NC Perinatal Health Strategic Plan

2022-2026

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Public Health

Table of Contents

Introduction/Executive Summary

The NC Perinatal Health Strategic Plan (PHSP) serves as a statewide guide to improve maternal and infant health and the health of all people of reproductive age. The plan's primary focus is increasing health equity, which is the opportunity for every person to have good health regardless of social and economic factors. The first PHSP was implemented in 2016, and the state continues to strive to achieve perinatal health equity. Rates of infant and maternal mortality are much higher for Black infants and mothers than for non-Hispanic white infants and mothers. The effects of structural racism have always impeded the ability of Black, Indigenous, and People of Color (BIPOC) to achieve the best possible health, and that has been compounded by the economic and social crises created by the COVID-19 pandemic. This plan, created for 2022-2026, seeks to address both the challenges of structural racism and of the pandemic by focusing on the drivers of health. These drivers of health (sometimes called social determinants of health) are the factors that influence and affect our health in the environments where we live, learn, work, worship, and play.

The PHSP framework is 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. Based on this framework, the PHSP includes three primary goals:

1) addressing economic and social inequities,
2) strengthening families and communities, and
3) improving health care for all people of childbearing age.

Beneath each goal are the four points that move that goal forward, and beneath each point are strategies to carry out the work that will improve health equity across the state. Where the PHSP calls for programs, services, and care, the best evidence-based and evidence-informed practices should be used, and those practices should be community- and person-centered.

This update establishes greater accountability by putting into place a monitoring plan with dozens of data indicators to track outcomes, including four overarching indicators. These overarching indicators are:

1) to eliminate the Black/white disparity in infant mortality,
2) to eliminate the Black/white disparity in severe maternal morbidity (excluding transfusions)
3) to decrease the percentage of preterm births to 7.3% or less for all racial/ethnic groups, and
4) to increase health insurance rates to 90% or above for all racial/ethnic groups.

The PHSP Data and Evaluation Workgroup developed the monitoring plan over several months with input from public health experts across the state. The workgroup will provide an annual update on these measurements on the PHSP website.

This revision strives to use language inclusive of all genders with the recognition that full equity and inclusiveness have not yet been achieved. To promote inclusivity, and out of respect for the diversity of identities of those who reside in North Carolina who are pregnant and give birth, the PHSP uses the terms "birthing person," "mother," "pregnant woman," and "pregnant person" in an all-inclusive manner. Some strategies refer specifically to fathers because of continued efforts to achieve greater involvement of men in reproductive health care and childcare. These outreach efforts should be inclusive of co-parents and caregivers regardless of gender identity.

The NC Division of Public Health (DPH) brought together more than 100 stakeholders from across the state, currently known as the Perinatal Health Equity Collective, to develop this revised plan and will continue to work with public, nonprofit, and private partners to implement the plan and assess progress. Since the plan's inception, other statewide plans, such as the NC Early Childhood Action Plan and Healthy NC 2030 have aligned with the PHSP.

Goal 1 – Address Economic and Social Inequities

- Point 1. Undo racism
- Point 2. Support working parents and families
- Point 3. Reduce poverty among people of reproductive age and families
- Point 4. Close the education gap

Goal 2 – Strengthen Families and Communities

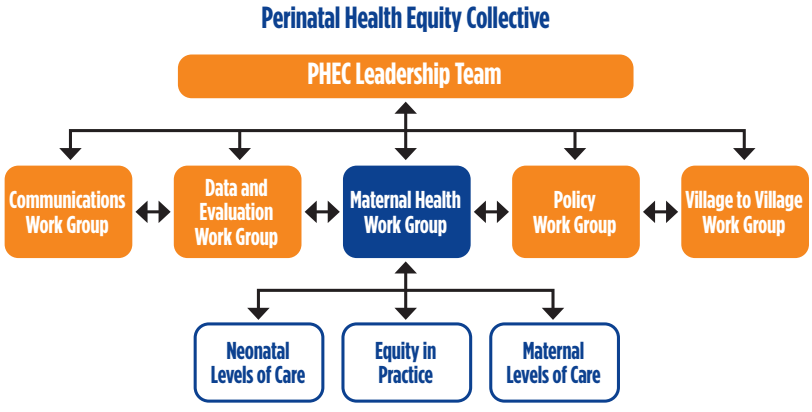
- Point 5. Invest in community building
- Point 6. Support coordination and cooperation to promote reproductive justice within communities
- Point 7. Enhance coordination and integration of family support services
- Point 8. Strengthen father and co-parent involvement in families

Goal 3 – Improve Health Care for All People of Reproductive Age

- Point 9. Expand access to high quality health care
- Point 10. Improve access to and quality of maternal care in all settings
- Point 11. Increase access to preconception, reproductive, and sexual health care for people of reproductive age
- Point 12. Provide interconception care

The PHSP strives to find alignment and collaboration opportunities with other initiatives occurring in the state. This includes connecting with consumer, community, and organizational partners to share and evaluate the plan.

The Perinatal Health Equity Collective (PHEC) meets every two months. Five work groups meet more frequently to further the work of the PHSP. These work groups include:



- **Communications –** promotes and shares the intent and goals of the PHSP to audiences and stakeholders across North Carolina.
- **Data and Evaluation –** compiles data annually for the PHSP Data Indicators and monitors new data sources. In addition, they promote data quality improvement and assist other PHEC work groups to move data to action, focusing on a research action plan and providing technical assistance for the environmental scan.

- **Maternal Health –** represents the work of the former Maternal Health Task Force, led by the North Carolina Institute of Medicine (NCIOM). Partners and experts from across North Carolina will work to identify evidence-based solutions to best improve maternal health outcomes. At least three action teams will fall under this work group: Maternal Levels of Care, Neonatal Levels of Care, and Equity in Practice.
- **Policy –** advocates for and promotes policies found in the PHSP through education and information sharing.
- **Village to Village –** formerly known as the Community and Consumer Engagement Work Group, this group strives to develop a network of preconception and interconception consumers and community members from across North Carolina who can create strategies and activities to strengthen the PHSP.

By eliminating inequities, we will improve the overall well-being of our state's individuals and communities.

For more information on the PHSP, to join as a partner, or to share ways that we can collaborate with you, please email PHSPquestions@dhhs.nc.gov.

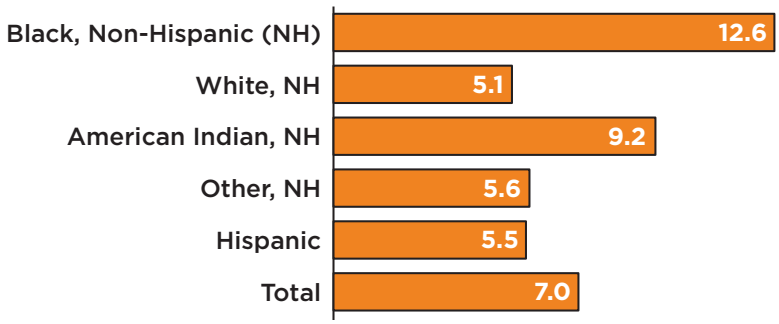
Data Notes

In an attempt to highlight inequities in health outcomes due to interpersonal, institutional, and systemic racism, every effort has been made to provide data for racial and ethnic population groups for North Carolina for each of the indicators. Where that is not possible due to data collection methods or because of small sample size, N/A (Not Available) has been noted in the data tables to highlight where additional efforts need to be made to be able to collect these important data as part of the ongoing work of the Perinatal Health Equity Collective.

