment	526	4.69%
Physical Abuse	985	8.79%
Sexual Abuse	405	3.61%
Alcohol (Child)	47	0.42%
Alcohol (Parent)	861	7.68%
Child's Behavior	845	7.54%
Child's Disability	125	1.21%
Coping	2,539	22.65%
Death of Parent	186	1.66%
Domestic Violence	1,806	16.11%
Drug Use (Child)	181	1.61%
Drug Use (Parent)	4,002	35.71%
Inadequate Housing	1665	14.86%
Incarceration	693	6.18%
Neglect	9,307	83.04%
Relinquishment	54	0.48%

Race	*Children*	*%*
American Indian	230	2.05%
Asian or Pacific Islander	51	0.46%
Biracial	689	6.15%
Black	3,478	31.03%
Hispanic/Latino	870	7.76%
Other/Unable to Determine	195	1.74%
White	5,695	50.81%
Total	11,208	100.00%

Select Performance Measures SFY 16-17	
Children in Care SFY 16-17:	16,581
Discharged to Permanency in 12 months	31.54%
Re-entered within 12 months of Discharge	3.05%
Median Days to TPR Order Finalization [3]	644

Exits from Foster Care SFY 16-17		
Exit Type	*Children*	*%*
Adoption	1,411	24.74%
Other	401	7.03%
Relative (non-Guardian)	655	11.48%
Death of Child	7	0.12%
Emancipation	604	10.59%
Guardianship with a Relative	828	14.52%
Guardianship with non-relative	181	3.17%
Reunification with Parents or Primary Caretakers	1,617	28.35%
Total	5,704	100.00%

Exits by Race	*Children*	*%*
American Indian	185	3.24%
Asian or Pacific Islander	37	0.65%
Biracial/Multiracial	343	6.01%
Black	1,664	29.17%
Hispanic/Latino	496	8.70%
Other/Unable to Determine	113	1.98%
White	2,866	50.25%
Total	5,704	100.00%

1 Population Estimates are from the NC Office of State Management Budgets (OSMB)
2 Children can have multiple reasons for entering care
3 Based on the 2016 Quarter 4 Reap Report in Management Assistance

Section Two

Child Fatality Prevention Team

(CFPT)

2017

Annual Report

SEEKING TO RECOGNIZE SYSTEMS' BARRIERS AND MAKING RECOMMENDATIONS TO PROTECT OUR COMMUNITY'S CHILDREN FROM PREVENTABLE DEATHS

Child Fatality Prevention Team

Introduction

The Local Child Fatality Prevention Teams (CFPTs) were established as a statewide multi-disciplinary, multiagency child fatality prevention system consisting of the North Carolina Child Fatality Prevention Team, North Carolina Child Fatality Task Force and the Local Teams, (CFPTs and CCPTs). The purpose of the system is to assess the records of selected cases of children being served by child protective services and the records of all deaths of children in North Carolina from birth to age 17 in order to (i) develop a communitywide approach to the problem of child abuse and neglect, (ii) understand the causes of childhood deaths, (iii) identify any gaps or deficiencies that may exist in the delivery of services to children and their families by public agencies that are designed to prevent future child abuse, neglect, or death, and (iv) make and implement recommendations for changes to laws, rules, and policies that will support the safe and healthy development of our children and prevent future child abuse, neglect, and death.

Local Child Fatality Prevention Teams (CFPTs) were established in 1993 to review all "additional" child fatalities and make recommendations to state policy makers. The purpose of these reviews is to improve local and statewide systems to better protect children. CFPT recommendations are reported to the county commissioners and local boards of health. CFPT recommendations are shared with the North Carolina Child Fatality Prevention Team, which incorporates local information into recommendations made to the North Carolina Child Fatality Task Force.

In most counties, the local CFPT and local CCPT have merged. Based on the state statute, the first 10 members on both teams represent the same discipline such as law enforcement, mental health professional, and community action agency. The same appointed individual represents the same discipline on both Teams. A few counties still maintain separate teams.

The Purpose and Goals of the Durham County Child Fatality Prevention Team

The CFPT reviews medical examiner reports, death transcripts, police reports, and other records for deceased county residents under age 18 whose fatalities are not due to abuse and neglect. Members discuss outcomes of services and circumstances surrounding the child's death and make recommendations as needed.

The purpose of the CFPTs is to:

- Identify deficiencies in the delivery of services to children and families by public agencies;
- Make and carry out recommendations for changes that will prevent future child deaths; and
- Promote understanding of the causes of child deaths.

The CFPT reviews findings to determine trends, target prevention strategies, identify family and community needs, and support community agencies in their services to children and families. The team recommendations

are forwarded, via the State CFPT Team Coordinator, to the State Team in order to make recommendations to the Task Force.

The goals of the CFPT are to:

1. Involve diverse agencies and disciplines: orient, inform, and involve professionals who serve children.
2. Collect data: collect uniform, retrievable data on all child deaths.
3. Share results: link child death patterns and trends with agencies and groups that can create and support strategies to prevent child deaths and identify system problems and make recommendations.
4. Act to prevent child deaths: develop and initiate local action to prevent child deaths.
5. Reduce the number and rate of child deaths.

Team Membership

Each CFPT shall consist of representatives of public and nonpublic agencies in the community that provide services to children and their families and other individuals who represent the community. No single team shall encompass a geographic or governmental area larger than one county. They shall meet at least four times each year on a quarterly basis and elect a member to serve as chair at the Team's pleasure.

Each team member shall serve a term of at least one year. There is no limit on the number of terms a member may serve. Notification of appointments by agencies or individuals named in G.S. 7B-1407(b) shall be made in writing to the chairperson, health director, or support staff. Vacancies on a Local Team shall be filled by the original appointing authority.

Each Local Team shall consist of the following persons:

1. The director of the county department of social services.
2. A member of the director's staff.
3. A local law enforcement officer, appointed by the board of county commissioners.
4. An attorney from the district attorney's office, appointed by the district attorney.
5. The executive director of the local community action agency, as defined by the Department of Health and Human Services, or the executive director's designee.
6. The superintendent of each local school administrative unit located in the county, or the superintendent's designee.
7. A member of the county board of social services, appointed by the chair of that board.
8. A local mental health professional, appointed by the director of the area authority.
9. The local guardian ad litem coordinator or the coordinator's designee.
10. The director of the local department of public health.

11. A local health care provider, appointed by the local board of health.

12. An emergency medical services provider or firefighter, appointed by the board of county commissioners.

13. A district court judge, appointed by the chief district court judge in that district.

14. A county medical examiner, appointed by the Chief Medical Examiner.

15. A representative of a local child care facility or Head Start program, appointed by the director of the county department of social services.

16. A parent of a child who died before reaching the child's eighteenth birthday, to be appointed by the board of county commissioners.

The board of county commissioners may appoint a maximum of five additional members to represent county agencies or the community at large to serve on the local CFPT. The Team Coordinator shall serve as an ex officio member of each Local Team that reviews the records of additional child fatalities.

2017 Child Fatality Prevention Team Roster

CCPT/CFPT Members			
Name	**Position**	**Membership**	**Appointed by:**
Ameshia A Cooper	Attorney from DA's office	CCPT/CFPT	Statute/District Attorney
Ann Granby	CCPT Review Coordinator	CCPT/CFPT	Statute/DSS Director
Beth Herold	Local Health Care Provider	CCPT/CFPT	Statute/BOH
Cheryl Scott	CFPT Review Coordinator	CCPT/CFPT	Ex-Officio
Christy Hamilton Malott	At Large-Chair CCPT	CCPT/CFPT	Statute/BOCC
Dr. Kimberly Janssen	County Medical Examiner	CCPT/CFPT	Chief Medical Examiner
Gayle Harris	Director Local Health Department	CCPT/CFPT	Statute
James Hill	District Court Judge	CCPT/CFPT	Chief District Court Judge
Jane Volland	Member DSS Board	CCPT/CFPT	Statute/DSS Board
Jovetta Whitfield	DSS Designee	CCPT/CFPT	Statute/DSS Director
Judy Mack	At Large	CCPT/CFPT	Statute/BOCC
Leigh Zaleon	Child Care Facility/Head Start	CCPT/CFPT	DSS Director
Michael Becketts	DSS Director	CCPT/CFPT	Statute
Michael Page	County Commissioner	CCPT/CFPT	BOCC
Milicia Tedder	At Large	CCPT/CFPT	Statute/BOCC
James F. Key II	Durham Public Schools Designee	CCPT/CFPT	Statute/Superintendent
Rick Pendergrass	Local Law Enforcement	CCPT/CFPT	Statute/BOCC
Shirley Harley-Smith	Local GAL Coordinator	CCPT/CFPT	Statute
Zakilya Taylor-Thompson	Local Mental Health Professional	CCPT/CFPT	Statute/Director LME
Position not filled	Parent Death of Child <18 years old	CCPT/CFPT	BOCC
Position not filled	Local Community Action Agency	CCPT/CFPT	Exec director or designee

Public Meetings

CFPT meetings are closed to the public. However, each local CFPT will schedule at least two public meetings annually, one presentation to the County Commissioners and one presentation to the board of health, according to state statute (G.S. 7B-1408.1.2 and G.S. 7B-1410.4) (Appendix 3, § 7B-1408, § 7B-1410). Additionally, the CFPT may hold periodic public meetings to discuss, in a general manner not revealing confidential information, the review findings and recommendations for preventive actions. Outcomes of individual case reviews are not to be disclosed to the public.

The following shall be included in public meeting agenda items: information about the local CFPT (including purposes, composition, confidentiality guidelines, access to records, statutory basis, frequency of meetings), information about child deaths in the county/state (number, causes, ages), number of deaths reviewed by the CFPT, system problems identified, recommendations, and action taken. No identifying information about individual child deaths may be addressed, including names, addresses, dates, or circumstances.

Child Fatalities and Racial/Ethnic Disparities

Glenn Flores, MD, Michelle Escala, MD and Brian Hall, MD co-authored the manuscript, Dead Wrong: The Growing List of Racial/Ethnic Disparities in Childhood Mortality[3]. Highlights from this manuscript are summarized as follows:

Over a 40 plus year period, racial/ethnic disparities in childhood mortality have persisted. When compared to white children African-American children have demonstrated the following:

- Twice the mortality rate for African-American children ages 1-4,
- An increase in the mortality disparity ratio,
- Are seven times more likely than white children to die from asthma (this disparity increased 40% from 2001 to 2010)
- Although the overall infant mortality rate in the US continues to fall, African-Americans continue to have the highest infant mortality rate, at double that of whites, and the disparity ratio has not changed over time,
- African-American children and young adults are significantly more likely than white children to die by drowning, including approximately six times the childhood death rate for drowning in swimming pools,
- African-American children are more than four times likely to die after a liver transplant,
- Have about twice the hazards of dying of acute lymphoblastic leukemia,
- Among those with Down Syndrome, African-Americans have twice the adjusted hazards of death across almost all age groups (including significant higher mortality in infants 2–12 months old), and
- A substantially lower median age at death (25 years old vs. 50 in whites).

The authors note the following with respect to Latino children in caparison with white children:

- Latino children are significantly more likely overall than white children to die from cancer,
- Are significantly more likely than white children to die from drowning in neighborhood pools,
- Puerto Rican children have four times the risks of dying from hazards as white children (and the highest mortality rate of any racial/ethnic group or subgroup, and
- Among children ages, 1 to 4, Central and South Americans, and Puerto Ricans have overall crude death rates that are significantly higher.

The mortality disparities for American Indian/Alaska Native (AIAN) and Asian/Pacific Islander (API) children have not been as widely studied though the documented disparities are just as notable.

- In specific age groups, AIAN children are two to three times more likely to die than white children,
- AIAN newborns and infants are significantly more likely than their white counterparts to die from congenital malformations, SIDS, and sepsis,
- AIAN children ages 1 -19 years have a notably higher relative risk of death from unintentional injuries, homicide, influenza, and pneumonia,
- AIAN children have twice the adjusted hazards of white children of dying from neuroblastoma,
- Hawaiian children have a significantly higher risk of death overall than white children and
- Asian children (but not Pacific Islander children) have significantly higher hazards of dying than white children.

The causes for these disturbing disparities are not obvious which brings additional attention to the need for ongoing research to identify and study root causes. Several areas that that merit investigation include the following:

- For some conditions, genetic differences may be the underlying causes of racial/ethnic mortality disparities. Improving patient-specific therapies may present opportunities to eliminate disparities in these diagnoses
- Delays in diagnosis and treatment can result in untreated conditions, less effective treatment in the early stages of illness and disease presentation and progression at higher-risk disease stages.
- Research has shown that children who are in need of specialty care and receive that care from specialists have significantly fewer emergency-department visits and hospitalizations, and are more likely to receive the level of care consistent with national practice guidelines, compared with children who need but do not receive specialty care.
- Culturally competent care has been shown to improve the quality of care for minority children though it is not clearly evident or consistently documented that minority children receive culturally competent care.
- Both conscious and unconscious bias occur in healthcare systems and the decision-making processes of some clinicians, which impacts care delivery.

Research into these areas may reveal interventions to potentially reduce or eliminate many of these disparities.

These facts provide ideas from which to develop a baseline from which the CFPT may assess systemic concerns, make recommendation and advocate for the community's children utilizing an evidence-based perspective.

Tables

Figures

*Rates and percentages based on counts less than 20 are unstable and should be interpreted with caution
**Social determinants contribute to racial disparities. Please review the racial disparity section of this document prior to interpreting data.
†Rates for other races based on counts less than 5 are suppressed to maintain confidentiality.

