Durham County
Fiscal Year 25 Mid-Year Report
Improving Community Outcomes for Maternal and Child Health (ICO4MCH)
Working together to improve maternal and child health in North Carolina

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ICO4MCH
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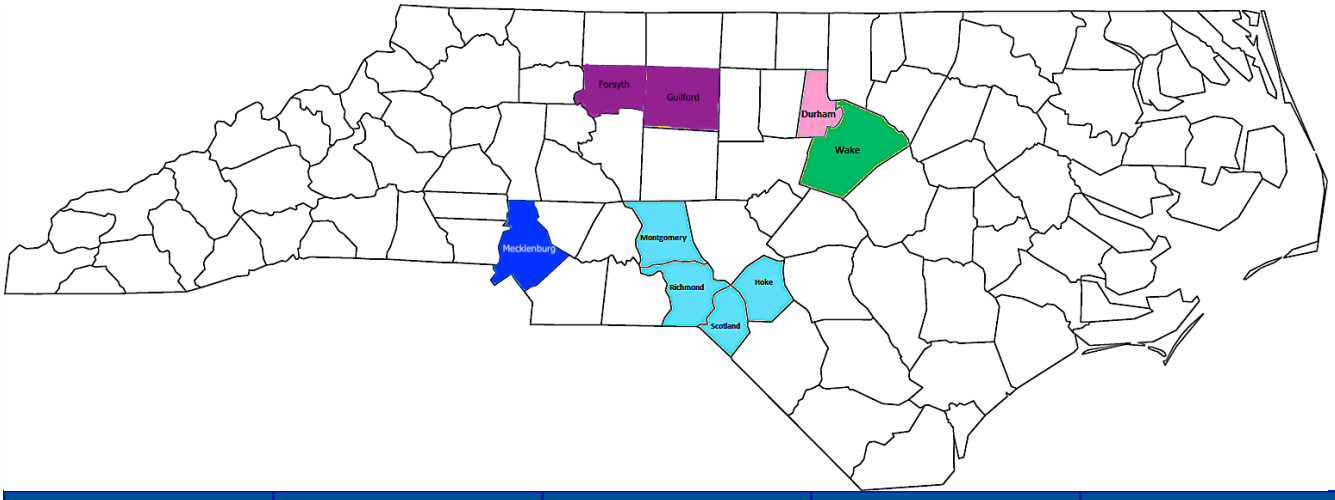
ICO4MCH Overview

In Session Law 2015-241, the North Carolina General Assembly allocated funding to be distributed to Local Health Departments (LHD) to implement evidence-based strategies (EBS) with the following aims: 1) Improving birth outcomes, 2) Reducing infant mortality, and 3) Improving child health ages 0 to 5. In June 2016, the NC Division of Public Health (DPH), Women, Infant, and Community Wellness Section funded five grantee LHDs to implement three evidence-informed strategies for two years. In June 2018, funding was renewed for the initial five grantee LHDs and Scotland County joined as a partner with Robeson County, increasing the reach of ICO4MCH from 13 to 14 counties. In June 2020, funding was renewed for four initial grantees, and a new grantee, Wake County, was added; 13 counties were funded for Fiscal Year (FY) 21-22. In June 2022, funding was renewed for four continuing grantees, and a new grantee, Guilford County was added; 9 counties were funded for FY23-24. In June 2024, funding was renewed for five continuing grantees; 9 counties were funded for FY24-25. Two of these grantees changed county composition: Mecklenburg Collaborative was previously composed of Mecklenburg and Union counties; Forsyth County joined Guilford County to create the Guilford-Forsyth Collaborative.

FY24-25 ICO4MCH Grantees (9 Counties)



Grantee	Counties	Improve birth outcomes	Reduce infant mortality	Improve child health, ages 0-5
Durham County	Durham	Preconception Health	Breastfeeding	Family Connects
Guilford-Forsyth Collaborative	Guilford, Forsyth	Preconception Health	Breastfeeding	Triple P
Mecklenburg Collaborative	Mecklenburg	Preconception Health	Breastfeeding	Triple P
Sandhills Collaborative	Hoke, Montgomery, Richmond, Scotland	Doula Services	Breastfeeding	Triple P
Wake County	Wake	Doula Services	Breastfeeding	Triple P

Evaluation Data and Measures

Performance measures for each evidence-based strategy (EBS) are collected from grantees quarterly in REDCap: Q1 (June, July, August), Q2 (September, October, November), Q3 (December, January, February), and Q4 (March, April, May) to document progress in the short-tern (one year) and intermediate outcomes (1-3 years). Existing evaluation tools and additional data are provided by partners including Triple P data from the Division of Child and Family Well-Being (DCFW)-Whole Child Health Section, and Family Connects International. The UNC Evaluation team holds meetings with advisors including grantees, implementation coaches, and DPH and DCFW content experts bi-annually to review data and improve evaluation protocols.