Overarching Indicators

1) Eliminate the Black/white disparity in infant mortality

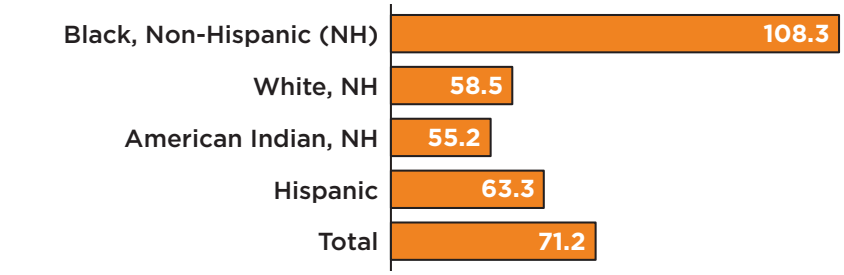
NC Baseline (2015-19) Ratio	2026 Goal
2.5	1.9



Source: NC Vital Statistics/State Center for Health Statistics (SCHS)

2) Eliminate the Black/white disparity in severe maternal morbidity (excluding transfusions)

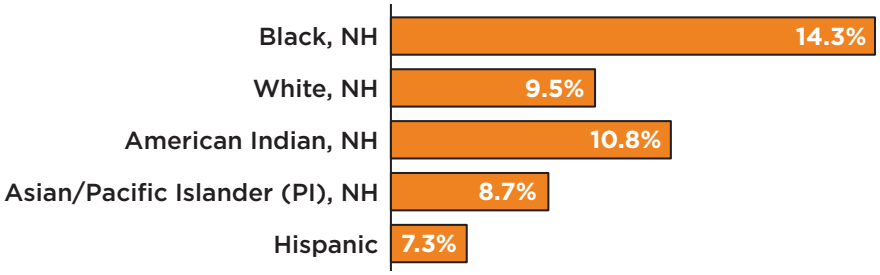
NC Baseline (2015-19) Ratio	2026 Goal
1.9	1.7



Note: Rates are per 10,000 delivery discharges.
Source: NC Vital Statistics/State Center for Health Statistics (SCHS)

3) Decrease the percentage of preterm births to 7.3% or less for all racial/ethnic groups

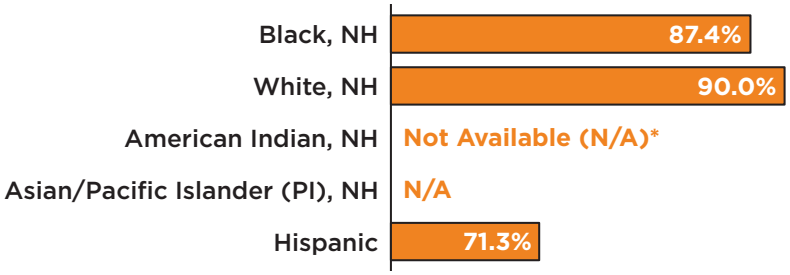
NC Baseline (2019) Total	2026 Goal
10.7%	7.3%



Source: NC Vital Statistics/State Center for Health Statistics (SCHS)

4) Increase health insurance rates to 90% or above for all racial/ethnic groups

NC Baseline (2019) Total	2026 Goal
87.3%	90.0%



Source: NC Vital Statistics/State Center for Health Statistics (SCHS)

*See Data Notes for more information.

Plan Goals, Points, Strategies, & Indicators

Goal 1 – Address Economic and Social Inequities

POINT 1. UNDO RACISM

- 1A Implement or update policies within public service agencies at state and local levels to reduce institutional and structural racism
- 1B Implement training to ensure high-quality data collection and analysis on race, ethnicity, gender identity, and disability status across health systems
- 1C Increase the number of health systems using data on race and ethnicity to improve the delivery of health services and monitor equity
- 1D Provide training to all NCDHHS staff and ongoing professional development on equity that builds understanding of and competencies to advance health equity
- 1E Perinatal health care providers should participate in training around health equity, implicit bias, and cultural competency
- 1F Increase the number of counties that recognize racism as a public health crisis and use collaborative community dialog to develop plans to increase equity, safety, and well-being in communities
- 1G Develop and implement plans in the workplace to increase diversity, especially in leadership positions
- 1H Implement the Reentry Action Plan developed by the Department of Public Safety to foster successful reintegration into community, including job placement, for people who were formerly incarcerated

Point 1 Data Indicators

1.1 Eliminate the Black/white disparity in unemployment

NC Baseline (2015-19) Ratio	2.1
Black	9.1%
White, NH	4.3%
American Indian	8.2%
Hispanic	5.8%
Total	5.6%

Source: American Community Survey/US Census Bureau

1.2 Eliminate the Black/white disparity in short-term suspensions (rate per 10 students)

NC Baseline (2018-19) Ratio	3.8
Black	2.82
White	0.74
American Indian	2.17
Asian	0.31
Hispanic	0.79
Total	1.31

Source: NC Department of Public Instruction

1.3 Increase life expectancy (years)

NC Baseline (2016-18 average) Total	78
Black	75.5
White	78.3
American Indian	75.6
Hispanic	N/A

Source: NC Vital Statistics/SCHS

POINT 2. SUPPORT WORKING PARENTS AND FAMILIES

- 2A Create and expand legislation to provide paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers
- 2B Increase accessible high quality childcare for all children (including infants, toddlers, and those with special health care needs) by expanding the availability of child care subsidies and by increasing the subsidy rate to more adequately meet the cost of care
- 2C Strengthen policies to support breastfeeding in the workplace and in childcare centers, and increase knowledge and uptake of breastfeeding friendly policies
- 2D Increase enrollment in Pathway 2 and Pathway 3 lactation training programs, and increase reimbursement for the breastfeeding support workforce
- 2E Create safe and healthy workplaces for people of reproductive age by passing legislation to ensure reasonable pregnancy accommodations
- 2F Work with employers to ensure tobacco cessation services are provided to all employees
- 2G Eliminate taxation on sanitary products including menstrual supplies, diapers, and breastfeeding supplies

Point 2 Data Indicators

2.1 Increase the percentage of children ages 0 to 2 years whose families receive child care subsidies and are enrolled in 4- or 5-star centers

NC Baseline (2018) Total	11.6%
Black	N/A
White	N/A
American Indian	N/A
Hispanic	N/A

Source: NC Division of Child Development and Early Education

2.2 At least 87.5% of infants from all racial/ethnic groups are breastfed at hospital discharge

NC Baseline (2019) Total	80.8%
Black, NH	70.1%
White, NH	83.7%
American Indian, NH	51.7%
Hispanic	87.5%

Source: NC Vital Statistics/SCHS

POINT 3. REDUCE POVERTY AMONG PEOPLE OF REPRODUCTIVE AGE AND FAMILIES

- 3A Improve data collection to comprehensively track how living in poor or near-poor homes and communities affects health outcomes over the life course
- 3B Implement policies that ensure a livable wage and equity in compensation
- 3C Implement policies to reduce poverty (e.g., promote financial literacy education, increase uptake of the federal Earned Income Tax Credit, and restore the state Earned Income Tax Credit)
- 3D Maintain the COVID-19 enhancements to federal nutrition programs
- 3E Increase funding for stable, safe, and affordable housing, especially during times of disaster and recovery