Healthy People 2020 Targets

Indicator	Target	United States	North Carolina	Durham County
Infant Deaths (Rate per 1,000 Live Births)				
Infant mortality rate	6.0[4]	5.9[3]	7.1[3]	7.0[3]
Neonatal mortality rate	4.1[4]	4.0[3]	4.9[3]	4.5[3]
Postneonatal mortality rate	2.0[4]	1.9[3]	2.2[3]	2.5[3]
SUID rate	0.84[4]	0.9[3]	1.1[3]	.93[3]*
Child Deaths (Rate per 100,000 Population)				
Child mortality rate, ages 1-4	26.5[4]	24.8[3]	28.8[3]	24.3[3]*
Child mortality rate, ages 5-9	12.4[4]	11.7[3]	12.3[3]	20.0[3]*
Adolescent Deaths (Rate per 100,000 Population)				
Adolescent mortality rate, ages 10-14	14.8[4]	14.2[3]	15.1[3]	18.2[5*]
Injury and Violence Prevention (Percent)				
Percent of deaths due to external causes among children less than 17 years old reviewed by a child fatality team	90.0[4]	Unknown	Unknown	Unknown

Acronyms

	Definition
ASSB	Accidental suffocation and strangulation in bed
CDR	Child Death Review
CMDCA	Congenital malformation, deformation and chromosomal abnormality
GA/LBW	Gestational age and low birth weight
ICD	International Classification of Diseases
NH-(race group)	Non-Hispanic (race group), e.g. NH Black
SIDS	Sudden Infant Death Syndrome
SUID	Sudden Unexpected Infant Death

Definitions

	Definition
Infant death	Deaths to infants under 1 year of age
Fetal death	Stillborn with gestation greater than 20 weeks or birth weight greater than 350 grams
Low birth weight	Less than 2,500 grams at delivery (5.5 lbs.)
Neonatal death	Deaths to infants less than 28 days of age
Perinatal death	Fetal deaths plus deaths to infants under 7 days of age
Postneonatal death	Deaths to infants between 28 and 364 days of age

Causes of Death

Cause of Death	Explanation
Congenital malformations, deformations and chromosomal abnormalities (CMDCA)	This category includes anencephaly and similar malformations, congenital hydrocephalus, spina bifida, other congenital malformations of the nervous system, congenital malformations of the heart, other congenital malformations of the circulatory system, congenital malformations of the genitourinary system, congenital malformations and deformations of musculoskeletal system, limbs and integument, Downs syndrome, Edward syndrome, Patau syndrome, other congenital malformations and deformations and other chromosomal abnormalities not elsewhere classified.[1]
Conditions originating in the perinatal period	This category includes disorders related to the length of gestational age and fetal growth, effects from maternal factors and complications, infections specific to the perinatal period, hemorrhage and hematological disorders and other perinatal conditions.[1]
Diseases of the circulatory system	This category includes rheumatic fever; hypertensive diseases; ischemic heart disease; pulmonary heart disease and diseases of pulmonary circulation; cerebrovascular diseases; diseases of arteries, arterioles and capillaries; and diseases of veins, lymphatic vessels and lymph nodes.[1]
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	This category includes nutritional anemias, hemolytic anemias, aplastic and other anemias and other bone marrow failure syndromes, coagulation defects, purpura and other hemorrhagic conditions, other disorders of blood and blood-forming organs, intraoperative and post procedural complications of the spleen, and certain disorders involving the immune mechanism.[1]
Diseases of the nervous system	This category includes inflammatory diseases of the central nervous system, systemic atrophies primarily affecting the central nervous system, degenerative diseases of the nervous system and cerebral palsy and other paralytic syndromes.[1]
Diseases of the respiratory system	This category includes respiratory infections, influenza, pneumonia, lung diseases due to external agents and diseases of the pleura.[1]
External causes of mortality (injuries)	This category includes deaths from injuries (unintentional and intentional) and causes not related to a medical condition, including motor vehicle accidents, other and unspecified transport accidents, cuts, falls, accidental discharge of firearms, homicide, suicide, drowning and submersion, accidental suffocation and strangulation in bed and other suffocation and strangulation.[1]
Infectious and parasitic diseases	This category includes transmissible diseases, including intestinal infectious diseases, tuberculosis, zoonotic bacterial diseases, spirochetal diseases, rickettsioses and viral diseases.[1]
Neoplasm	This category includes tumors and abnormal growths of body tissue. Neoplasms can be malignant (cancerous) or benign (noncancerous).
Sudden infant death syndrome (SIDS)	This category includes deaths among infants less than one year of age that occur suddenly, unexpectedly and for which the causes of death are not immediately obvious prior to investigation.[1]
Sudden unexpected infant death (SUID)	This category includes ill-defined and unknown causes of mortality, SIDS, and accidental suffocation and strangulation in bed.[1]

Key Findings

Focus on Perinatal Mortality

Infant Mortality

- The majority of infant deaths (70.2%) occur during the first month of life, which is consistent with the leading cause of infant death in Durham County: conditions originating in the perinatal period. Non-Hispanic Black infants were 3.3 times more likely to die compared to non-Hispanic White infants and 4.9 times more likely to die compared to Hispanic infants ($p<.05$) during 2011-2015. There were not disparities by sex in Durham County during 2011-2015.

Neonatal Mortality

- Conditions originating in the perinatal period were the leading cause of death among neonatal infants in Durham County during 2011-2015. Non-Hispanic Black infants in the neonatal stage were 2.9 times more likely to die compared to non-Hispanic Whites and 5.1 times more likely to die compared to Hispanics during 2011-2015 ($p<.05$). Disparities by sex did not exist.

Postneonatal Mortality

- Congenital malformations, deformations, and chromosomal abnormalities (CMDCA) and external causes of mortality (injuries) were the leading causes of post neonatal death in Durham County during 2011-2015. During this time period, there were not disparities by sex. However, non-Hispanic Black infants in the post neonatal stage were 4.9 times more likely to die compared to non-Hispanic Whites and 2.4 times more likely to die compared to Hispanics ($p<.05$).

Facts about Perinatal Mortality

- The United States spends more on maternity care than any other country in the world; despite this investment in care for pregnant women, the United States shares, with other industrialized countries, some of the highest maternal mortality rates and infant mortality rates in the world[11]. Since 2006, while pregnant women substantially increased their use of maternity services, the maternal mortality ratios increased in the United States.[13] Severe maternal morbidity and perinatal morbidity is increasing in the United States and has been estimated to occur in up to approximately one percent of all deliveries. [17]

- Services that are delayed, unnecessary, harmful or inadequate minimize opportunities for improved health gains [13]and health care payers are in agreement with this observation.[10] Obstetrical and neonatal outcomes are associated with hospital quality of care, and patients and payers are placing increasing pressure on health care systems to measure and improve the quality of obstetrical care services. [10]

- One striking reason the United States rates so poorly in perinatal outcomes is due to the persistent disparities in outcomes between white women and minority women.[10] These researchers also note that racial/ethnic minorities experience a disproportionate number of maternal deaths and other adverse obstetric and perinatal outcomes, and bring attention to the fact that maternal mortality is elevated among certain subgroups of Latino women, Native American and Native Alaskan women, Asian women and Pacific Islander women. African-American women are three to four times more likely to die from adverse obstetrical causes than white women, and ten times more likely to die from a pregnancy related complication than white women.[12]

- This representation of the largest disparity among standard population perinatal health measures is directly related to the persistent disparities in outcomes between white women and minority women with respect to adverse perinatal outcomes, and this is one reason the United States ranks among the highest in industrialized countries with poor maternal and perinatal morbidity rates; quality maternal health care improves the health of all pregnant women.[10] These authors note further that research reveals hospital quality is an important factor to improve maternal and prenatal outcomes, obstetrical and neonatal outcomes are associated with hospital quality ratings, increasing attention is being focused on obstetrical and neonatal quality of care and safety, and that almost one-half of maternal mortality and other adverse perinatal events are preventable.

- Hospital quality is one of the few modifiable factors that can be addressed by healthcare systems.[4] Howell, Egorova, Balbierz, Zeitlin and Hebert (2016) assert that the quality of maternity care provided in hospitals is an essential step for improving outcomes, narrowing disparities and preventing a significant proportion of maternal and perinatal deaths.

- Historical and contemporary reductions in perinatal mortality highlight timely, effective, appropriate and affordable care.[18]

- The NC Child, February 2018 edition notes that North Carolina ranks 39th in fetal and infant mortality.

- The NC Child, February 2018 edition notes, the Durham County fetal death rate is slightly higher than the statewide rate, at 7.0 per 100,000 live births. The infant death rate, meanwhile, is slightly lower: 7.1 per 1,000 births, compared to a 7.2 statewide rate. Still, these rates are significantly higher than in several of North Carolina's other urban counties, including Wake, Mecklenburg, Orange, and Buncombe. (Guilford County has the same fetal death rate but a higher infant death rate.)

Recommendations

The team will have representation on, and adopt the recommendations of the Durham County Preconception Task Force for care and resources. The team will also review the NC Perinatal Health Strategic Plan, released on March 24, 2016, and adopt recommendations from this plan to address infant mortality, maternal health, maternal morbidity, and the health of men and women of childbearing age. Recommendations include:

- Increase access to preconception care
- Provide inter-conception care to women with prior adverse pregnancy outcomes
- Improve the quality of prenatal care
- Address racism (Recent research continues to document an inverse association between discrimination and health. [19])

Infant Mortality: Deaths to persons under one year old

Figure 1. Trend in Infant Mortality Rate, 2011-2015[5]

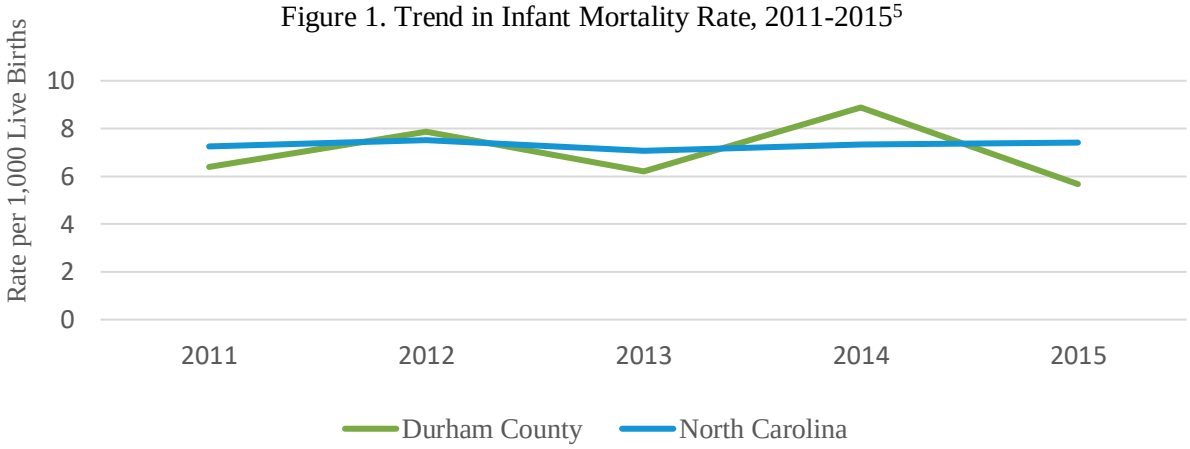


Figure 2. Number of Infant Deaths by Age in Months, Durham County, 2011-2015[5]

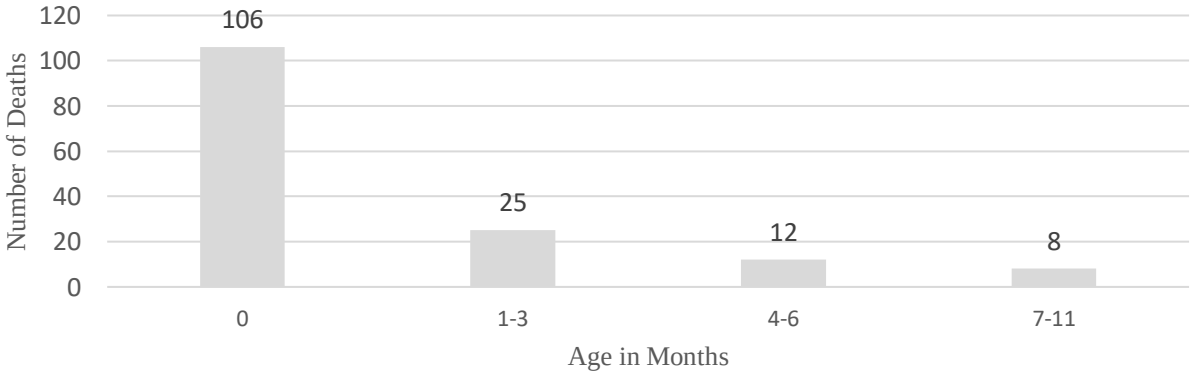
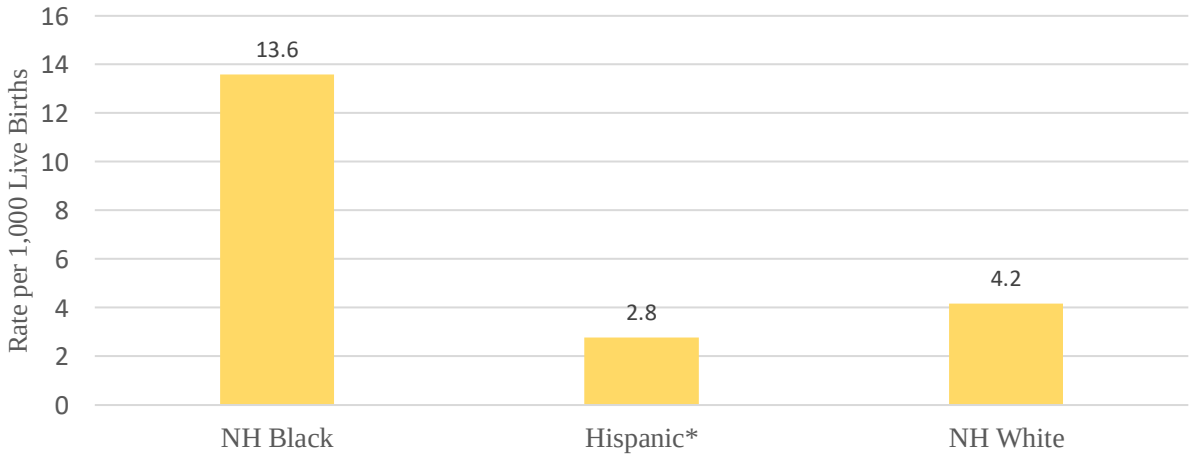


Figure 3. Infant Mortality by Race and Ethnicity, Durham County, 2011-2015[5†]



Infant Mortality

Figure 4. Proportion of Infant Deaths by Cause, Durham County, 2011-2015[5]

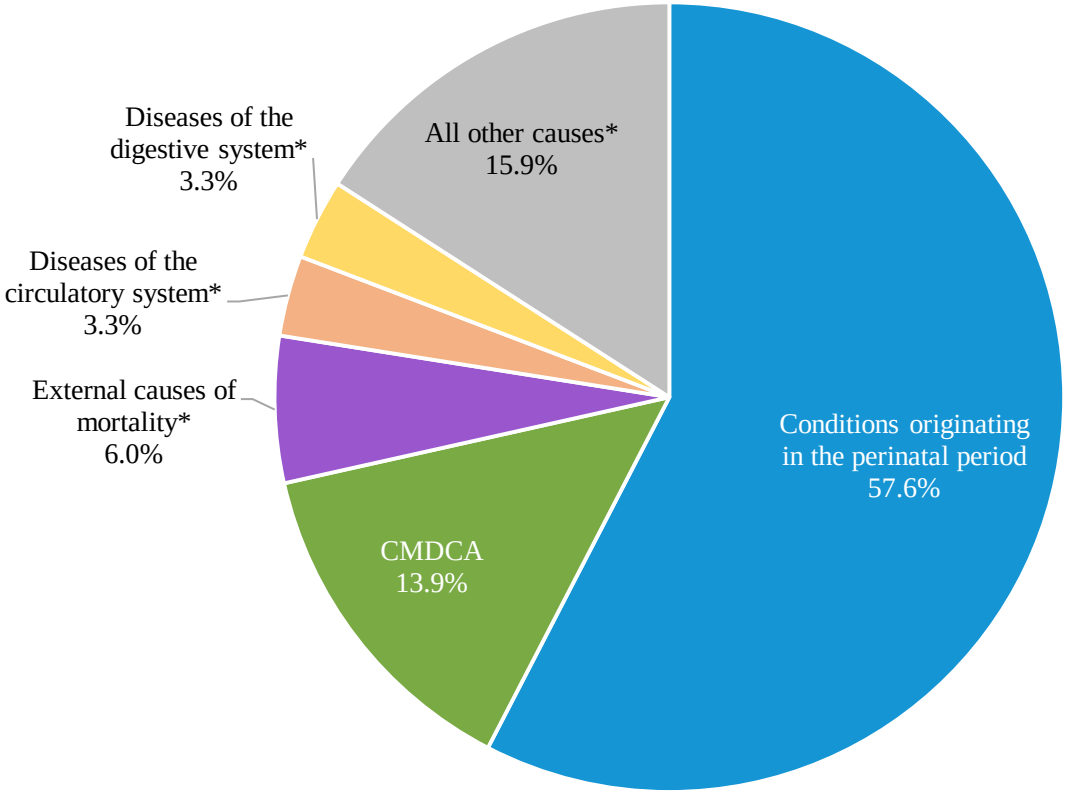


Table 1. Leading Causes of Infant Death, Durham County, 2011-2015[5]

Cause of Death	Count	Rate per 1,000 live births
Conditions originating in the perinatal period	87	4.1
CMDCA	21	1.0
External causes of mortality	9	0.4*
Diseases of the circulatory system	5	0.2*
Diseases of the digestive system	5	0.2*
All causes	151	7.0

Key Findings and Interpretation

The majority of infant deaths (70.2%) occur during the first month of life, which is consistent with the leading cause of infant death in Durham County: conditions originating in the perinatal period.

In Durham County, non-Hispanic Black infants were 3.3 times more likely to die compared to non-Hispanic White infants and 4.9 times more likely to die compared to Hispanic infants ($p<.05$) during 2011-2015. Social determinants of health contribute to the racial disparities seen in infant mortality and are pivotal in interpreting the data.

There were no disparities by sex in Durham County during 2011-2015.

Neonatal Mortality: Deaths to persons under 28 days old

Figure 5. Neonatal Mortality Rate, 2011-2015[5]

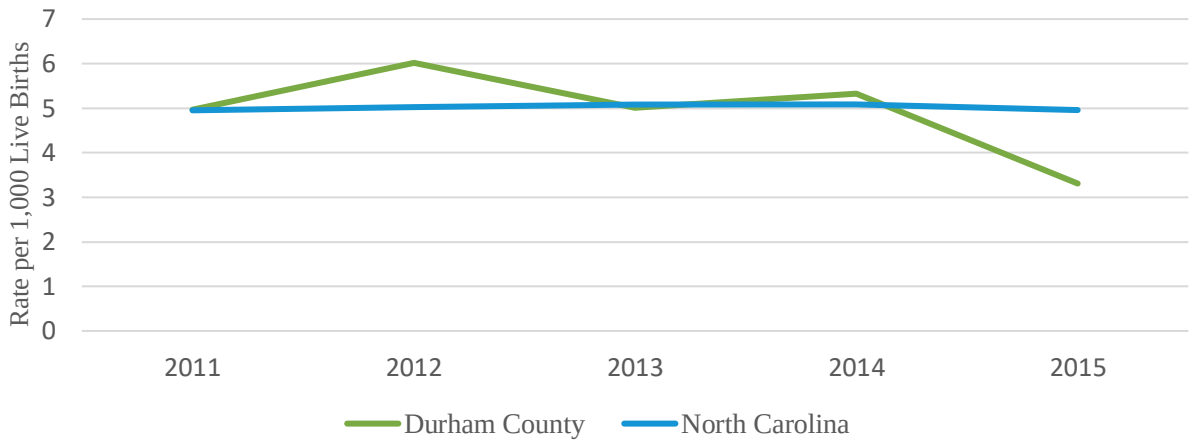
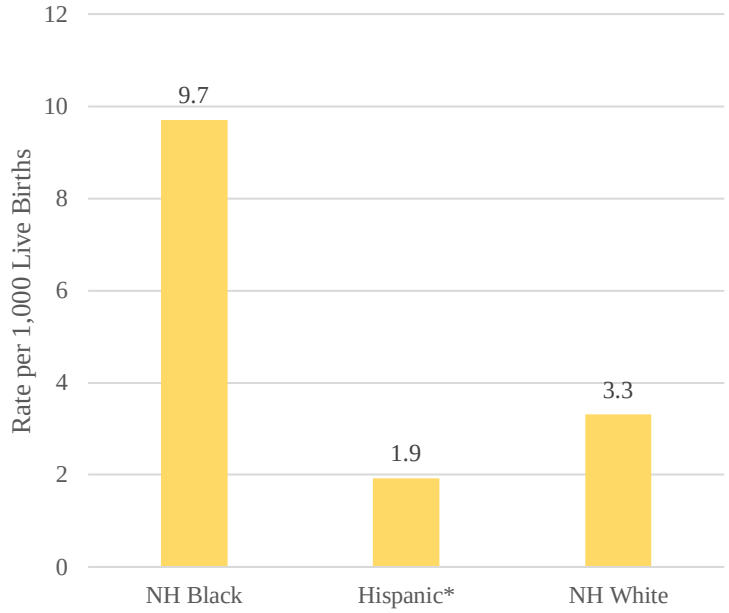


Figure 6 Neonatal Mortality by Race and Ethnicity, Durham County, 2011-2015†



Key Findings and Interpretation

Conditions originating in the perinatal period were the leading cause of death among neonatal infants in Durham County during 2011-2015.

Non-Hispanic Black infants in the neonatal stage were 2.9 times more likely to die compared to non-Hispanic Whites and 5.1 times more likely to die compared to Hispanics during 2011-2015 ($p<.05$). Social determinants of health should be taken into account when interpreting this data. Please see page eight for more information.

Disparities by sex did not exist.

Table 2. Leading Causes of Neonatal Death, Durham County, 2011-2015[5]

Cause of Death	Count	Rate per 1,000 live births
Conditions originating in the perinatal period	84	3.9
CMDCA	14	0.7*
Diseases of the digestive system	2	0.1*
All other causes (6 unique causes)	6	0.3*
All causes	106	4.9

Postneonatal Mortality: Deaths to persons between 28 and 264 days old

Figure 7. Postneonatal Mortality Rate, 2011-2015[5]

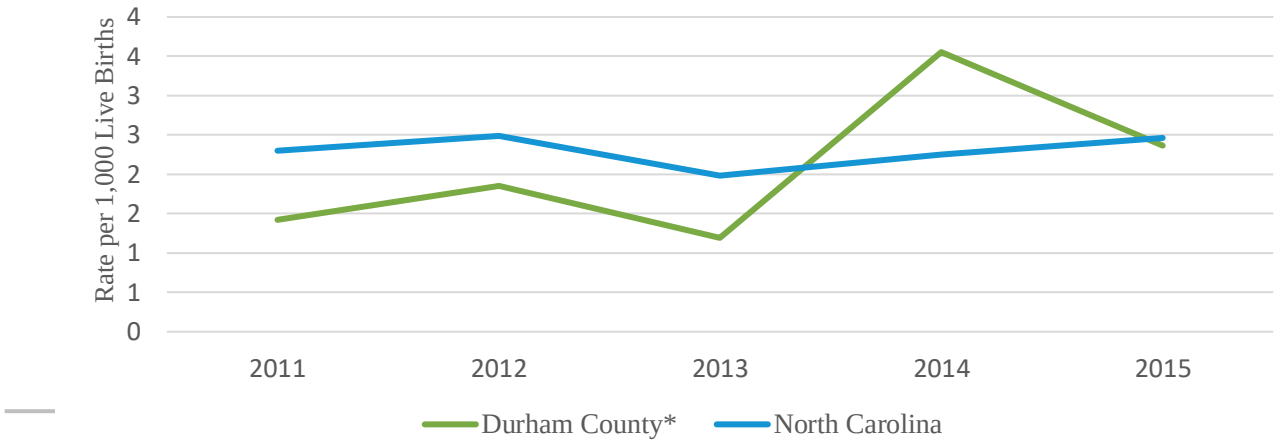


Figure 8. Postneonatal Mortality Rate by Race and Ethnicity, Durham County, 2011-2015[5†]

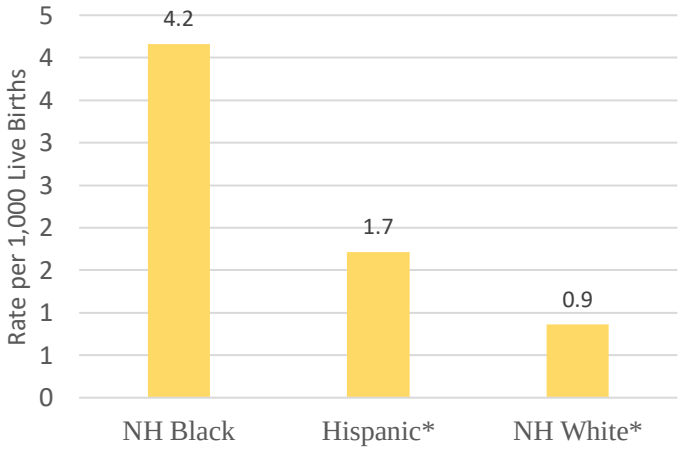


Table 3. Leading Causes of Postneonatal Death, Durham County, 2011-2015[5]

Cause of Death	Count	Rate per 1,000 live births
CMDCA	7	0.3*
External causes of mortality	7	0.3*
Diseases of the circulatory system	5	0.2*
SIDS	4	0.2*
Diseases of the digestive system	3	0.1*
All causes	45	2.1

Key Findings and Interpretation

Congenital malformations, deformations, and chromosomal abnormalities (CMDCA) and external causes of mortality (injuries) were the leading causes of post neonatal death in Durham County during 2011-2015.

During this time period, there were not disparities by sex. However, non-Hispanic Black infants in the post neonatal stage were 4.9 times more likely to die compared to non-Hispanic Whites and 2.4 times more likely to die compared to Hispanics during 2011-2015 ($p<.05$). It is important to take into consideration how racial disparities impact infant and maternal morbidity when interpreting this data.

Sudden Unexpected Infant Death

Sudden Unexpected Infant Death, commonly referred to as SUID, includes deaths to infants less than one year old who die from accidental suffocation and strangulation in bed (ASSB), unknown causes, or Sudden Infant Death Syndrome (SIDS).

According to the CDC, SIDS should only be diagnosed when "the sudden death of an infant less than 1 year of age cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and a review of clinical history."

Figure 9. Proportion of SUID by Sex, Durham County, 2011-2015[5]

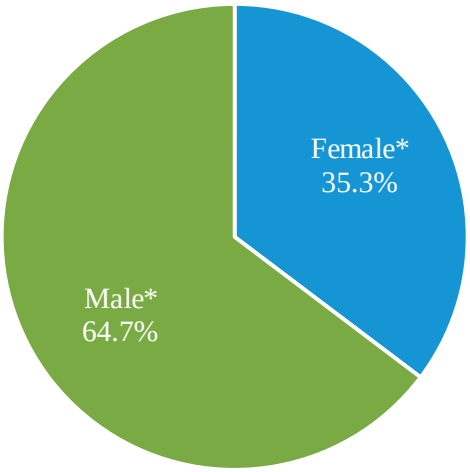


Table 4. SUID by Sex, Durham County, 2011-

Sex	Count	Percent	Rate per 1,000 live births
Female	6	35.3*	0.3*
Male	11	64.7*	0.5*
Total	17	100.0	0.8*

Table 5. SUID by Cause of Death, Durham County, 2011-2015[5]

Cause of Death	Count	Percent	Rate per 1,000 live births
ASSB	3	17.6*	0.1*
SIDS	4	23.5*	0.2*
Unknown	10	58.8*	0.5*
All causes	17	100.0	0.8*

Key Findings and Interpretation

The majority of deaths contributing to SUID were unknown during 2011-2015. Deaths may be classified as unknown when complete information is not available, making it difficult to distinguish accidental strangulation and suffocation in bed from SIDS.

SUIDs could not be disaggregated by race and ethnicity due to the small number of events. Data are suppressed in order to maintain confidentiality

Key Findings

Child Mortality

Child Mortality, Ages 1-4

- During 2011-2015, injuries were the leading cause of death among children ages 1-4 in Durham County. Deaths were evenly distributed among females and males. The difference in mortality rates among non-Hispanic Black and non-Hispanic White children was not statistically significant. Rates for children of other races and ethnicities are suppressed to maintain confidentiality due to small case counts.

Child Mortality, Ages 5-9

- Injuries were the leading cause of death among children ages 5-9 in Durham County. During that time, 61.1% of deaths were to males. The difference in the mortality rate among non-Hispanic Black and non-Hispanic White children was not statistically significant. Rates for other races and ethnicities are suppressed to maintain confidentiality due to small case counts.

Adolescent Mortality, Ages 10-14

- Injuries were the leading cause of death among adolescents ages 10-14 in Durham County during 2011-2015. Fifty three percent of deaths were to males. Rates by race and ethnicity were not included, as the case counts were small and are suppressed to maintain confidentiality.

Adolescent Mortality, Ages 15-17

- During 2011-2015, injuries were the leading cause of death among adolescents ages 15-17 in Durham County, contributing to 70.4% of all deaths. Males were overrepresented when looking at adolescent deaths by sex, with 63.0% of deaths occurring to males. The difference in mortality rate seen among non-Hispanic Black and non-Hispanic White adolescents was not statistically significant. Rates for other races and ethnicities are suppressed to maintain confidentiality due to small case counts.

Child Mortality, Ages 1-17

Key Findings and Interpretation
During 2011-2015 in Durham County, Non-Hispanic Black children and adolescents were 1.6 times more likely to die compared to non-Hispanic White children and adolescents (p<.05) and 2.5 times more likely to die than Hispanic children and adolescents. Social determinants of health should be taken into consideration when interpreting data on racial disparities.