Point 3 Data Indicators

3.1 Decrease the percentage of individuals living at or below 200% of the federal poverty level for all racial/ethnic groups

NC Baseline (2015-19) Total	34.4%
Black	47.6%
White	28.7%
American Indian/Alaskan Native	50.4%
Asian/Hawaiian Islander	27.9%
Hispanic	58.8%

Source: American Community Survey/US Census Bureau

3.2 Reduce the proportion of children living in households with a high housing cost burden

NC Baseline (2018) Total	27%
Black	41%
White	18%
American Indian/Alaskan Native	N/A
Asian/Hawaiian Islander	23%
Hispanic	36%

Source: Kids Count tracking of American Community Survey data

3.3 By 2025, decrease the percentage of children living in food insecure homes to 17.5%

NC Baseline (2018) Total	19.3%
Black	N/A
White	N/A
American Indian	N/A
Hispanic	N/A

Source: Feeding America

3.4 Increase home ownership among all racial/ethnic groups

NC Baseline (2015-19) Total	65.2%
Black	45.5%
White, NH	73.4%
American Indian	N/A
Hispanic	46%

Source: American Community Survey/US Census Bureau

POINT 4. CLOSE THE EDUCATION GAP

- 4A Increase high school and post-high school graduation rates, and promote and increase access to higher education, trade schools, and continuing education over the life course
- 4B Develop secondary and post-secondary education initiatives such as child care, parental leave, and breastfeeding accommodations to support educational goals during the childbearing years
- 4C Increase racial, ethnic, gender, and disability status diversity among school and child care leadership, school and child care staff, and the institutions that train them
- 4D Implement training with the early childhood workforce around social emotional health in families
- 4E Ensure that child care teachers receive compensation and benefits (including health insurance) that match their skills and education
- 4F Disrupt the school-to-prison pipeline, beginning with preschool, by reducing the use of school suspensions and expulsions and increasing the use of counseling services

Point 4 Data Indicators

4.1 At least 95% of all high school students will graduate within 4 years across all racial/ethnic groups

NC Baseline (School Year 19-20) Total	87.6%
Black	85.2%
White	90.7%
American Indian	85.1%
Asian/Pacific Islander	94.4%
Hispanic	81.7%

Source: NC Department of Public Instruction

4.2 Increase the percentage of income-eligible children enrolled in NC Pre-K statewide

NC Baseline (2018) Total	47.4%
Black	N/A
White	N/A
American Indian	N/A
Hispanic	N/A

Source: NC Division of Child Development and Early Education

4.3 At least 70% of students will be proficient in reading at the end of third grade

NC Baseline (School Year 18-19) Total	56.8%
Black	40.8%
White	70.1%
American Indian	44.5%
Asian/Pacific Islander	75.6%
Hispanic	42.6%

Source: NC Department of Public Instruction

4.4 Increase racial diversity among school administrators, teachers, and other professionals

NC Baseline (School Year 19-20) Total	-
Black	17.6%
White	77.6%
American Indian	5.8%
Hispanic	N/A

Source: NC Department of Public Instruction

POINT 5. INVEST IN COMMUNITY BUILDING

- 5A Lower barriers to broadband internet deployment
- 5B Educate community leaders and low-income households on affordable broadband options
- 5C Increase access to stable, safe, and affordable housing
- 5D Increase access to nutrition education and healthy foods by referring families to local WIC clinics and other nutrition food assistance and nutrition education resources (e.g., Supplemental Nutrition Assistance Program (SNAP), National School Lunch Program (NSLP), Child and Adult Care Food Program (CACFP), School Nutrition Program (SNP)
- 5E Incorporate active transportation infrastructure (e.g., sidewalks, bicycle routes, public transit) into jurisdictional planning
- 5F Reduce exposures to environmental toxins including, but not limited to, lead, agricultural pesticides, flame retardants, and Per- and Polyfluoroalkyl Substances (PFAS)
- 5G Support civic participation through building community networks and increasing voter participation and engagement with policymakers at the local and state levels
- 5H Invest in programs and resources to mitigate and reduce forms of community violence including intimate partner violence, police brutality and over-policing, gun violence, and human trafficking

Point 5 Data Indicators

5.1 Eliminate racial/ethnic disparities in the percentages of children <18 living in areas of concentrated poverty (Census tract with >=30 percent poverty)

NC Baseline (2014-2018) Total	9.4%
Black	20.1%
White	3.1%
American Indian	N/A
Hispanic	15.2%

Source: Kids Count tracking of American Community Survey data

5.2 Eliminate the racial/ethnic disparities in violent deaths (rate per 100,000 people)

NC Baseline (2017) Total	22.4
Black	26
White	23.4
American Indian	27.7
Asian/Pacific Islander	6.7
Hispanic	11.2

Source: NC Violent Death Reporting System

5.3 Increase the percentage of registered voters who voted across all racial/ethnic groups

NC Baseline (2018) Total	52.4%
Black	51.4%
White	54.4%
American Indian	N/A
Asian/Pacific Islander	45.8%
Hispanic	38.6%

Source: U.S. Census, Current Population Survey via Kaiser Family Foundation (KFF) State Health Facts

POINT 6. SUPPORT COORDINATION AND COOPERATION TO PROMOTE REPRODUCTIVE JUSTICE WITHIN COMMUNITIES

6A Increase implementation sites for programs that offer evidence-based and community-informed reproductive life planning, including Teen Pregnancy Prevention Initiatives (TPPI), Healthy Beginnings, and fatherhood initiatives

6B Develop and implement programs in schools and community settings about puberty, reproductive health care, healthy relationships, and selecting a provider for youth and their parents/caregivers

6C Work with state partners to implement reproductive life planning and reproductive justice trainings for health care providers, school staff, and others

6D Increase businesses, faith entities, and public buildings that qualify as breastfeeding friendly, and normalize breastfeeding in public spaces

Point 6 Data Indicators

6.1 By 2025, 75% of local health departments (LHDs) will have staff complete training on the reproductive justice framework, contraceptive methods, and reproductive life planning

NC FY21 Baseline Total	33%

Source: Women, Infant, and Community Wellness Section/Reproductive Health Branch reports from LHDs

6.2 Increase the percentage of women who say their pregnancy was intended

NC Baseline (2019) Total	55.9%
Black, NH	27.9%
White, NH	64.1%
American Indian, NH	N/A
Hispanic	60.8%

Source: NC Pregnancy Risk Assessment Monitoring System/SCHS

POINT 7. ENHANCE COORDINATION AND INTEGRATION OF FAMILY SUPPORT SERVICES

7A Increase enrollment of community agencies and providers into NCCARE360

7B Increase the use of NCCARE360 by Care Management for High-Risk Pregnant Women (CMHRP)

7C Decrease fragmentation in service delivery by automatically transitioning postpartum people on Pregnancy Medicaid to Medicaid, if eligible, or to the Be Smart Family Planning Medicaid Program

7D Complete a feasibility study on adding Medicaid coverage for antepartum, intrapartum, and postpartum doula services

7E Increase the number of Prepaid Health Plans (PHPs) that cover doula services

7F Increase the number of patient and family advisory councils within DPH agencies, and increase patient and community members on advisory boards of contracted partners

7G Elevate the role of community health workers in addressing the social drivers of health