Figure 10. Trend in Mortality among Children Ages 1-17, 2011-2015

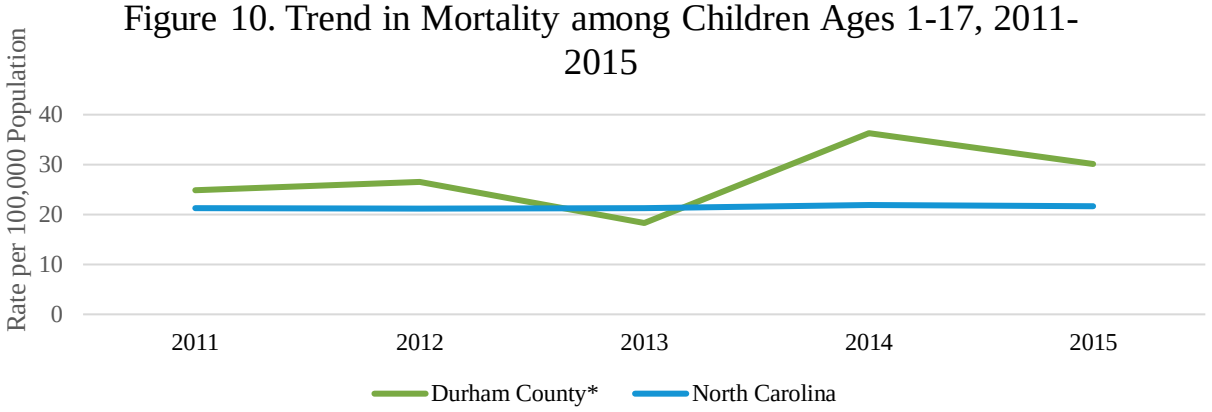


Figure 11. Mortality among Children Ages 1-17 by Sex, Durham County, 2011-2015[5]

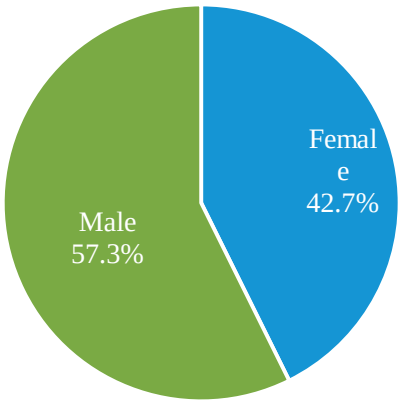


Figure 12. Mortality among Children Ages 1-17 by Race and Ethnicity, 2011-2015[5]

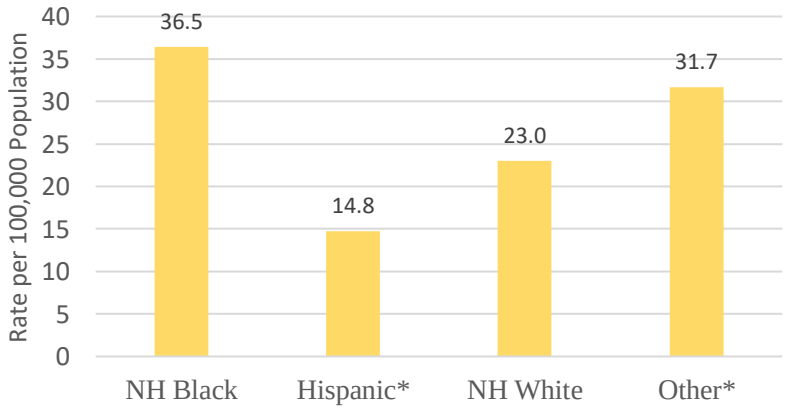
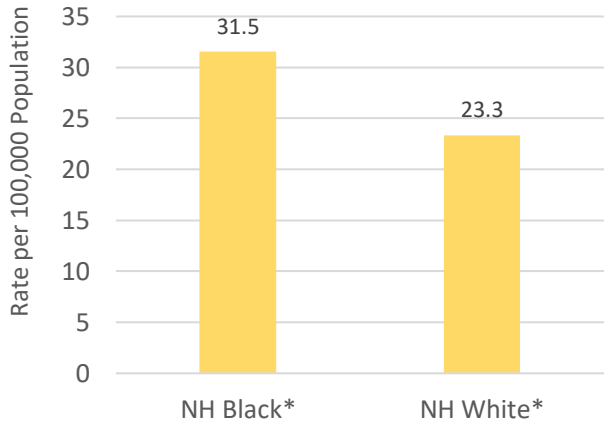


Table 6. Leading Causes of Death among Children Ages 1-17, Durham County, 2011-2015[5]

Cause of Death	Count	Rate per 100,000 population
External causes of mortality (injuries)	40	13.3
Neoplasm	8	2.7*
Diseases of the blood and blood-forming organs	6	2.0*
Diseases of the circulatory system	6	2.0*
CMDCA	6	2.0*
All causes	82	27.2

Child Mortality, Ages 1-4

Figure 13. Mortality among Children Ages 1-4, Durham County, 2011-2015[5†]



Key Findings and Interpretation

During 2011-2015, a total of 22 children aged 1-4 living in Durham County died. A trend line with the mortality rate from 2011 to 2015 is not displayed due to very small and unstable rates during this time period.

Deaths to children ages 1-4 were evenly distributed among females and males (50% female; 50% male) during 2011-2015 in Durham County. The difference in mortality rates among non-Hispanic Black and non-Hispanic White children ages 1-4 was not statistically significant.

Figure 14. Proportion of Child Mortality by Cause, Ages 1-4, Durham County, 2011-2015[5]

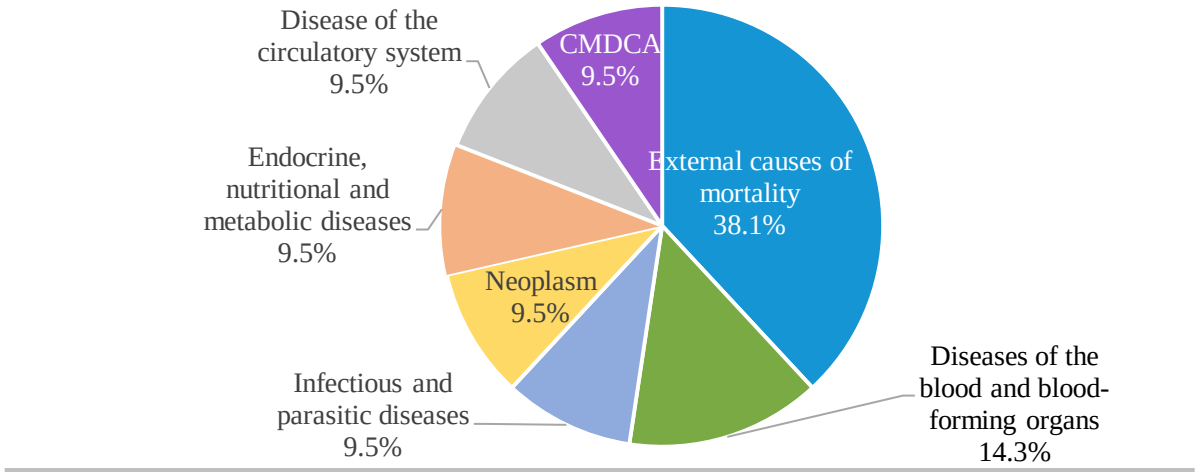


Table 7. Leading Causes of Death among Children Ages 1-4, Durham County, 2011-2015[5]

Cause of Death	Count	Rate per 100,000 population
External causes of mortality (injuries)	8	9.5*
Diseases of the blood and blood-forming organs	3	3.6*
Infectious and parasitic diseases	2	2.4*
Neoplasm	2	2.4*
Endocrine, nutritional and metabolic diseases	2	2.4*
Diseases of the circulatory system	2	2.4*
CMDCA	2	2.4*
All causes	22	26.2

Child Mortality, Ages 5-9

Key Findings and Interpretation

During 2011-2015, 18 children ages 5-9 in Durham County died. Of those deaths, 61.1% were to males. The difference in the mortality rate among non-Hispanic Black and non-Hispanic White children was not statistically significant. Rates for other races are suppressed to maintain confidentiality, due to small case counts.

A trend line showing the number of deaths by year during 2011-2015 is not displayed, as the total number of deaths each year was very small, yielding unstable rates. However, when looking at all deaths that occurred during that time period, injuries were the leading cause of death at a rate of 5.6* per 100,000 population.

Figure 15. Mortality among Children Ages 5-9, Durham County, 2011-20155†

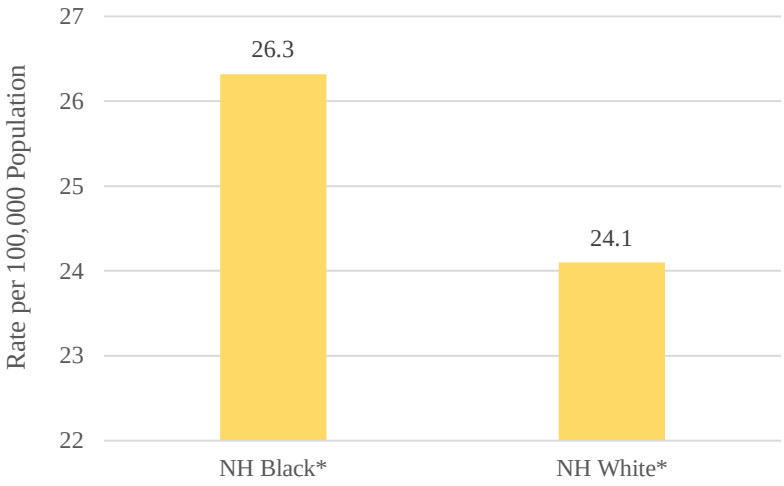


Figure 16. Mortality among Children Ages 5-9 by Sex, Durham County, 2011-2015[5]

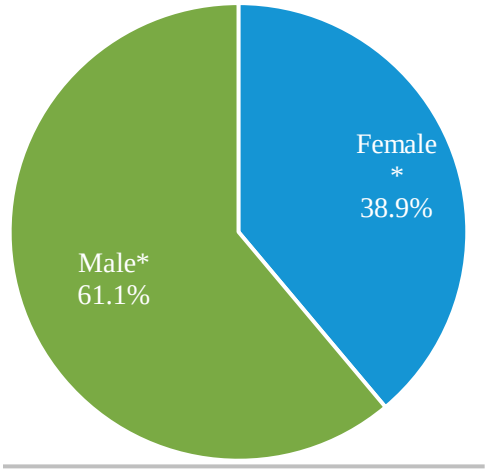
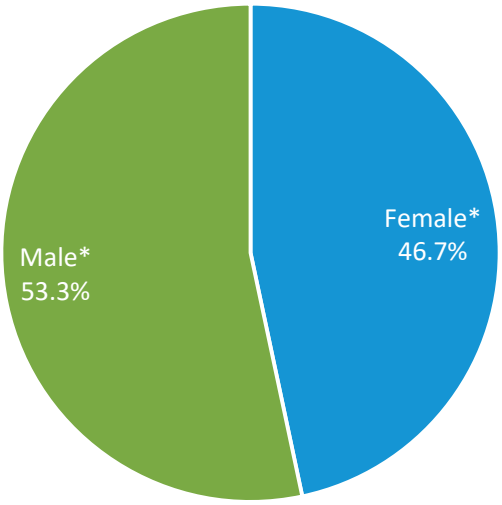


Table 8. Leading Causes of Death among Children Ages 5-9, Durham County, 2011-2015[5]

Cause of Death	Count	Percent	Rate per 100,000 population
External causes of mortality (injuries)	5	27.8*	5.6*
Neoplasm	3	16.7*	3.3*
Diseases of the blood and blood-forming organs	3	16.7*	3.3*
Infectious and parasitic diseases	2	11.1*	2.2*
Diseases of the circulatory system	2	11.1*	2.2*
All causes	18	100.0	20.1*

Adolescent Mortality, Ages 10-14

Figure 17. Mortality among Adolescents Ages 10-14 by Sex, Durham County, 2011-2015[5]



Key Findings and Interpretation

Injuries were the leading cause of death among adolescents ages 10-14 in Durham County during 2011-2015. A mortality trend showing rates by year was not included due to small counts, which make the rates unstable.

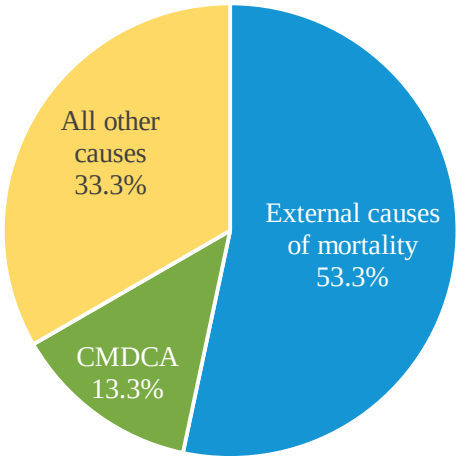
Fifty three percent of deaths were to males.

Rates by race and ethnicity were not included for adolescents ages 10-14 in Durham County, as the case counts were small and are suppressed to maintain confidentiality.

Table 9. Leading Causes of Death among Adolescents Ages 10-14, Durham County, 2011-2015[5]

Cause of Death	Count	Rate per 100,000 population
External causes of mortality (injuries)	8	9.7*
CMDCA	2	2.4*
All other causes (5 individual causes)	5	6.1*
All causes	15	18.2*

Figure 18. Proportion of Adolescent Mortality by Cause, Ages 10-14, Durham County, 2011-2015[5]



Adolescent Mortality, Ages 15-17

Figure 19 Mortality among Adolescents Ages 15-17 by Race and Ethnicity, Durham County, 2011-20155†

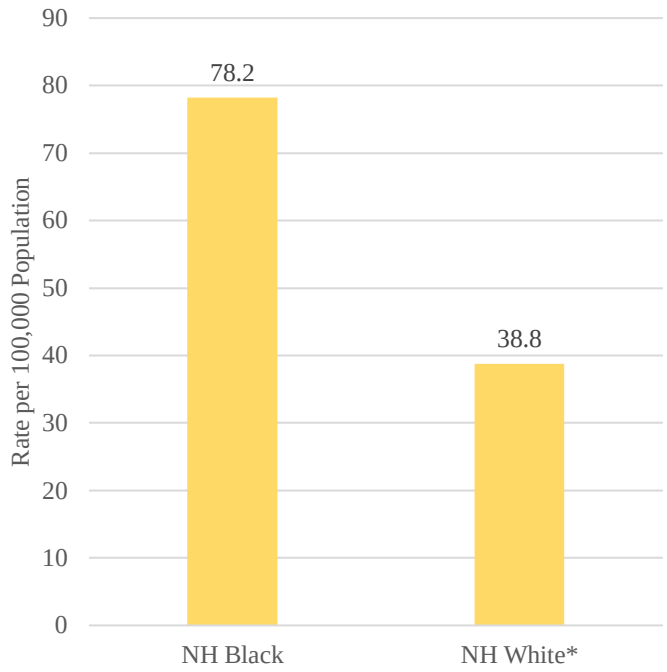


Figure 20. Mortality among Adolescents Ages 15-17, Durham County, 2011-2015[5]

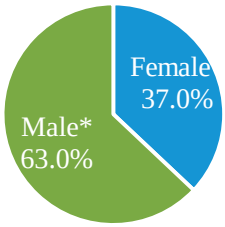


Table 10. Leading Causes of Death among Adolescents Ages 15-17, Durham County, 2011-2015[5]

Cause of Death	Count	Percent	Rate per 100,000 population
External causes of mortality (injuries)	19	70.4	42.2*
Neoplasm	2	4.4	4.4*
Endocrine, nutritional and metabolic diseases	2	4.4	4.4*
Diseases of the respiratory system	2	4.4	4.4*
All other causes (2 individual causes)	2	4.4	4.4*

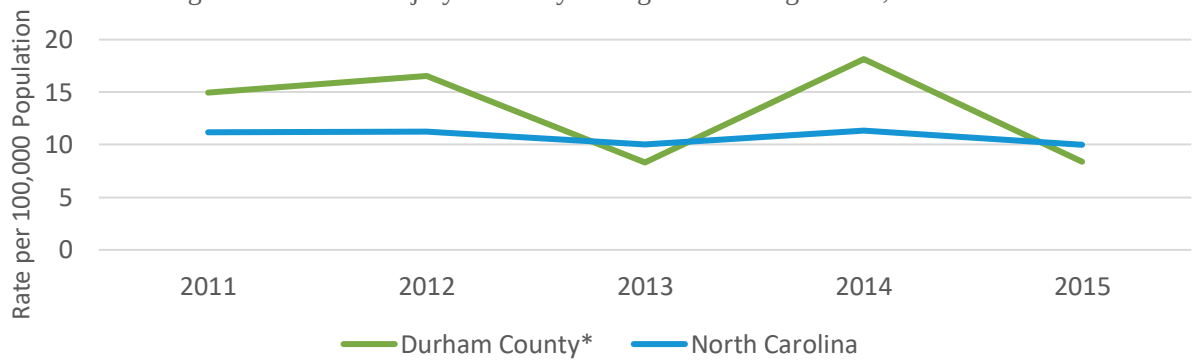
Key Findings and Interpretation

During 2011-2015, injuries were the leading cause of death among adolescents ages 15-17 in Durham County, contributing to 70.4% of all deaths. Males were overrepresented when looking at adolescent deaths by sex, with 63.0% of deaths occurring to males.

The difference in mortality rate seen among non-Hispanic Black and non-Hispanic White adolescents ages 15-17 was not statistically significant. Rates for other races and ethnicities are suppressed to maintain confidentiality due to small case counts.

Injury Related Mortality, Ages 1-17

Figure 21. Trend in Injury Mortality among Children Ages 1-17, 2011-2015[5]



Key Findings and Interpretation

Homicides were the leading cause of deaths due to injuries among all children and adolescents (ages 1-17) in Durham County during 2011-2015, contributing to 27.5% of injury deaths.

Non-Hispanic Black children and adolescents were 3.0 times more likely to die from an injury related death compared to non-Hispanic Whites (p<.05). Social determinants of health should be considered when interpreting this data.

Figure 22. Injury Mortality among Children Ages 1-17 by Sex, Durham County, 2011-2015[5]

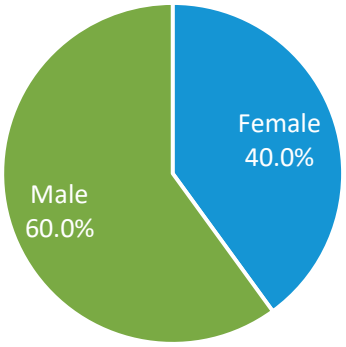


Figure 23. Injury Mortality among Children Ages 1-17 by Race and Ethnicity, Durham County, 2011-2015[5†]

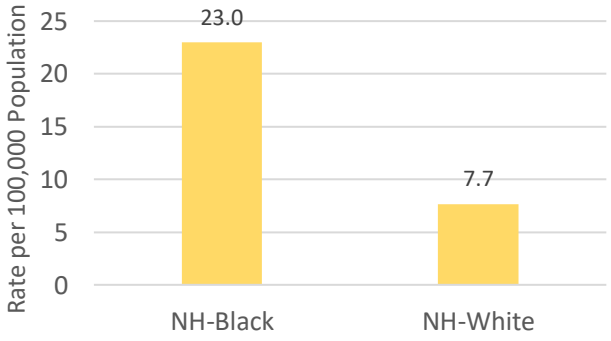


Table 11. Leading Causes of Death due to Injury among Children Ages 1-17, Durham County, 2011-2015[5]

Cause of Death	Count	Percent	Rate per 100,000 population
Assault (homicide)	11	27.5*	0.5*
Motor vehicle accidents	9	22.5*	0.4*
Suicide	6	15.0*	0.3*
Other unspecified accidents	4	10.0*	0.2*
Accidental poisoning and exposure to noxious substances	2	5.0*	0.1*
Other external causes	2	5.0*	0.1*
Complications of medical and surgical care	2	5.0*	0.1*
All causes	40	100.0	1.8

Data Methods

Data in this report were analyzed using Statistical Analysis System (SAS) 9.4 and Epi Info 7. When testing for statistical significance, the alpha was set at 0.05. The International Classification of Disease (ICD) guidelines were used to categorize cause of death.

Only deaths among Durham residents were included in this report.

Limitations

Although multiple years were included in the data for this report, many of the counts for subgroups of populations were less than 20. While counts of less than 20 were included in the report, percentages, rates, and trends based on counts of less than 20 are unstable and should be interpreted cautiously, as these data may change drastically in the future. All rates and percentages based on counts of less than 20 are noted with an asterisk.

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Appendices

Appendix 1: Durham County Community Child Protection

Appendix 2: Local Child Fatality Prevention Team Review Guide

Appendix 3: State Statutes

Appendix 4: 2016-2020 North Carolina's Perinatal Health Strategic Plan

PROMOTING THE DEVELOPMENT OF A COMMUNITY-WIDE APPROACH TO ISSUES OF CHILD ABUSE AND NEGLECT

SEEKING TO RECOGNIZE SYSTEMS' BARRIERS AND MAKING RECOMMENDATIONS TO PROTECT OUR COMMUNITY'S CHILDREN FROM PREVENTABLE DEATHS

Appendix 1

Durham County Community Child Protection Team Handbook

PROMOTING THE DEVELOPMENT OF A COMMUNITY-WIDE APPROACH TO ISSUES OF CHILD ABUSE AND NEGLECT

SEEKING TO RECOGNIZE SYSTEMS' BARRIERS AND MAKING RECOMMENDATIONS TO PROTECT OUR COMMUNITY'S CHILDREN FROM PREVENTABLE DEATHS

Appendix 2

Durham County Child Fatality Prevention Team Handbook

PROMOTING THE DEVELOPMENT OF A COMMUNITY-WIDE APPROACH TO ISSUES OF CHILD ABUSE AND NEGLECT

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Appendix 3

NC Statutes

CCPT

CFPT

PROMOTING THE DEVELOPMENT OF A COMMUNITY-WIDE APPROACH TO ISSUES OF CHILD ABUSE AND NEGLECT

SEEKING TO RECOGNIZE SYSTEMS' BARRIERS AND MAKING RECOMMENDATIONS TO PROTECT OUR COMMUNITY'S CHILDREN FROM PREVENTABLE DEATHS

Appendix 3: State Statutes

§ 7B-1400. Declaration of public policy.

The General Assembly finds that it is the public policy of this State to prevent the abuse, neglect, and death of juveniles. The General Assembly further finds that the prevention of the abuse, neglect, and death of juveniles is a community responsibility; that professionals from disparate disciplines have responsibilities for children or juveniles and have expertise that can promote their safety and well-being; and that multidisciplinary reviews of the abuse, neglect, and death of juveniles can lead to a greater understanding of the causes and methods of preventing these deaths. It is, therefore, the intent of the General Assembly, through this Article, to establish a statewide multidisciplinary, multiagency child fatality prevention system consisting of the State Team established in G.S. 7B-1404 and the Local Teams established in G.S. 7B-1406. The purpose of the system is to assess the records of selected cases in which children are being served by child protective services and the records of all deaths of children in North Carolina from birth to age 18 in order to (i) develop a communitywide approach to the problem of child abuse and neglect, (ii) understand the causes of childhood deaths, (iii) identify any gaps or deficiencies that may exist in the delivery of services to children and their families by public agencies that are designed to prevent future child abuse, neglect, or death, and (iv) make and implement recommendations for changes to laws, rules, and policies that will support the safe and healthy development of our children and prevent future child abuse, neglect, and death. (1991, c. 689, s. 233(a); 1993, c. 321, s. 285(a); 1998-202, s. 6.)

§ 7B-1401. Definitions.

The following definitions apply in this Article:

(1) Additional Child Fatality. – Any death of a child that did not result from suspected abuse or neglect and about which no report of abuse or neglect had been made to the county department of social services within the previous 12 months.
(2) Local Team. – A Community Child Protection Team or a Child Fatality Prevention Team.
(3) State Team. – The North Carolina Child Fatality Prevention Team.
(4) Task Force. – The North Carolina Child Fatality Task Force.
(5) Team Coordinator. – The Child Fatality Prevention Team Coordinator. (1991, c. 689, s. 233(a); 1993, c. 321, s. 285(a); 1998-202, s. 6.)

§ 7B-1402. Task Force – creation; membership; vacancies.

(a) There is created the North Carolina Child Fatality Task Force within the Department of Health and Human Services for budgetary purposes only.

(b) The Task Force shall be composed of 35 members, 11 of whom shall be ex officio members, four of whom shall be appointed by the Governor, 10 of whom shall be appointed by the Speaker of the House of Representatives, and 10 of whom shall be appointed by the President Pro Tempore of the Senate. The ex officio members other than the Chief Medical Examiner shall be nonvoting members and may designate representatives from their particular departments, divisions, or offices to represent them on the Task Force.

The members shall be as follows:

(1) The Chief Medical Examiner;
(2) The Attorney General;
(3) The Director of the Division of Social Services;
(4) The Director of the State Bureau of Investigation;
(5) The Director of the Division of Maternal and Child Health of the Department of Health and Human Services;
(6) The Director of the Governor's Youth Advocacy and Involvement Office;
(7) The Superintendent of Public Instruction;
(8) The Chairman of the State Board of Education;
(9) The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services;
(10) The Secretary of the Department of Health and Human Services;
(11) The Director of the Administrative Office of the Courts;

(12) A director of a county department of social services, appointed by the Governor upon recommendation of the President of the North Carolina Association of County Directors of Social Services;
(13) A representative from a Sudden Infant Death Syndrome counseling and education program, appointed by the Governor upon recommendation of the Director of the Division of Maternal and Child Health of the Department of Health and Human Services;
(14) A representative from the North Carolina Child Advocacy Institute, appointed by the Governor upon recommendation of the President of the Institute;
(15) A director of a local department of health, appointed by the Governor upon the recommendation of the President of the North Carolina Association of Local Health Directors;
(16) A representative from a private group, other than the North Carolina Child Advocacy Institute, that advocates for children, appointed by the Speaker of the House of Representatives upon recommendation of private child advocacy organizations;
(17) A pediatrician, licensed to practice medicine in North Carolina, appointed by the Speaker of the House of Representatives upon recommendation of the North Carolina Pediatric Society;
(18) A representative from the North Carolina League of Municipalities, appointed by the Speaker of the House of Representatives upon recommendation of the League;
(18a) A representative from the North Carolina Domestic Violence Commission, appointed by the Speaker of the House of Representatives upon recommendation of the Director of the Commission;
(19) One public member, appointed by the Speaker of the House of Representatives;
(20) A county or municipal law enforcement officer, appointed by the President Pro Tempore of the Senate upon recommendation of organizations that represent local law enforcement officers;
(21) A district attorney, appointed by the President Pro Tempore of the Senate upon recommendation of the President of the North Carolina Conference of District Attorneys;
(22) A representative from the North Carolina Association of County Commissioners, appointed by the President Pro Tempore of the Senate upon recommendation of the Association;
(22a) A representative from the North Carolina Coalition Against Domestic Violence, appointed by the President Pro Tempore of the Senate upon recommendation of the Executive Director of the Coalition;
(23) One public member, appointed by the President Pro Tempore of the Senate; and
(24) Five members of the Senate, appointed by the President Pro Tempore of the Senate, and five members of the House of Representatives, appointed by the Speaker of the House of Representatives.

(c) All members of the Task Force are voting members. Vacancies in the appointed membership shall be filled by the appointing officer who made the initial appointment. Terms shall be two years. The members shall elect a chair who shall preside for the duration of the chair's term as member.

In the event a vacancy occurs in the chair before the expiration of the chair's term, the members shall elect an acting chair to serve for the remainder of the unexpired term. (1991, c. 689, s. 233(a); 1991 (Reg. Sess., 1992), c. 900, s. 169(b); 1993, c. 321, s. 285(a); 1993 (Reg. Sess., 1994), c. 769, s. 27.8(d); 1996, 2nd Ex. Sess., c. 17, s. 3.2; 1997-443, s. 11A.98; 1997-456, s. 27; 1998-202, s. 6; 1998-212, s. 12.44(a), (b); 2004-186, s. 5.1.)

§ 7B-1403. Task Force – duties.

The Task Force shall:

(1) Undertake a statistical study of the incidences and causes of child deaths in this State and establish a profile of child deaths. The study shall include (i) an analysis of all community and private and public agency involvement with the decedents and their families prior to death, and (ii) an analysis of child deaths by age, cause, and geographic distribution;
(2) Develop a system for multidisciplinary review of child deaths. In developing such a system, the Task Force shall study the operation of existing Local Teams. The Task Force shall also consider the feasibility and desirability of local or regional review teams and, should it determine such teams to be feasible and desirable, develop guidelines for the operation of the teams. The Task Force shall also examine the laws, rules, and policies relating to confidentiality of and access to information that affect those agencies with responsibilities for children, including State and local health, mental health, social services, education, and law enforcement agencies, to determine whether those laws, rules, and policies inappropriately impede the exchange of information necessary to protect children from preventable deaths, and, if so, recommend changes to them;
(3) Receive and consider reports from the State Team; and

(4) Perform any other studies, evaluations, or determinations the Task Force considers necessary to carry out its mandate. (1991, c. 689, s. 233(a); 1996, 2nd Ex. Sess., c. 17, s. 3.2; 1998-202, s. 6; 1998-212, s. 12.44(a), (c).)