7H Develop a statewide structure for maternal home visiting to ensure equitable access for all pregnant and postpartum women

7I Promote the use of the Breastfeeding Attrition Prediction Tool-Breastfeeding Control (BAPT-BFC), and/or another applicable screening tool, by maternal health providers to identify mothers at risk for not meeting their breastfeeding goal

7J Expand efforts to prevent infant deaths related to unsafe sleep environments

Point 7 Data Indicators

7.1 Increase the percentage of people served through NCCARE360 who have an accepted referral.

NC Baseline (2019) Total	85.0%
Black	89.0%
White	85.0%
American Indian	92.0%
Hispanic	78.0%
Undisclosed Race (23% of total)	75.0%
Undisclosed Ethnicity (29% of total)	79.0%

Source: NCDHHS/NCCARE360

7.2 Increase the percentage of children ages 12-17 who receive services needed to transition to adult health care, and close the racial disparity

NC Baseline (2018-19) Total	20.4%
Black, NH	N/A
White, NH	19.0%
American Indian, NH	N/A
Hispanic	N/A

Source: National Survey of Children's Health

POINT 8. STRENGTHEN FATHER AND CO-PARENT INVOLVEMENT IN FAMILIES

8A Increase implementation sites for evidence-based parenting programs to strengthen parenting skills (e.g., Family Connects, Triple P, Centering Parenting, Nurturing Parenting)

8B Improve/develop guidelines for the inclusion of males and other caregivers in preconception, prenatal, interconception, postpartum, and early childhood health and human services

8C Institute gender equity in policies, and use evidence-based strategies to promote healthy family relationships (e.g., normalizing the use of paid family leave and kin care leave by fathers, installing changing tables in men's restrooms)

8D Increase implementation sites for evidence-based fatherhood programs to promote fatherhood engagement within the family (e.g., 24/7 Dad and DoctorDad)

Point 8 Data Indicators

8.1 Increase the percentage of parents who say they receive emotional support from a spouse or domestic partner

NC Baseline (2018-19) Total	78.8%
Black, NH	66.9%
White, NH	85.4%
American Indian, NH	N/A
Hispanic	N/A

Source: National Survey of Children's Health

8.2 Eliminate the Black/white disparity in the incarceration rate (per 100,000)

NC Baseline (2017) Ratio	4.5
Black	915
White	203
American Indian	488
Hispanic	209
Total	341

Source: US Bureau of Justice Statistics

Goal 3 – Improve Health Care for All People of Reproductive Age

POINT 9. EXPAND ACCESS TO HIGH QUALITY HEALTH CARE

9A Expand Medicaid to provide affordable, comprehensive health, behavioral health, and dental insurance coverage, including mobile health and telehealth, for all

9B Increase access to and utilization of the comprehensive adolescent well visit, including time for confidential reproductive health conversations between provider and patient

9C Increase flexibility in office hours of providers to include evenings and weekends, and ensure that care is affordable

9D Increase the uptake of vaccinations

9E Implement more community-informed education, including a social media campaign aimed at men, to increase use of preventive health care

9F Create and engage patient and family advisory councils that have influence in decisions at hospitals and clinics

9G Increase access to and utilization of medical and dental homes

9H Expand access to family centered SUD treatment, including services for opioid use disorders

9I Implement the NC Area Health Education Centers (AHEC) Scholars program to recruit and train students of color and students from rural backgrounds to become providers in underserved areas

9J Expand the use of health innovations such as mobile health, telehealth, and linked electronic health records (EHR), and maintain gains made in this area during the COVID-19 pandemic

9K Make it easier for families and people of reproductive age to receive mental, physical, and behavioral health supports, including breastfeeding support, during times of disaster and recovery

9L Increase the use of Medicaid Transportation to ensure appointments are accessible

Point 9 Data Indicators

9.1 At least 84% of people ages 18-44 will have received a routine checkup in the past year

NC Baseline (2019) Total	79.1%
Black, NH	84.0%
White, NH	79.8%
American Indian, NH	77.2%
Hispanic	63.9%

Source: NC Behavioral Risk Factor Surveillance System (BRFSS)/SCHS

9.2 Increase the percentage of adolescents ages 12 through 17 who have a preventive medical visit in the past year

NC Baseline (2016-17) Total	81.0%
Black, NH	72.7%
White, NH	87.1%
American Indian, NH	N/A
Hispanic	76.1%

Source: National Survey of Children's Health

9.3 Increase the percentage of medical school graduates who identify as Black, American Indian, or Hispanic

NC Baseline (2016-17) Total	-
Black	10%
White	63%
American Indian	0%
Hispanic	2%

Source: Association of American Medical Colleges via KFF

POINT 10. IMPROVE ACCESS TO AND QUALITY OF MATERNAL CARE

10A Expand the use of evidence-based and evidence-informed models of perinatal care highlighted in the Maternal Health Innovation Program, including doula services, group prenatal care, group child visits, and community health workers

10B Integrate the Alliance for Innovation on Maternal Health (AIM) bundles championed by the Perinatal Quality Collaborative of North Carolina (PQCNC) into maternal care

10C Improve access to and utilization of first trimester prenatal care and comprehensive postpartum care

10D Expand access to prenatal care by passing legislation that allows the Children's Health Insurance Program (CHIP) to cover immigrants without documentation

10E Pass legislation supporting full practice authority for certified nurse-midwives

10F Adopt maternal and neonatal risk-appropriate levels of care that align with national standards

10G Increase use of the Levels of Care Assessment Tool (LOCATe) by delivering/birthing hospitals

10H Improve maternal care for incarcerated pregnant people by eliminating the use of shackling and ensuring adequate prenatal and postpartum care, nutrition, and breastfeeding support

10I Improve WIC utilization in the first trimester by referring pregnant people to local WIC clinics

10J Increase utilization of dental care by Medicaid for Pregnant Women recipients

10K Promote access to comprehensive breastfeeding education and support services including medical lactation services

10L Integrate the CDC's Hear Her campaign on post-birth warning signs into provider and patient education

10M Increase use of the North Carolina Psychiatry Access Line (NCPAL)/ NC Maternal Health MATTERS Line to improve access to maternal mental health services

10N Develop an evidence-based assessment tool to aid North Carolina health care facilities in assessing their capabilities for the provision of perinatal mental health care

10O Increase use of the NC Perinatal Substance Use Project hotline to improve access to Substance Use Disorder (SUD) treatment for pregnant, postpartum, and parenting people

10P Develop and implement a public health awareness campaign around maternal health for the general public

10Q Support the creation of a statewide 24-hour breastfeeding support hotline

10R Develop education on trauma-informed breastfeeding support and consultation for maternal and pediatric care providers

10S Establish a licensure board for the provision of lactation services provided by Lactation Consultants (IBCLCs) and Lactation Counselors (CLCs)

Point 10 Data Indicators

10.1 Increase the percentage of infants born to people receiving prenatal care in their first trimester

NC Baseline (2019) Total	73.3%
Black, NH	66.3%
White, NH	80.2%
American Indian, NH	66.4%
Other, NH	73.2%
Hispanic	61.9%

Source: NC Vital Statistics/SCHS

10.2 Eliminate the Black/white disparity in fetal mortality rate (per 1,000 deliveries)

NC Baseline (2015-2019) Ratio	2.2
Black, NH	11.3
White, NH	5.1
Other, NH	5.8
Hispanic	5.6
Total	6.7

Source: NC Vital Statistics/SCHS

10.3 Increase the percentage of WIC-eligible families that receive WIC services

NC Baseline (2019) Total	58.0%
Black	N/A
White	N/A
American Indian	N/A
Asian/Pacific Islander	N/A
Hispanic	N/A

Source: NC Nutrition Services Branch

10.4 Increase the percentage of MPW recipients who receive at least one dental service

NC Baseline (SFY 2019) Total	6.8%
Black	8.0%
White	6.3%
American Indian	6.5%
Asian	7.3%
Hispanic	3.7%

Source: NC Medicaid

POINT 11. INCREASE ACCESS TO PRECONCEPTION, REPRODUCTIVE, AND SEXUAL HEALTH CARE FOR PEOPLE OF REPRODUCTIVE AGE

- 11A Include preconception and reproductive health in health education programs to reach students of all genders in middle schools, high schools, colleges, universities, graduate schools, community colleges, and adult learning programs
- 11B Increase Prepaid Health Plan (PHP)/payor implementation of preconception health screenings during primary care visits
- 11C Increase the number of programs that provide adolescents with information on reproductive health and healthy relationships (e.g., PREPare for Success)
- 11D Eliminate coercion and bias in service delivery and barriers to contraceptive access for people of reproductive age
- 11E Implement the Be Smart Family Planning Medicaid Strategic Plan
- 11F Increase access to reproductive life planning and referrals to resources in the NC Perinatal and Maternal Substance Use and CASAWORKS for Families Residential Initiatives
- 11G Increase social media campaigns on preconception health awareness (e.g., Ready for Life and Show Your Love)
- 11H Implement the "Get Real. Get Tested. Get Treatment." campaign to increase testing and treatment for sexually transmitted infections

Point 11 Data Indicators

11.1 Decrease the percentage of people who smoke in the 3 months before pregnancy

NC Baseline (2019) Total	10.1%
Black, NH	10.3%
White, NH	12.8%
American Indian, NH	21.6%
Hispanic	2.3%

Source: NC Vital Statistics/SCHS

11.2 Decrease the birth rate for 15- to 17-year-olds (rate per 1,000)

NC Baseline (2019) Total	7.7
Black, NH	11.4
White, NH	4.0
American Indian, NH	15.3
Hispanic	16.3

Source: NC Vital Statistics/SCHS

11.3 Increase the percentage of LHDs offering same day insertion of both contraceptive implants and intrauterine devices

NC Baseline (2019) Total	74%

Source: NC Family Planning LHD Clinical Practice Survey

11.4 Reduce the newly diagnosed HIV annual rate to 7.8 (rate per 100,000 people)

NC Baseline (2019) Total	15.6
Black, NH	45.0
White, NH	5.2
American Indian, NH	16.5
Asian/Pacific Islander, NH	7.0
Hispanic	21.2

Source: NC HIV Surveillance Report

POINT 12. PROVIDE INTERCONCEPTION CARE

12A Increase the number of primary care providers across the state

12B Increase the number of primary care providers who accept Medicaid

12C Expand Medicaid coverage to 12 months for the postpartum period

12D Expand Medicaid for Pregnant Women (MPW) dental coverage to at least 60 days postpartum

12E Eliminate coercion in service delivery and barriers to contraceptive access for people of reproductive age, and implement patient-centered decision-making strategies

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

12G Increase pediatric sites partnering to implement efforts focused on maternal health such as depression and tobacco use screenings (e.g., IMPLICIT Network)

12H Increase reimbursement for services that are recommended by the 4th Trimester Project, especially education on post-birth warning signs

12I Increase care coordination through the implementation of the Provider Support Network, including the re-establishment of the Perinatal and Neonatal Outreach Coordinator program

12J Increase the number of provider trainings on the AIM postpartum bundle

Point 12 Data Indicators

12.1 Increase the percentage of continuously enrolled Medicaid recipients who had a primary care visit within 12 months of delivery

NC Baseline (2019) Total	16.8%
Black, NH	18.4%
White, NH	14.7%
American Indian, NH	17.9%
Hispanic	19.1%

Source: Linked NC Medicaid and Vital Statistics birth data/SCHS

12.2 Reduce the proportion of pregnancies conceived within 18 months of previous birth

NC Baseline (2019) Total	37.6%
Black, NH	37.7%
White, NH	40.3%
American Indian, NH	39.7%
Hispanic	30.4%

Source: NC Vital Statistics/SCHS

North Carolina's Maternal Health Efforts

As part of the NC Maternal Health Innovation Program, DHHS and the NC Institute of Medicine (NCIOM) launched the Maternal Health Task Force in the summer of 2020. The Maternal Health Task Force convened healthcare providers, community organizers and advocates, consumers, researchers, and other key partners from across North Carolina. Members of the Maternal Health Task Force identified the evidence-based recommendations presented here to best improve maternal health outcomes to support the target outcomes of North Carolina's Maternal Health Innovation Program:

- Reduce the Severe Maternal Morbidity rate by 10% from the 2019 baseline value of 76.9 cases per 10,000 deliveries by September 29, 2024.
- Reduce the Pregnancy-Related Mortality rate by 10% from the 2016 baseline value of 20.7 deaths per 100,000 deliveries by September 29, 2024.
- Reduce the rate of Severe Maternal Morbidity by 10% among non-Hispanic Black women from the 2019 baseline value of 124.9 cases per 10,000 deliveries to 112.4 cases per 10,000.

In March 2022, a decision to further streamline existing state maternal health efforts was made to embed the Maternal Health Task Force and its recommendations into the broader structure of the Perinatal Health Equity Collective and Perinatal Health Strategic Plans. These priorities were chosen based on the primary challenges impacting maternal health in North Carolina, as identified by members of the Maternal Health Task Force: disparities in maternal mortality, lack of standardized and modernized assessment of levels of care provided in hospitals, and challenges for access to care in rural areas.

Recommendation 1. Improving Access to Maternal Care

1.1 EXPAND CONTINUOUS POSTPARTUM MEDICAL COVERAGE FOR MEDICAID-ELIGIBLE WOMEN IN NORTH CAROLINA

The North Carolina General Assembly should direct Medicaid to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services to expand continuous postpartum Medicaid coverage through one year after birth.

1.2 STATEWIDE ANALYSIS OF DOULA SUPPORT SERVICES

1. To inform the development of insurance coverage and reimbursement policies for doula support services in North Carolina, the North Carolina Department of Health and Human Services Division of Public Health should conduct a statewide landscape analysis of doula support services. The following should be assessed in the analysis:
    a. The availability of doulas and doula services across the state and the diversity of providers of doula services (demographics and background).
    b. Standards for the attestation, training, and certifications of doulas.
    c. Practical options for coverage policies that include or incentivize doula support services during pregnancy, labor, and delivery; and during the postpartum period as part of value-based payments, enhanced reimbursements, or as value-added services.

d. Focus groups with doulas across the state to further inform and acquire input on the development of insurance coverage and reimbursement policies.