§ 7B-1404. State Team – creation; membership; vacancies.

(a) There is created the North Carolina Child Fatality Prevention Team within the Department of Health and Human Services for budgetary purposes only.

(b) The State Team shall be composed of the following 11 members of whom nine members are ex officio and two are appointed:

(1) The Chief Medical Examiner, who shall chair the State Team;
(2) The Attorney General;
(3) The Director of the Division of Social Services, Department of Health and Human Services;
(4) The Director of the State Bureau of Investigation;
(5) The Director of the Division of Maternal and Child Health of the Department of Health and Human Services;
(6) The Superintendent of Public Instruction;
(7) The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services;
(8) The Director of the Administrative Office of the Courts;
(9) The pediatrician appointed pursuant to G.S. 7B-1402(b) to the Task Force;
(10) A public member, appointed by the Governor; and
(11) The Team Coordinator.

The ex officio members other than the Chief Medical Examiner may designate a representative from their departments, divisions, or offices to represent them on the State Team.

(c) All members of the State Team are voting members. Vacancies in the appointed membership shall be filled by the appointing officer who made the initial appointment. (1991, c. 689, s. 233(a); 1993, c. 321, s. 285(a); 1997-443, s. 11A.99; 1997-456, s. 27; 1998-202, s. 6.)

§ 7B-1405. State Team – duties.

The State Team shall:

(1) Review current deaths of children when those deaths are attributed to child abuse or neglect or when the decedent was reported as an abused or neglected juvenile pursuant to G.S. 7B-301 at any time before death;
(2) Report to the Task Force during the existence of the Task Force, in the format and at the time required by the Task Force, on the State Team's activities and its recommendations for changes to any law, rule, and policy that would promote the safety and well-being of children;
(3) Upon request of a Local Team, provide technical assistance to the Team;
(4) Periodically assess the operations of the multidisciplinary child fatality prevention system and make recommendations for changes as needed;
(5) Work with the Team Coordinator to develop guidelines for selecting child deaths to receive detailed, multidisciplinary death reviews by Local Teams that review cases of additional child fatalities; and
(6) Receive reports of findings and recommendations from Local Teams that review cases of additional child fatalities and work with the Team Coordinator to implement recommendations. (1991, c. 689, s. 233(a); 1993, c. 321, s. 285(a); 1997-443, s. 11A.99; 1997-456, s. 27; 1998-202, s. 6.)

§ 7B-1406. Community Child Protection Teams; Child Fatality Prevention Teams; creation and duties.

(a) Community Child Protection Teams are established in every county of the State. Each Community Child Protection Team shall:

(1) Review, in accordance with the procedures established by the director of the county department of social services under G.S. 7B-1409:
    a. Selected active cases in which children are being served by child protective services; and
    b. Cases in which a child died as a result of suspected abuse or neglect, and
        1. A report of abuse or neglect has been made about the child or the child's family to the county department of social services within the previous 12 months, or

2. The child or the child's family was a recipient of child protective services within the previous 12 months.

(2) Submit annually to the board of county commissioner's recommendations, if any, and advocate for system improvements and needed resources where gaps and deficiencies may exist.

In addition, each Community Child Protection Team may review the records of all additional child fatalities and report findings in connection with these reviews to the Team Coordinator.

(b) Any Community Child Protection Team that determines it will not review additional child fatalities shall notify the Team Coordinator. In accordance with the plan established under G.S. 7B-1408(1), a separate Child Fatality Prevention Team shall be established in that county to conduct these reviews. Each Child Fatality Prevention Team shall:

(1) Review the records of all cases of additional child fatalities.

(2) Submit annually to the board of county commissioners' recommendations, if any, and advocate for system improvements and needed resources where gaps and deficiencies may exist.

(3) Report findings in connection with these reviews to the Team Coordinator.

(c) All reports to the Team Coordinator under this section shall include:

(1) A listing of the system problems identified through the review process and recommendations for preventive actions;

(2) Any changes that resulted from the recommendations made by the Local Team;

(3) Information about each death reviewed; and

(4) Any additional information requested by the Team Coordinator. (1993, c. 321, s. 285(a); 1998-202, s. 6.)

§ 7B-1407. Local Teams; composition.

(a) Each Local Team shall consist of representatives of public and nonpublic agencies in the community that provide services to children and their families and other individuals who represent the community. No single team shall encompass a geographic or governmental area larger than one county.

(b) Each Local Team shall consist of the following persons:

(1) The director of the county department of social services and a member of the director's staff;

(2) A local law enforcement officer, appointed by the board of county commissioners;

(3) An attorney from the district attorney's office, appointed by the district attorney;

(4) The executive director of the local community action agency, as defined by the Department of Health and Human Services, or the executive director's designee;

(5) The superintendent of each local school administrative unit located in the county, or the superintendent's designee;

(6) A member of the county board of social services, appointed by the chair of that board;

(7) A local mental health professional, appointed by the director of the area authority established under Chapter 122C of the General Statutes;

(8) The local guardian ad litem coordinator, or the coordinator's designee;

(9) The director of the local department of public health; and

(10) A local health care provider, appointed by the local board of health.

(c) In addition, a Local Team that reviews the records of additional child fatalities shall include the following five additional members:

(1) An emergency medical services provider or firefighter, appointed by the board of county commissioners;

(2) A district court judge, appointed by the chief district court judge in that district;

(3) A county medical examiner, appointed by the Chief Medical Examiner;

(4) A representative of a local child care facility or Head Start program, appointed by the director of the county department of social services; and

(5) A parent of a child who died before reaching the child's eighteenth birthday, to be appointed by the board of county commissioners.

(d) The Team Coordinator shall serve as an ex officio member of each Local Team that reviews the records of additional child fatalities. The board of county commissioners may appoint a maximum of five additional members to represent county agencies or the community at large to serve on any Local Team. Vacancies on a Local Team shall be filled by the original appointing authority.

(e) Each Local Team shall elect a member to serve as chair at the Team's pleasure.

(f) Each Local Team shall meet at least four times each year.

(g) The director of the local department of social services shall call the first meeting of the Community Child Protection Team. The director of the local department of health, upon consultation with the Team Coordinator, shall call the first meeting of the Child Fatality Prevention Team. Thereafter, the chair of each Local Team shall schedule the time and place of meetings, in consultation with these directors, and shall prepare the agenda. The chair shall schedule Team meetings no less often than once per quarter and often enough to allow adequate review of the cases selected for review. Within three months of election, the chair shall participate in the appropriate training developed under this Article. (1993, c. 321, s. 285(a); 1997-443, s. 11A.100; 1997-456, s. 27; 1997-506, s. 52; 1998-202, s. 6.)

§ 7B-1408. Child Fatality Prevention Team Coordinator; duties.

The Child Fatality Prevention Team Coordinator shall serve as liaison between the State Team and the Local Teams that review records of additional child fatalities and shall provide technical assistance to these Local Teams. The Team Coordinator shall:

(1) Develop a plan to establish Local Teams that review the records of additional child fatalities in each county.
(2) Develop model operating procedures for these Local Teams that address when public meetings should be held, what items should be addressed in public meetings, what information may be released in written reports, and any other information the Team Coordinator considers necessary.
(3) Provide structured training for these Local Teams at the time of their establishment, and continuing technical assistance thereafter.
(4) Provide statistical information on all child deaths occurring in each county to the appropriate Local Team, and assure that all child deaths in a county are assessed through the multidisciplinary system.
(5) Monitor the work of these Local Teams.
(6) Receive reports of findings, and other reports that the Team Coordinator may require, from these Local Teams.
(7) Report the aggregated findings of these Local Teams to each Local Team that reviews the records of additional child fatalities and to the State Team.
(8) Evaluate the impact of local efforts to identify problems and make changes. (1993, c. 321, s. 285(a); 1998-202, s. 6.)

§ 7B-1409. Community Child Protection Teams; duties of the director of the county department of social services.

In addition to any other duties as a member of the Community Child Protection Team, and in connection with the reviews under G.S. 7B-1406(a)(1), the director of the county department of social services shall:

(1) Assure the development of written operating procedures in connection with these reviews, including frequency of meetings, confidentiality policies, training of members, and duties and responsibilities of members;
(2) Assure that the Team defines the categories of cases that are subject to its review;
(3) Determine and initiate the cases for review;
(4) Bring for review any case requested by a Team member;
(5) Provide staff support for these reviews;
(6) Maintain records, including minutes of all official meetings, lists of participants for each meeting of the Team, and signed confidentiality statements required under G.S. 7B-1413, in compliance with applicable rules and law; and
(7) Report quarterly to the county board of social services, or as required by the board, on the activities of the Team. (1993, c. 321, s. 285(a); 1998-202, s. 6.)

§ 7B-1410. Local Teams; duties of the director of the local department of health.

In addition to any other duties as a member of the Local Team and in connection with reviews of additional child fatalities, the director of the local department of health shall:

(1) Distribute copies of the written procedures developed by the Team Coordinator under G.S. 7B-1408 to the administrators of all agencies represented on the Local Team and to all members of the Local Team;

(2) Maintain records, including minutes of all official meetings, lists of participants for each meeting of the Local Team, and signed confidentiality statements required under G.S. 7B-1413, in compliance with applicable rules and law;
(3) Provide staff support for these reviews; and
(4) Report quarterly to the local board of health, or as required by the board, on the activities of the Local Team. (1993, c. 321, s. 285(a); 1998-202, s. 6.)

§ 7B-1411. Community Child Protection Teams; responsibility for training of team members.

The Division of Social Services, Department of Health and Human Services, shall develop and make available, on an ongoing basis, for the members of Local Teams that review active cases in which children are being served by child protective services, training materials that address the role and function of the Local Team, confidentiality requirements, an overview of child protective services law and policy, and Team record keeping. (1993, c. 321, s. 285(a); 1997-443, s. 11A.118(a); 1998-202, s. 6.)

§ 7B-1412. Task Force – reports.

The Task Force shall report annually to the Governor and General Assembly, within the first week of the convening or reconvening of the General Assembly. The report shall contain at least a summary of the conclusions and recommendations for each of the Task Force's duties, as well as any other recommendations for changes to any law, rule, or policy that it has determined will promote the safety and well-being of children. Any recommendations of changes to law, rule, or policy shall be accompanied by specific legislative or policy proposals and detailed fiscal notes setting forth the costs to the State. (1991, c. 689, s. 233(a); 1991 (Reg. Sess., 1992), c. 900, s. 169(a); 1993 (Reg. Sess., 1994), c. 769, s. 27.8(a); 1996, 2nd Ex. Sess., c. 17, ss. 3.1, 3.2; 1998-202, s. 6; 1998-212, s. 12.44(a), (d).)

§ 7B-1413. Access to records.

(a) The State Team, the Local Teams, and the Task Force during its existence, shall have access to all medical records, hospital records, and records maintained by this State, any county, or any local agency as necessary to carry out the purposes of this Article, including police investigations data, medical examiner investigative data, health records, mental health records, and social services records. The State Team, the Task Force, and the Local Teams shall not, as part of the reviews authorized under this Article, contact, question, or interview the child, the parent of the child, or any other family member of the child whose record is being reviewed. Any member of a Local Team may share, only in an official meeting of that Local Team, any information available to that member that the Local Team needs to carry out its duties.

(b) Meetings of the State Team and the Local Teams are not subject to the provisions of Article 33C of Chapter 143 of the General Statutes. However, the Local Teams may hold periodic public meetings to discuss, in a general manner not revealing confidential information about children and families, the findings of their reviews and their recommendations for preventive actions. Minutes of all public meetings, excluding those of executive sessions, shall be kept in compliance with Article 33C of Chapter 143 of the General Statutes. Any minutes or any other information generated during any closed session shall be sealed from public inspection.

(c) All otherwise confidential information and records acquired by the State Team, the Local Teams, and the Task Force during its existence, in the exercise of their duties are confidential; are not subject to discovery or introduction into evidence in any proceedings; and may only be disclosed as necessary to carry out the purposes of the State Team, the Local Teams, and the Task Force. In addition, all otherwise confidential information and records created by a Local Team in the exercise of its duties are confidential; are not subject to discovery or introduction into evidence in any proceedings; and may only be disclosed as necessary to carry out the purposes of the Local Team. No member of the State Team, a Local Team, nor any person who attends a meeting of the State Team or a Local Team, may testify in any proceeding about what transpired at the meeting, about information presented at the meeting, or about opinions formed by the person as a result of the meetings. This subsection shall not, however, prohibit a person from testifying in a civil or criminal action about matters within that person's independent knowledge.

(d) Each member of a Local Team and invited participant shall sign a statement indicating an understanding of and adherence to confidentiality requirements, including the possible civil or criminal consequences of any breach of confidentiality.

(e) Cases receiving child protective services at the time of review by a Local Team shall have an entry in the child's protective services record to indicate that the case was received by that Team. Additional entry into the record shall be at the discretion of the director of the county department of social services.

(f) The Social Services Commission shall adopt rules to implement this section in connection with reviews conducted by Community Child Protection Teams. The Health Services Commission shall adopt rules to implement this section in connection with Local Teams that review additional child fatalities. In particular, these rules shall allow information generated by an executive session of a Local Team to be accessible for administrative or research purposes only. (1991, c. 689, s. 233(a); 1993, c. 321, s. 285(a); 1998-202, s. 6.)

§ 7B-1414. Administration; funding.

(a) To the extent of funds available, the chairs of the Task Force and State Team may hire staff or consultants to assist the Task Force and the State Team in completing their duties.

(b) Members, staff, and consultants of the Task Force or State Team shall receive travel and subsistence expenses in accordance with the provisions of G.S. 138-5 or G.S. 138-6, as the case may be, paid from funds appropriated to implement this Article and within the limits of those funds.

(c) With the approval of the Legislative Services Commission, legislative staff and space in the Legislative Building and the Legislative Office Building may be made available to the Task Force. (1991, c. 689, s. 233(a); 1998-202, s. 6.)

-202, s. 6.)

Appendix 4

North Carolina's Perinatal Health Strategic Plan 2016-2020

PROMOTING THE DEVELOPMENT OF A COMMUNITY-WIDE APPROACH TO ISSUES OF CHILD ABUSE AND NEGLECT

SEEKING TO RECOGNIZE SYSTEMS' BARRIERS AND MAKING RECOMMENDATIONS TO PROTECT OUR COMMUNITY'S CHILDREN FROM PREVENTABLE DEATHS

NORTH CAROLINA'S PERINATAL HEALTH STRATEGIC PLAN: 2016 – 2020

NC Perinatal Health Strategic Plan - Released March 24, 2016

This plan is designed to address infant mortality, maternal health, maternal morbidity, and the health of men and women of childbearing age.