2. After completion of the landscape analysis, the North Carolina Department of Health and Human Services Division of Public Health should implement the following processes:
    a. Partner with community-based doulas/community-based doula collectives, doula training programs and childbirth education organizations, such as DONA International, Birth Arts International, Childbirth and Postpartum Professional Association, and the International Childbirth Education Association, to set standards for attestation and training and certifications of doulas in North Carolina.
    b. Develop doula services coverage and reimbursement options and strategies for North Carolina Medicaid and Private Insurers to consider.
    c. Develop Standards for agency billing.
    d. Create a statewide directory of doula service providers and services.
    e. Develop a system to reimburse for doula training and certification.
3. To provide support and resources for implementing the processes in Section 2, the North Carolina General Assembly should appropriate funding to the North Carolina Department of Health and Human Services Division of Public Health.

1.3 EXPAND ACCESS TO COMPREHENSIVE PRENATAL CARE FOR UNDOCUMENTED WOMEN WHO RESIDE IN NORTH CAROLINA

The North Carolina General Assembly should expand access to comprehensive prenatal care for all Medicaid-eligible women who reside in North Carolina, regardless of immigration status.

1.4 ADOPT MATERNAL AND NEONATAL RISK-APPROPRIATE LEVELS OF CARE THAT ALIGN WITH NATIONAL STANDARDS.

1. The North Carolina Division of Health Services Regulation (NCDHSR) should work with the Division of Public Health and stakeholders to review and update:
    a. North Carolina Administrative Code 10A NCAC 13B .4301-04 (maternal services) to reflect the uniform, nationally recognized, and evidence-based guidelines for regionalized and risk-appropriate maternal levels of care offered by ACOG/SMFM (American College of Obstetricians and Gynecologists/Society for Maternal-Fetal Medicine;
    b. North Carolina Administrative Code 10A NCAC 13B .4305-08 (neonatal services) to reflect the uniform, nationally recognized, and evidence-based guidelines for regionalized and risk-appropriate neonatal levels of care offered by the American Academy of Pediatrics (AAP). The NCDHSR should ensure that these rule updates do not conflict with other North Carolina Administrative Codes. If there are conflicting rules, they should be included in and mirror this update.
2. The Medical Care Commission should approve updates to North Carolina Administrative Code 10A NCAC 13B .4301-08; and,

3. Once the rulemaking process is complete, the NC DHSR should update the hospital licensure form to include a section that will allow for all facilities submitting the form to indicate their highest level of maternal care services available.

1.5 REQUIRE EXTERNAL VERIFICATION OF BIRTHING FACILITIES' MATERNAL AND NEONATAL LEVEL OF CARE DESIGNATIONS

The North Carolina General Assembly should implement legislation requiring:

1. External verification every three years by staff as designated by the North Carolina Division of Health Services Regulation, for any birthing facility in North Carolina that self identifies as providing Level I maternal or neonatal care.
2. External verification every three years by staff as designated by the North Carolina Division of Health Services Regulation, of facilities that have self-identified as maternal and/or neonatal Level II, Level III, and Level IV facilities.
    a. External Neonatal Levels of Care Verification should be conducted by the American Academy of Pediatrics Newborn Intensive Care Unit (NICU) Verification Program.
3. External maternal care Level II, III, or IV verification should be conducted by the American College of Obstetricians and Gynecologists/Society for Maternal-Fetal Medicine Levels of Maternal Care verification program.

1.6 RE-ESTABLISH NORTH CAROLINA'S PERINATAL AND NEONATAL OUTREACH COORDINATOR PROGRAM

1. Funding for at least one Perinatal and one Neonatal Outreach Coordinator per regional perinatal center and one Program Coordinator should be provided by:
    a. The North Carolina General Assembly should allocate $1.25 million in recurring state appropriations to support half the cost of up to 10 Perinatal and 10 Neonatal Outreach Coordinators and roles;
    b. Regional perinatal centers should cover half the cost of their own Perinatal and Neonatal Outreach Coordinator positions, so they can fulfill the duties of regional perinatal health care centers and neonatal intensive care units, referred to by the American College of Obstetricians and Gynecologists/ Society for Maternal-Fetal Medicine maternal level of care guidelines and the American Academy of Pediatrics neonatal level of care guidelines.
2. The North Carolina Division of Public Health should administer state funding for Perinatal and Neonatal Regional Outreach Coordinator positions, including outlining the duties and responsibilities of Perinatal and Neonatal Regional Outreach Coordinator positions receiving state funding. Duties and responsibilities should include:
    a. Developing and fostering relationships between all referring health care centers located in their region.
    b. Working with health care center evaluation teams in their designated region to identify the most appropriate self-identified level of neonatal and maternal care.

c. Developing management procedures and systems of referral for transport and back-transport to different facilities within their region.

d. Developing relationships with all birthing facilities in their region to ensure they are best meeting quality, performance, and best practice standards outlined in North Carolina Administrative Code 10A NCAC 13B .4301-08 (when updated).

e. Attending quarterly meetings with all regional Perinatal and Neonatal Coordinators to discuss lessons learned, best practices, (i.e. relationship development), etc.

f. Attend monthly Provider Support Network Meetings.

1.7 PROMOTE SCREENING FOR MATERNAL RISK FACTORS DURING WELL CHILD VISITS

1. The North Carolina Academy of Family Physicians and the North Carolina Pediatric Society should partner with NC AHEC to educate their members on:
    a. The Implicit Interconception Care Model and providing maternal health screening within the context of well-child visits for screening for Maternal Behavioral Risk Factors.
    b. Importance of screening mothers at well-child visits for their children for risk factors that could have adverse effects on future birth outcomes, such as smoking, depression, family planning and birth spacing, multivitamins with folic acid use, and interpersonal violence.
    c. When scheduling well-child visits to also include the mother as the patient along with their child so that practices can bill for reimbursement for screening for maternal health risk factors.
2. NC Medicaid, prepaid health plans, and private payers should provide reimbursement for screening for the maternal health risks during well-child visits for children 0-24 months of age.

Recommendation 2. Maternal Care Quality Improvement and Data Collection

2.1 DEVELOPMENT OF ASSESSMENT TOOL TO AID IN EVALUATION OF PERINATAL MENTAL HEALTH CARE CAPABILITIES

The North Carolina Department of Health and Human Services Divisions of Health Services Regulation and Mental Health, Developmental Disabilities and Substance Abuse Services should partner with the North Carolina Healthcare Association to develop an assessment tool to aid North Carolina health care facilities in assessing their capabilities for the provision of perinatal mental health care.

2.2 ESTABLISHING STANDARDIZED PROTOCOLS FOCUSED ON BEST PRACTICES FOR MATERNAL CARE IN NORTH CAROLINA HOSPITALS

The North Carolina Healthcare Association should work with the Perinatal Quality Collaborative of North Carolina to educate and encourage their members to establish standardized safety protocols and guidelines similar to the Alliance for Innovation on

Maternal Health and other national safety bundles/guidelines focused on best practices for maternal care for the following:

1. Sepsis
2. Infection control
3. Management of hyperemesis
4. Discharge instructions/follow-up after pregnancy loss/miscarriage
5. Postpartum hemorrhage
6. Trauma
7. Screening for interpersonal violence
8. Use and access of telemedicine in emergency situations
9. Perinatal substance use and mental health screening
10. Cardiac conditions in obstetric care
11. Reduction of peripartum racial and ethnic disparities

2.3 IMPROVED TRANSITIONS OF CARE FOR POSTPARTUM WOMEN TO PRIMARY CARE

1. Organizations that provide professional support, practice guidelines, practice management and career support, and educational materials such as the American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives should partner with North Carolina AHEC to develop educational resources and guidance for maternal health care providers in North Carolina around the importance of the identification, referral, and transition of postpartum women to a primary care provider one-year after delivery. Educational resources and guidance should include:
    a. Screening for current primary care provider before delivery and during postpartum visits.
    b. Seamless referral and documentation of chronic conditions and other maternal health risks.
    c. Connecting and referring patients who do not have a primary care provider with a primary medical home.
2. The North Carolina Obstetrical and Gynecological Society and the North Carolina Affiliate of the American College of Nurse-Midwives, and the North Carolina Academy of Family Physicians should disseminate educational resources on the transition of postpartum women to primary care to their members.
3. The North Carolina Community Health Center Association and the North Carolina Association of Free & Charitable Clinics should encourage their members to develop relationships with maternal care providers to facilitate information about the referral process for postpartum women who are uninsured and underserved to primary care services offered at community health centers and free and charitable clinics.

Recommendation 3. Provider Education and Workforce Development

3.1 HEALTH CARE LICENSURE FOR LACTATION CONSULTANTS AND LACTATION COUNSELORS

The North Carolina General Assembly should establish a licensure board to formulate, promulgate, amend, and repeal procedures, rules, and regulations for the provision of lactation services provided by Lactation Consultants (IBCLCs) and Lactation Counselors (CLCs). The Licensure Board should be directed and have the authority for the following:

1. The licensing and regulations of the International Board of Lactation Consultant Examiners (IBCLC) and Certified Lactation Counselor (CLC).
2. Setting the standards and specifications for education, knowledge, and experience required for licensure as an IBCLC and CLC.
    a. In establishing these requirements, the Licensure Board should give due consideration to criteria established by the International Board of Lactation Consultant Examiners (IBLCE), The Academy of Lactation Policy and Practice (ALPP), or other national standards established by professional societies with expertise in the training and certification of IBCLCs and CLCs.
3. Establishment of a minimum standard of care for providing lactation care and services.
4. Establishment of a non-refundable application fee and license renewal fee.

3.2 FULL PRACTICE AUTHORITY FOR CERTIFIED NURSE-MIDWIVES

The North Carolina General Assembly should pass laws supporting full practice authority of certified nurse-midwives.

3.3 HEALTH CARE LICENSURE FOR CERTIFIED PROFESSIONAL MIDWIVES (CPM)

The North Carolina General Assembly should establish a licensure board to formulate, promulgate, amend, and repeal procedures, rules, and regulations for midwifery practice by Certified Professional Midwives (CPMs). The Licensure Board should be directed and have the authority for the following:

1. The licensing and regulation of CPMs.
2. Setting the standards and specifications for education, knowledge, and experience required for licensure as a CPM.
    a. In establishing these requirements, the Licensure Board should give due consideration to criteria established by the North American Registry of Midwives (NARM) or other national standards established by professional societies with expertise in the training and certification of CPMs.
3. Establishment of a minimum standard of care for the provision of care by CPMs.
4. Establishment of a non-refundable application fee and license renewal fee.

3.4 TRAINING AND EDUCATIONAL RESOURCES FOR MATERNAL HEALTH PROVIDERS AROUND HEALTH EQUITY, IMPLICIT BIAS, AND CULTURAL COMPETENCY

Organizations with expertise in promoting health equity and reducing implicit bias in healthcare settings should partner with North Carolina AHEC to develop training and educational resources for maternal health care providers around health equity, implicit bias, and cultural competency.

1. The North Carolina Obstetrical and Gynecological Society, the North Carolina Affiliate of the American College of Nurse-Midwives, Nurses Association, North Carolina Academy of Physician Assistants, and the North Carolina Academy of Family Physicians should encourage their members to participate in training around health equity, implicit bias, and cultural competency.

3.5 EDUCATION ON TRAUMA-INFORMED BREASTFEEDING SUPPORT AND CONSULTATION

1. The March of Dimes and the North Carolina Breastfeeding Coalition should partner with North Carolina AHEC to develop educational materials for maternal and pediatric care providers on personal, societal, and contextual risk factors to the uptake of breastfeeding, such as:
    a. childhood trauma history
    b. maternal depression
    c. lack of social support from family, friends, or health care professionals
    d. chronic psychosocial stress
    e. racial discrimination and biased treatments
    f. low socioeconomic status
    g. inflexible work environments
2. The North Carolina Pediatric Society, North Carolina Academy of Family Physicians, and North Carolina Obstetrical and Gynecological Society, North Carolina Affiliate of American College of Nurse-Midwives should widely disseminate the developed education materials to their members.

Recommendation 4. Patient Support and Education

4.1 SUSTAINABLE MATERNAL HOME VISITING STATEWIDE LEADERSHIP STRUCTURE

The North Carolina Home Visiting and Parenting Education System should partner with the North Carolina Department of Health and Human Services and community-based home visiting programs to develop a statewide structure for maternal home visiting to ensure equitable access for all pregnant and postpartum women in North Carolina.

4.2 BREASTFEEDING CESSATION SCREENING AND SUPPORT REFERRAL

1. To identify postpartum women at risk for early cessation of breastfeeding, North Carolina maternal health care providers should use the Breastfeeding Attrition Prediction Tool–Breastfeeding Control (BAPT-BFC) and/or other applicable screening tools to identify mothers at risk for not meeting their breastfeeding goal.

2. North Carolina maternal health care providers should utilize statewide resource referral systems and directories such as NCCARE360 to refer mothers at risk for not meeting their breastfeeding goal to breastfeeding support resources in their community.

4.3 IMPLEMENT FAMILY-FRIENDLY WORKPLACE POLICIES

North Carolina employers, including the state, should provide pregnancy accommodations such as:

1. Paid family and medical leave.
2. Paid sick days.
3. Pregnancy and breastfeeding accommodations.

4.4 PUBLIC HEALTH AWARENESS CAMPAIGN ON MATERNAL HEALTH

The North Carolina Department of Health and Human Services should partner with the March of Dimes, Health Care Systems, and Advocacy Organizations to develop and implement a public health awareness campaign around maternal health for the general public around the following:

1. Delivering in a safe place if you have high-risk conditions.
2. Informing women of birth facility levels so they can be informed and advocate for themselves.
3. The importance of prenatal care and relay the risks of pregnancy.
4. Pre-conception health, Inter-conception health, and reproductive health and family planning.
5. Health system trust among people of color.
6. Levels of care.
7. Disparities in maternal health outcomes and care experiences.

Glossary

4th Trimester Project: The 4th Trimester project brings together new mothers, health care providers, researchers, and other stakeholders to build knowledge about postpartum health issues.

Adolescence: Stage of physical and psychological development that occurs between puberty and adulthood. The age range includes the teen years and can also include those younger than 13 and older than 18.

Adolescent well visit: A comprehensive visit should include adverse childhood experience (ACE) screening, social determinants of health (SDOH) screening, and conversation among adolescents, parents, and providers about respectful care.

AIM: The Alliance for Innovation on Maternal Health

Anticipatory guidance: Proactive counseling that health care providers offer to patients in anticipation of changes or problems with health that may arise between visits.

Be Smart Family Planning Medicaid Strategic Plan: Includes six key strategies, which are 1) expand agency and stakeholder partnerships that offer program services, 2) increase training opportunities for all agencies implementing the program, 3) provide training and outreach opportunities to program enrollees and potential recipients, 4) improve and clarify the process of determining eligibility for current and future beneficiaries, 5) create an easy access and enrollment process for consumers, and 6) provide automatic transitions from existing Medicaid programs for beneficiaries, caseworkers, and providers.