The Plan:

The framework selected by the Perinatal Health Strategic Planning Committee was adapted from the "12-Point Plan to Close the Black-White Gap in Birth Outcomes: A Life-Course Approach" developed by Lu, Kotelchuck, Hogan, Jones, Wright, and Halfon (http://www.unnaturalcauses.org/assets/uploads/file/ClosingTheGapBWBirthOutcome.pdf).
Upon review of the framework, it was evident that these strategies were appropriate for all populations, not just African American families. This adapted framework was used to develop the strategies of this Plan. The action steps were developed by over 125 maternal and child health experts from across the state.

The 12-point plan includes:

Improve health care for women and men:

1. Provide interconception care to women with prior adverse pregnancy outcomes
2. Increase access to preconception care
3. Improve the quality of prenatal care
4. Expand healthcare access over the life course

Strengthen families and communities:

5. Strengthen father involvement in families
6. Enhance coordination and integration of family support services
7. Support coordination and cooperation to promote reproductive health within communities
8. Invest in community building and urban renewal

Addressing social and economic inequities:

9. Close the education gap
10. Reduce poverty among families
11. Support working mothers and families
12. Undo racism

Below are the planned strategies and action steps of the perinatal health strategic plan:

GOAL 1 - IMPROVING HEALTH CARE FOR WOMEN AND MEN

Point 1. Provide interconception care to women with prior adverse pregnancy outcomes

1A. Support healthy pregnancy intervals through access to effective methods of contraception, including increased access to Long-Acting Reversible Contraception (LARC)
1. Provide payment for postpartum placement of LARC in hospital setting by addressing the billing issue
2. Expand training opportunities for clinicians on LARC provision specifically for family medicine and pediatricians, Nurse Practitioners, Certified Nurse Midwives, and other specialists
3. Expand LARC education opportunities related to counseling and referring patients for LARC for providers who do not provide LARC.
4. Use shared decision-making model, also known as interactive counseling, to educate patients about available contraception including the benefits and barriers of LARC.
1B. Provide care coordination/case management/home visiting services that includes promotion of resiliency, mental health screening, substance use intervention, tobacco cessation and prevention, reproductive life planning, chronic disease management and access to health care
1. Add prior adverse pregnancy outcomes as a risk factor for Medicaid, Tri-care and state health plan case management services. Expand to include other private insurance.
2. Improve access to community services for case management programs by providing orientation for clinicians in order to increase awareness of services and referral mechanisms.
3. Increase opportunities for insurance reimbursement for services offered through case management/home visiting programs
4. Provide evidence-based coverage for tobacco cessation treatment and counseling for all tobacco users who want to quit, including populations at greater risk for tobacco use (e.g., populations with mental health and/or substance use problems, low income and educational attainment, homeless, and those in the criminal justice system)
1C. Assure women are transitioned from different points of care and have access to postpartum/primary/well woman care including access to ongoing health insurance coverage and a medical home
1. Increase utilization of the postpartum clinic visit by offering dual appointment scheduling for mom and baby and/or dual home visit for mom and baby
2. Develop a plan to increase postpartum home visits
3. Improve mechanisms for maternity care providers to refer patients to medical homes by developing a patient handout (on-line/print) with medical home providers
4. Provide access to evidence-based tobacco cessation and treatment and tobacco free living to help tobacco users quit and stay quit in the postpartum period and when leaving tobacco free environments (e.g., hospitals, prisons, behavioral health facilities, and group homes)

1D.	Provide outreach to all providers who care for children (pediatric and family practice clinics, community settings, etc.) to ensure women are receiving interconception care services
1.	Increase outreach to substance use treatment programs with interconception care and family planning services
2.	Conduct outreach to pediatric clinics pertaining to interconception care. Educate providers on timing and methods of introduction of interconception care with the pediatric population and their families.
3.	Incorporate interconception care into routine well-child care
4.	Engage pediatric providers to provide evidence based tobacco treatment services, including education on a tobacco free living environments, remaining tobacco free in the postpartum period and protection from secondhand and thirdhand smoke.
5.	Work with public and private decision-makers to make multi-unit housing, government buildings, grounds, child care facilities, and public places smoke-free/tobacco-free.
6.	Engage community stakeholders and educate on the benefits of interconception care and its impact on the community by hosting town halls or town summits. Utilize methods identified during town summits to implement educational sessions and efforts.

1E.	Increase quality and frequency of risk assessment at the postpartum clinic visit.
1.	Continue development and implementation of *Pregnancy Medical Home Care Pathway: Postpartum Care and Transition to Well-Woman Care* as the recommended check-list for risk assessment
2.	Ensure providers have access to referral services if needs are identified during risk assessment

Point 2. Increase access to preconception health and health care to women and men

2A.	Expand the college-based Preconception Peer Education (PPE) Program to reach additional women and men in colleges, universities, graduate schools, community colleges and adult learning programs.
1.	Increase the number of new PPE program sites by 5 per year by procuring start-up funds through sorority and fraternity alumnae chapters
2.	Implement the PPE program model through minority-based student-led groups at five NC community colleges
3.	Obtain lessons learned from other states that have implemented the PPE program within non-African American populations to determine program design, successes, challenges, and barriers for possible adaptation in NC
4.	Partner with other public health programs that have experience working within colleges, community colleges, and community settings that reach young adults in order to deliver the PPE program in 2 new institutions
5.	Work with all tobacco control partners and colleges in NC to go 100% tobacco-free, as is allowed by law, and to provide evidence-based tobacco treatment services to all tobacco users
6.	Obtain funding to expand March of Dimes free folic acid distribution program to colleges and universities via the PPE program and social media messages

2B.	Integrate preconception health (PCH) care and messages into primary care for people of reproductive age.
1.	Design, administer, and analyze survey for primary care providers to assess what PCH care and education they are currently providing. Use existing professional networks and conferences to administer the survey.
2.	Disseminate PCH interventions and messaging through professional organizations on how to implement these messages in a 10-minute primary care visit
3.	Identify and disseminate effective PCH social media messages (e.g. Show Your Love campaign, Tobacco-free living messages) that are targeted throughout the life course via ongoing and newly established PCH health campaigns
4.	Provide PCH messaging through intergenerational conversations facilitated by ongoing family-centered, community-based programs
5.	Provide reproductive life planning counseling and ensure that people have a reproductive life plan in place, particularly those women identified with medical conditions that put them at risk for maternal mortality/morbidity

2C.	Integrate the use of evidence-based and evidence-informed curricula with adolescent and young adult populations in educational and community settings.
1.	Implement evidence-informed preconception /reproductive life planning curricula in GED and workforce development programs by expanding pre-existing PCH trainings
2.	Ensure compliance with the Healthy Youth Act and facilitate its full implementation via monitoring, reporting and general oversight
3.	Implement *Healthy Before Pregnancy* curriculum in charter schools
4.	Integrate PCH education into school-based health centers
5.	Incorporate breastfeeding positive messaging into PCH trainings for high-school students
6.	Educate young people about the dangers of all tobacco products, including menthol, and new and emerging electronic nicotine delivery systems with youth-attractive flavorings and promotional messages. Empower young people to carry out effective peer educational campaigns.

2D. Implement the *North Carolina Preconception Health Strategic Plan* and *Supplement*.
1. Identify key stakeholders and electronically distribute plan and supplement
2. Identify champions who can share plan and supplement
3. Identify other health promotion/educational campaigns that can integrate plan and supplement

Point 3. Improve the quality of maternal care (includes prenatal, labor, delivery and postpartum care)

3A.	Expand the use of evidence-based models of prenatal care
1.	Establish 6 additional CenteringPregnancy® sites by procuring start-up funds and providing training. Focus on expanding this model to populations who are at higher risk for poor birth outcomes.
2.	Evaluate outcomes for CenteringPregnancy® patients in North Carolina by developing evaluation measures

3. Increase continuity of care by promoting that the same provider sees the prenatal patient on a consistent basis
4. Use shared decision-making model to provide patient education on contraception during the third trimester of prenatal care

3B. Provide evidence-based clinical standards in prenatal care (e.g., early elective deliveries, cesarean rate, 17P, tobacco cessation, hypertensive disorders, gestational diabetes, mental health, substance abuse, intimate partner violence, perinatal mood disorders, etc.)

1. Continue development and implementation of Pregnancy Medical Home Pathways through utilization of flow sheet/checklist of required (or recommended) clinical elements for prenatal care
2. Increase health care clinician training (public and private) on recommended clinical standards
3. Track specific measurements related to provision of recommended clinical care including data on maternal mortality and severe maternal morbidity by race & ethnicity
4. Implement maternity safety bundle (i.e. OB hemorrhage, hypertension management and prevention of thromboembolism for in- patient care; OB clinical checklist for providers)
5. Offer Pregnancy Medical Home providers training and/or technical assistance regarding the use of SBIRT (Screening, Brief Intervention, and Referral to Treatment) to identify, intervene, and refer pregnant women for substance use
6. Ensure all pregnant women with substance use who contact the local management entities-managed care organizations (LME-MCO) Access Line are considered emergent (within 2 hours) referrals
7. Implement You Quit, Two Quit to improve quality of tobacco cessation and prevention efforts among providers
8. Ensure all pregnant women receive appropriate gestational weight gain guidance

3C. Improve access to and utilization of first trimester prenatal care

1. Allow private providers to complete Medicaid pregnancy presumptive eligibility determination forms
2. Ensure that each health department is providing pregnancy testing and completion of Medicaid presumptive eligibility at the same visit
3. Decrease length of time for approving Medicaid for Pregnant Women (MPW) applications
4. Increase the number of private providers who will accept women with presumptive eligibility for Medicaid and with MPW
5. Improve first trimester access to care for undocumented pregnant women by using open access scheduling

3D. Provide care coordination/case management/home visiting services that includes promotion of resiliency, mental health screening, substance use intervention, tobacco cessation and prevention, reproductive life planning, chronic disease management, perinatal mood disorders, and access to health care

1. Improve access to community services for case management programs by providing orientation and ongoing technical assistance for providers in order to increase awareness of services and referral mechanisms

2. Provide care coordination for pregnant women with substance use disorder and/or mental health disorder through LME-MCO

3E. Ensure that all pregnant women and high-risk infants have access to the appropriate level of care through a well-established regional perinatal system

1. Decrease the percent of Very Low Birthweight (VLBW) and high-risk babies who are born at Level 1 and Level 2hospitals
2. Define, identify and promote centers of excellence for VBAC (vaginal birth after cesarean)
3. Assess the levels of neonatal and maternity care services for hospitals using the consensus recommendations of the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the Society for Maternal-Fetal Medicine (SMFM)

3F. Promote access to comprehensive breastfeeding support services including medical lactation services

1. Expand breastfeeding peer counseling program to all counties in NC
2. Increase the number of International Board Certified Lactation Consultants (IBCLCs) per live birth, especially people of color, by increasing educational support (including mentoring) and financial support
3. Reimburse for the provision of medical lactation services by IBCLCs, MDs, CNMs, and NPs
4. Increase the number of facilities participating in NC Maternity Center Breastfeeding Friendly Designation or NC Breastfeeding-Friendly Child Care Designation Program or achieving a Baby Friendly Hospital Designation
5. Reduce infant formula utilization by increasing the initiation, duration, and exclusivity of breastfeeding

3G. Provide evidence-based culturally competent patient education and anticipatory guidance

1. Provide evidence-informed childbirth education information to expectant families that includes:
   - Letting labor begin on its own
   - Walking, moving & changing position in labor
   - Have continuous labor support
   - No routine intervention in labor
   - Upright position for pushing
   - Immediate skin-to-skin: skin-to-skin for the first hour or until the first feed (this is for all babies for thermal regulation)
   - Keep baby with you, it's good for breastfeeding "rooming in"

   *adapted from *Lamaze International Six Healthy Birth Practices*
2. Increase perinatal health literacy by ensuring that families are provided with appropriate educational resources and support
3. Increase the availability of continuing education for individuals providing patient education to ensure most current evidenced based practices are presented to patients and ensure that individuals are able to maintain certification
4. Increase community awareness and comprehension of reproductive health literacy

5. Convene community focus groups to test existing patient education materials and find out the best routes for accessing information by integrating focus groups with pre-existing forums

6. Educate clinicians on the latest, evidence-based information and guidance through continuing education, conferences, and graduate curricula updates. Utilize inter-professional techniques to effectively integrate and facilitate team learning.