Birth spacing: The time interval between a woman birthing one child and a subsequent child. It is recommended that women have at least a 2-year interval between births for improved maternal and child health.

Breastfeeding: Also includes chestfeeding for those who do not identify as women.

CACFP: The Child and Adult Care Food Program

Care in all settings: Includes care in clinics, hospitals, schools, jails and prisons, transitional housing, and homeless shelters.

Care Management for High Risk Pregnancies (CMHRP): Provides intensive, face-to-face care management services to low-income women at increased risk of adverse birth outcomes. The goal of the CMHRP model is to improve the quality of maternity care, improve birth outcomes, and reduce costs by partnering with obstetrical providers to support clinical care plans as well as address social determinants of health.

Cultural humility: A commitment to self-evaluation and critique, to redressing power imbalances, and to developing mutually beneficial partnerships with communities.

Dental home: Consistent source of dental care, which includes, at minimum, an annual comprehensive dental exam.

Drivers of health: Includes educational, economic, environmental, ecological, and cultural factors that can greatly influence health and quality of life for individuals, populations, and communities.

Evidence-based clinical maternal care: Should include monitoring of early elective deliveries, cesarean rate, tobacco cessation, hypertensive disorders, gestational diabetes, mental health, substance use, intimate partner violence, perinatal mood disorders, exposure to environmental toxins, breastfeeding education, oral health, and dental home, etc.

Evidence-based prenatal care: Includes group-based care and doula services.

Evidence-informed care: Use of the best available research to guide the creation and implementation of programs.

Federal nutrition programs: Includes WIC, Supplemental Nutrition Assistance Program (SNAP), Electronic Benefit Transfer (EBT) cards, school meals, summer nutrition, and other safety net programs.

Financial literacy: Knowledge about personal finance, including loans, credit cards, and budgeting, that allows individuals to weather emergencies and plan for the future.

Health disparities: Measurable differences or gaps in a group's health status in relation to another group.

Health equity: The opportunity for everyone to have good health.

Health inequity: Unjust and avoidable differences that prevent everyone from having the opportunity for good health.

Infant mortality: The death of an infant before the first birthday.

Interconception care: The healthcare and ancillary services provided to a mother after the birth of one child and before the birth of a subsequent child.

Interconception care coordination/case management/home-visiting: The promotion of resiliency, mental health screening, substance use intervention, prevention of exposure to environmental toxins, tobacco cessation and prevention, patient-centered reproductive life planning, chronic disease management, oral health screening, food security, nutrition, and access to health care.

Intimate partner violence: Physical violence, sexual violence, stalking, or psychological harm by a current or former spouse or partner.

Lactation training programs: Pathway 1 programs are designed for health care professionals; Pathway 2 programs are comprehensive academic programs; and Pathway 3 programs train those outside of the health care professions through mentored clinical experience.

Levels of care: A classification system, set forth by the American College of Obstetricians and Gynecologists (ACOG) that establishes levels of maternal care that pertain to basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV). The goal of levels of maternal care is to reduce maternal morbidity and mortality, including existing disparities, by encouraging the growth and maturation of systems for the provision of risk-appropriate care specific to maternal health needs.

Long-acting reversible contraception (LARC): Highly effective birth control methods including intrauterine devices (IUDs) and implants.

Maternal care: Prenatal, labor, delivery, and postpartum care

Maternal care coordination/case management/home visiting: the promotion of resiliency, mental health screening, environmental health screening, substance use intervention, tobacco cessation and prevention, patient-centered reproductive life planning, chronic disease management, perinatal mood and anxiety disorders screening, oral health screening, food security, nutrition, and access to health care.

Maternal mortality: The death of a woman while pregnant or within one year of the end of pregnancy from any cause related to or aggravated by the pregnancy.

NCCARE360: A statewide coordinated care network that provides electronic connections between community resources and individuals in need of those resources.

NSLP: The National School Lunch Program

Patient advisory board: Also known as a family advisory board or a community advisory board or council; the goal is to increase communication and collaboration in clinics, health systems, and communities to create personalized patient- and family-centered care.

Patient-centered decision-making: Ensures that 1) a patient's physical comfort and emotional well-being are top priorities, 2) the patient's viewpoints are respected and valued, 3) the patient is always included in decisions, 4) the family is welcome in care settings, 5) care is given with full transparency and fast delivery of information, 6) the health care system's mission and values are aligned with patient goals, and 7) care is collaborative, coordinated, and accessible.

Perinatal period: The period immediately before and after birth, typically from the 20th week of gestation until 6 weeks after birth.

PFAS: Per- and polyfluoroalkyl substances

PQCNC: The Perinatal Quality Collaborative of North Carolina

Preconception health screenings: Recommended items include managing chronic conditions; medication, alcohol, tobacco, and substance use; prevention of exposure to environmental toxins; vaccinations; folic acid; maintaining a healthy weight; domestic violence; family health history; oral health; and mental health screenings.

Premature/preterm: Babies born before 37 weeks of pregnancy are complete.

Provider Support Network: The Provider Support Network will work closely with statewide groups and organizations, like PQCNC/AIM, to strengthen the quality of care for outpatient providers serving pregnant, postpartum, and interconception care women. The network will include Obstetric & Family Practice Champions, along with Perinatal Outreach Coordinators, and each of the six perinatal care regions will have one obstetrician and one Family Practice Champion. The network connects the OB and the Family Practice Champion to address overlapping needs that include, but are not limited to, providing consistent messaging and support on warning signs pertaining to severe maternal morbidity and mortality as well as providing information and prevention strategies to alleviate some of the long-term health effects of pregnancy complications.

Reproductive justice: The human right to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities.

Severe maternal morbidity (SMM): Includes the unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. Data for this indicator are analyzed using the Alliance for Innovation on Maternal Health SMM Codes List (https://safehealthcareforeverywoman.org/aim/resources/aim-data-resources/), although transfusions are excluded and peripartum cardiomyopathy is added. The SMM rates presented here are subject to change as specifications are modified by AIM.

SNAP: The Supplemental Nutrition Assistance Program

SNP: The School Nutrition Plus program

Social determinants of health: see Drivers of health

WIC: The Special Supplemental Nutrition Program for Women, Infants, and Children funded by the United States Department of Agriculture. The WIC program aims to safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

Sources

www.ncminorityhealth.org/definitions.htm

www.mchnavigator.org/documents/Glossary_of_MCH_Terms_and_Acronyms_2012-11-17.pdf

www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html

For cultural humility: https://journals.sagepub.com/doi/full/10.1177/1524839919884912#bibr17-1524839919884912

For lactation training programs: https://iblce.org/step-1-prepare-for-ibclc-certification/

Levels of maternal care: www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care

Maternal mortality: www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm

Patient-centered decision making: https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559

Reproductive justice: www.sistersong.net/reproductive-justice

Shared decision-making: www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/communication/strategy6i-shared-decisionmaking.html

Severe Maternal Morbidity (SMM): www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

WIC: www.fns.usda.gov/wic; www.nutritionnc.com/wic/index.htm

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Public Health

Women, Infant, and Community Wellness Section
www.dph.ncdhhs.gov • NCDHHS is an equal opportunity employer and provider. • 9/2022