Point 4. Expand healthcare access over the life course for all

4A. Promote access to and utilization of the adolescent well visit
1. Increase enrollment of adolescents in Health Check/Health Choice by working with community-based organizations
2. Educate adolescents and parents/caregivers about the importance of the adolescent well visit, health benefits, and perceived barriers through social media campaigns
3. Increase school-based healthcare access through legislative action and increased funding

4B. Promote access to and utilization of evidence-based preventive health services
1. Educate clinicians about evidence-based strategies through continuing education, conferences, and graduate curricula updates
2. Educate consumers about benefits of the Affordable Care Act (ACA) and evidence-based strategies through social media

4C. Increase access to and utilization of medical homes
1. Educate population about the concept of a medical home and services provided

4D. Provide affordable, comprehensive insurance coverage
1. Close the health care insurance gap for low income populations
2. Increase accessibility of health care services through safety net providers

4E. Promote access to and utilization of immunizations according to the American Committee on Immunization Practice guidelines
1. Launch a social media campaign on immunization benefits for people of reproductive age via pre-existing marketing channels
2. Assess current inventory and supply management needs for vaccines amongst safety net providers
3. Address immunization data gap for adults by monitoring immunization rates through statewide registry

4F. Provide evidence-based culturally competent patient education and anticipatory guidance
1. Compile evidence-based education for priority patient populations, e.g. African Americans, American Indians, LGBTQ, etc.
2. Compile evidence-based education for men

3. Convene community focus groups to test existing patient education materials and find out the best routes for accessing information by integrating focus groups with pre-existing forums
4. Educate clinicians on the latest, evidence-based information and guidance through continuing education, conferences, and graduate curricula updates

GOAL 2 STRENGTHENING FAMILIES AND COMMUNITIES

Point 5. Strengthen father involvement in families

5A. Promote parenting and co-parenting skills and responsible strategies

1. Expand Triple P, NC Prevent Child Abuse parenting curriculum, etc. to five additional community agencies
2. Identify number of counties with an evidence-based parenting program
3. Increase support for evidence-based programs by providing funding and technical assistance.
4. Identify successful fatherhood programs and resources/contacts by collaborating with local fatherhood task forces

5B. Improve/develop guidelines for the inclusion of men in preconception, prenatal, and interconception health services

1. Incorporate PCH into the routine primary care of men
2. Promote preventative health education for boys, adolescents and men, to include mental health and substance use, and the impact it has on childbearing and parenting by incorporating education into school, faith-based community and other community programs

5C. Use evidence-based strategies to promote healthy family relationships

1. Broadly disseminate, through provider training, evidence-based programs that address healthy relationships/ families/parenting, including trauma-informed care
2. Educate providers on warning signs of conflict in relationships and previous trauma history and develop referral pathways

5D. Promote the role of fathers to change the culture

1. Link local and regional fatherhood task forces to the NC Fatherhood Council
2. Create/Implement messaging to build an evidence-based awareness campaign with messages tailored for fathers and male caregivers in NC by working with father-focused groups
3. Incorporate the role of fathers into the current First 2000 Days of Life media campaign
4. Support paid parental leave efforts

Point 6. Enhance coordination and integration of family support services

6A. Promote agency and community coordination in providing services
1. Improve the integration and collaboration of services and programs in the Division of Public Health/DHHS that impact women's and children's health by increasing cross communication, sharing what is known, and assessing strengths and challenges
2. Create a DHHS plan to provide coordinated services across the across the life course continuum
3. Share the lessons learned, plans and information collected through the increased communication and planning in #1 and #2 with the larger public health community in North Carolina to model innovation and set the pace for local groups
4. Improve transitions of care/improved communication among clinical case managers

6B. Decrease fragmentation in the service delivery system to reduce burden on families
1. Identify existing gap analysis models and review them for use in North Carolina with a focus on services and supports for families
2. Support a pilot project/learning collaborative with agencies to conduct a gap analysis of their services for families
3. Share findings of the learning collaborative along with recommendations for other agencies and counties to conduct their own analysis
4. Utilize technology to better drive connectivity and sharing of information with and about families to improve service systems and utilization of resources
5. Convene a stakeholder meeting to map out and understand the various systems that families must navigate

6C. Improve family and community driven service provision
1. Conduct listening sessions with women, families and communities to learn more about how current systems are working for them and what might work better. Apply what is learned to system improvements.
2. Review the evidence base for the use of community health workers and assess if and how they are being utilized in North Carolina. Encourage agencies and non-profits that are working in the same communities to consider pooling their resources/staff to hire from within high-need communities and potentially better coordinate efforts.
3. Provide training to home visitors and people who are providing services to families and communities around cultural competency in order to prevent internalized racism/oppression and focusing on resilience and community building vs "I know best." • Explore the Smart Start training model. • Assess current curriculum and training provided. • Develop online, reading and other materials to support ongoing learning. • Find resources to support retreats

Point 7. Support coordination and cooperation to promote reproductive health within communities

7A. Promote reproductive life planning
1. Use evidence-based reproductive life planning tools
2. Expand provider and consumer education and outreach by increasing the number of reproductive life planning trainings available to a variety of groups including faith communities, clinicians, case workers, and others
3. Advocate for incentives to create reproductive life plans
4. Use standardized evidence-based contraceptive counseling across NC's perinatal case management programs

7B. Expand community stakeholder involvement and community engagement in service design and implementation
1. Increase education and community support by presenting existing preconception health high school curricula to local decision makers
2. Work with agencies and providers to develop and utilize community advisory groups inclusive of community members and consumers of services when developing and implementing services and programs.

7C. Promote utilization of breastfeeding friendly policies and services in local communities
1. Increase the number of facilities participating in NC Maternity Center Breastfeeding Friendly Designation or NC Breastfeeding-Friendly Child Care Designation Program or achieving a Baby Friendly Hospital Designation
2. Advocate among the business community to adopt breastfeeding-friendly policies and practices by supporting use of breastfeeding-friendly designations

7D. Promote utilization of evidence-based strategies to prevent all forms of violence and promote coordinated community response
1. Increase awareness of the impact of toxic stress and exposure to violence on children's health and development.
2. Broadly disseminate, through provider training, evidence-based programs that address healthy relationships/ families/parenting, including trauma-informed care
3. Educate providers on warning signs of conflict in relationships and previous trauma history and develop referral pathways
4. Increase the number of nurses with Sexual Assault Nurse Examiner (SANE) qualifications

Point 8. Invest in community building

8A. Create and improve transportation systems and infrastructure
1. Establish collaborative relationships with Council of Governments, Department of Transportation, Division of Social Services and City Planning to develop a report to describe transportation issues and recommendations for young families in NC
2. Assess access to prenatal and family planning services based on the report from the Institute of Medicine to learn more about the distance of primary care services and specialty services in and around rural areas. Review data and talk with women/men to assess if and why some women travel further for their care instead of visiting local providers (potential trust/discrimination issues).
3. Convene a daylong meeting to review all the information above along with any policies or procedures that may be impacting access to care (e.g. being able to bring a family member / baby along for an important visit) and develop a list of recommendations to improve services and ease of use

4. Collectively advocate for changes in bus routes, bus stops, location of recreational facilities, availability of transportation services, etc. based on the recommendations made by the meeting described above

8B. Support capacity building in areas of concentrated disadvantage
1. Use existing method of GIS mapping and other data resources such as Emergency Management to identify communities at high-risk for poor birth and child health outcomes (hot spot) to describe and prioritize their needs
2. Establish collaborative partnership with community housing program (housing authority) and others to assess housing needs, impact on health (particularly young adults and young families), and push for local planning and funding strategies to improve safety and healthy housing options for families, including housing opportunities outside of neighborhoods of concentrated poverty • Review model programs from other states and programs that are doing this work – e.g. Healthy Start and Best Babies Zones
3. Make free Wi-Fi available within disadvantaged housing to enable residents to apply for jobs, connect to resources in community and connect their children to online school resources
4. Take inventory of communities in NC implementing promise zone like initiatives (taking multigenerational approaches to ensure the child's success). Share their work, successes and challenges via a report or webinar or conference presentation so other communities can learn from their work. Collaborate with projects to provide support / expertise as needed to make sure that key services such as reproductive life planning are included / considered.

8C. Improve environments to support healthy living
1. Promote smoke-free/tobacco-free public housing and multi-unit housing through policy change and tax incentives
2. Increase community gardens and support permaculture in low income neighborhoods
3. Educate and inform decision makers to adopt the following evidence-based interventions: • Local regulations that make local government buildings, grounds, and public places tobacco free. • Smoke-free multi-unit housing that also bans e-cigarettes, including public housing, affordable housing and as resources allow, market rate housing. • Tobacco-free community colleges and colleges. • Local tobacco-free mental health and substance abuse facilities along with evidence-based tobacco treatment provided by counselors • Tobacco-free child care centers for those who serve the 0-5 population
4. Educate the public and decision-makers about how menthol added to tobacco products and promoted to populations impacts tobacco addiction, disease, and premature death for those populations that use menthol tobacco products
5. Collaborate with environmental justice coalitions to promote access to safe water, clean air, and chemically toxic-free environment
6. Continue partnering with local and state initiatives to educate communities about healthy living, including exercise and nutrition
7. Collaborate with initiatives that focus on regular access to healthy foods and food security

8D. Create and promote local employment opportunities that provide at least a livable wage
1. Support and encourage businesses that seek to provide jobs (with benefits, paid sick leave) as well as services in areas of concentrated disadvantage
2. Collaborate with partners and organizations that advocate for living wage, community development, and community reinvestment

8E. Support civic participation through building community networks
1. Partner with existing groups to make sure that MCH populations are registered to vote, know where to vote, have identification for voting, know how to access information about candidates and have transportation to the polls
2. Bring the policy issues to the kitchen table – make politics both state and local understandable to busy, over extended young adults and families
3. Provide information and education to MCH clients about the policy decision-making process, how local governments work and how they can collectively share their issues and concerns

GOAL 3 - ADDRESSING SOCIAL AND ECONOMIC INEQUITIES

Point 9. Close the education gap

9A. Promote and increase access to higher education
1. Promote enrollment of youth in foster care settings in post-secondary education
2. Compile research on the effect of early college attendance on the achievement gap and racial/geographical disparities in post-secondary enrollment and completion rates; collaborate with key stakeholders to locate data and create document to share findings
3. Increase the number of high quality student and family centered counseling services in middle and high schools by enhancing the cultural and geographic humility-capacity of counselors to work with students/families from all cultures and regions of the state
4. Partner with NC Area Health Education Center's (NC AHEC) Health Careers and Diversity Council and other key stakeholders to develop an action plan to promote awareness of health careers and academic preparation for secondary education among guidance counselors, students and parents

9B. Increase high school and post high school graduation rates
1. Increase the number of high quality student and family centered counseling services (middle and high schools) by enhancing the cultural and geographic humility-capacity of counselors to work with students/families from diverse cultures and regions across the state
2. Implement policies and promote model programs that address barriers to school attendance for high school and college pregnant and parenting students

9C. Expand race/ethnic/gender diversity representation in schools (administrators, faculty, and staff)
1. Promote the teaching profession as a viable career option to underrepresented groups, non-traditional audiences (lateral entry programs) and populations through the

development of social marketing and media campaigns and related efforts to identify and recruit new teachers

2. Identify new revenue sources (e.g., tobacco products tax) and obtain legislative approval to design and implement funding mechanisms that underwrite and increase teacher/staff compensation

9D. Promote and increase access to early childhood education

1. Raise awareness of the developmental and financial impacts of high quality early learning programs
2. Increase the availability of early childhood programming to those who qualify (e.g., Early Head Start, etc.)
3. Support the recommendations outlined in NC Institute of Medicine Essentials for Childhood report
4. Support the recommendations of the NC Early Childhood Foundation's NC Pathways to Grade-Level Reading Project
5. Promote the NC Pathways to Grade-Level Reading Measures of Success Framework

9E. Disrupt the school to prison pipeline, beginning with pre-school

1. Raise awareness of implicit bias
2. Support policies that require training on implicit bias for education staff
3. Advocate for disaggregated data collection and reporting for school suspension
4. Promoting the use of EB positive social behavior and discipline strategies in all school settings
5. Provide developmentally appropriate services to justice involved youth by raising the age of juvenile jurisdiction from 16 to 18

Point 10. Reduce poverty among families

10A. Learn, collaborate, and partner with organizations, agencies, and institutes that focus on poverty reduction

1. Collaborate and partner with the following organizations and agencies that are already engaged and/or leading poverty reduction initiatives and activities across the state such as NC Community Action Association and NC Child

10B. Formulate and/or enhance ways that data can be collected to comprehensively track on how living in poor or near poor homes and communities affects health outcomes over the life course

1. Collaborate and partner with the following organizations and agencies that are already engaged and/or leading poverty reduction initiatives and activities across the state such as NC Community Action Association and NC Child

10C. Recommend and support legislation of a livable wage and equity in compensation

1. Collaborate and partner with the following organizations and agencies that are already engaged and/or leading poverty reduction initiatives and activities across the state such as NC Community Action Association and NC Child

10D. Standardize poverty reduction strategies into systems, services, and programs
1. Expand effective financial literacy curriculums in services and programs for families by integrating consistent use of evidence-based financial literacy curriculum, e.g., Bridges Out of Poverty
2. Collaborate with organizations/advocates that work to stop predatory lending to low-income families and to repeal the NC food tax

Point 11. Support working mothers and families

11A. Create and expand paid parental and sick leave policies
1. Identify research that other states have done to create policies through key informant interviews (including work done by National Partnership for Women and Families and through university business schools)
2. Promote the evidence base around policies to promote paid parental (mothers, fathers, partners) leave and sick leave (disability insurance/act)
3. Create and expand safe work place environments and accommodations for pregnant and breastfeeding women; develop policy recommendations around safe work environments and identify models of excellence

11B. Increase affordable, available, and accessible high quality child care
1. Identify and publish geographic gaps to inform policies and guide future funding decisions of high quality child care centers
2. Identify and engage in ongoing efforts with other state and national partners to expand access to high quality child care for low wage working families

11C. Increase support for breastfeeding
1. Promote expansion and regulation for the Business Case for Breastfeeding model by integrating policies and best practice standards in labor laws and work place policies
2. Train a diverse workforce to support breastfeeding (e.g., clinical, peer support); identify resources for scholarships to train diverse resources; incorporate training and resources in state programs; promote linkages between community health workers and clinical professionals; credentialing
3. Locate resources to compensate a diverse workforce to support breastfeeding; compile research on funding models in other states; develop and submit request to support increase in reimbursement

11D. Create safe work place and incarceration environments for women
1. Make all public workplaces in North Carolina smoke free
2. Provide tobacco cessation services through employee health benefits packages
3. Improve the quality of perinatal care for incarcerated women
4. Work with employers and payers to offer evidence-based tobacco cessation services for their employees or members at no cost (ACA requirement)

Point 12. Undo racism

12A. Infuse and incorporate equity in the delivery of health services
1. Support and fund a fully functioning NC Office of Minority Health and Health Disparities to promote and implement this plan in all local health departments, rural services, and CBOs receiving any funds from NC DHHS
2. Engage and employ consumers of our programs, services, and initiatives in the planning, design, and implementation of health delivery services
3. Collaborate with stakeholders working specifically on addressing disparities in perinatal health to build on community health assessment process to identify needs and goals
4. Build and strengthen trust in communities by engaging community health workers that are from the community that is being served
5. Promote use of the Health Equity Review Planning Tool

12B. Promote high quality training about institutional and structural racism and its impact on poor communities and communities of color
1. Partner with NC Racial Equity Institute/Open Source/People's Institute, etc. to expand their training across the state by providing funding, support, and access to partner database
2. Partner with NC AHEC to include health equity training within the standard curriculum for medical, nursing, and other healthcare professional students

12C. Modify and change policies and practices to address institutional and structural racism
1. Collaborate with and fund outside consulting services that have a strong record in systems change and implementing health equity such as *Community Catalyst*
2. Formally collaborate/partner with entities such as the North Carolina Chapter of the National Diversity Council and NC AHEC in diversifying healthcare leadership in local areas to reflect the communities they service
3. Promote policies that enforce collecting health disparities data and developing data dashboards to be implemented in all hospitals in NC by partnering with the NC Hospital Association

12D. Promote community and systems dialog and discussion on racism
1. Collaborate with and incorporate dramatic arts in the dissemination of "issues" to encourage dialogue across systems
2. Partner with existing organizations and collaboratives that are working to address racism to create opportunities for discussion across systems

Special thanks to the **Perinatal Health Strategic Planning Committee** for their leadership, commitment, and guidance in the development of this Strategic Plan.

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This report was published on ~~April~~ June------, 2018. This report can also be found online at (link to CCPT-CFPT DCo webpage).