Health Equity, Mid-Year FY25

Health equity is the attainment of the highest level of health for all people. Durham County examines the social determinants of health within each evidence-based strategy (EBS) to address health inequities in their county.

Health Equity Impact Assessments (HEIA)

HEIAs are used to evaluate the impact of programs, policies, or initiatives on the health of the population. In the first half of FY25, Durham County continued to work on their previous Breastfeeding HEIA modifications while planning for their upcoming Family Connects HEIA in the second half of FY25.

In Q2, an asset mapping activity was conducted during the Community Action Team (CAT) meeting to allow CAT members to collaborate on modifications identified during the FY24 breastfeeding HEIA. One modification identified involved forming a breastfeeding coalition team made up of stakeholders, community members, and various community-based organizations to expand breastfeeding support across Durham County. During the asset mapping activity, CAT members mapped out organizations not yet involved with the group. Another modification focused on increasing outreach to Durham zip codes with the highest infant mortality, aiming to rebuild trust and engagement. County maps of infant mortality rates were used during the activity in the first quarter to track progress toward this goal. Additionally, the group introduced a branding effort, unveiling the highly anticipated new program name, logo, and icons, **Family Matters Durham**.

Ongoing preparations for the upcoming Family Connects HEIA include finding a facilitator and recruiting participants. Family Connects Durham leadership is involved in the statewide Perinatal Health Equity Collaborative and staff are engaged in center-wide racial equity efforts, including regular listening circles and racial caucus groups.

Source: Grantee quarterly reports, FY25.

Collective Impact, Mid-Year FY25

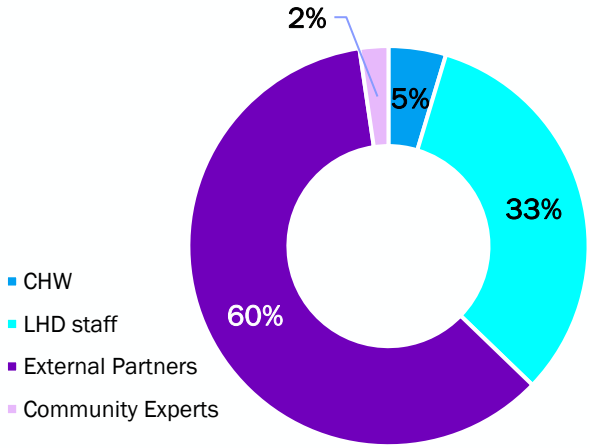
ICO4MCH uses a Collective Impact Framework. Durham County maintains a Community Action Team (CAT) that meets regularly with the goal of providing partner and community input on ICO4MCH activities. CATs are made up of local health department (LHD) staff, community health workers (CHW), and external community organizations and experts.

The Five Conditions for Collective Impact

In the first two quarters of FY25, Durham County has maintained a CAT that is embodied by their community partners. Three key community partners, MAAME, Breastfeed Durham, and Family Connects Durham, play a crucial role in implementing these strategies alongside the **backbone organization,** the local health department (LHD). In Q1, the Durham CAT shifted their meeting schedule from quarterly to bi-monthly, while sharing meeting minutes and presentations with all partner organizations, to ensure effective **continuous communication** across each strategy. Additionally, smaller implementation teams (IT) have been created for some strategies: the Breastfeeding IT meets bi-weekly and Family Connects hosted a community advisory board meeting in Quarters 1 and 2 (Q1 and Q2).

In Q1, Durham held a Fall Kickoff CAT meeting and several outreach events for National Breastfeeding Month. In Q2, Durham held a CAT meeting at which the local program manager and UNC implementation coach led an asset mapping activity centered around the breastfeeding HEIA (health equity impact assessment) modifications. During Q1 and Q2, the CAT has played a crucial role in finalizing the Durham County Human Milk Feeding Strategic Plan, which aims to improve birth and early childhood health outcomes by creating a community where human milk feeding is normalized and accessible to all families. Rallying around this plan has created a **common agenda** and opportunities for **mutually reinforcing activities,** such as the asset mapping activity. The CAT plans to complete and present this plan in Q3; CAT members gathered community feedback through listening sessions with LHD Centering groups (in Spanish and in English). The asset mapping activity sparked discussion surrounding the **shared measurement system** and data collection and highlighted the need to invite other organizations not currently part of the CAT to future meetings. In Q1 and Q2, the local program manager and CHW have implemented new outreach strategies, including participation in community health fairs and events and joining more community groups.

In Q1 and Q2, Durham County held 2 CAT meetings with 43 total attendees. Most CAT members (26) were external partners.



Trainings

In the first half of FY25, Durham County held 9 trainings with 10 total attendees. Trainings included Northwestern University's Mothers and Babies *Train the Trainer*, a *Perinatal Loss Conference* with Wake AHEC, and one racial equity training, *Health Impact Assessment Facilitator Training* with the NC Department of Health and Human Services Title V Office.

9 trainings

- 1 racial equity training in Q2
- 8 collective impact trainings; 4 in Q1 and 4 in Q2

10 trainees

- 3 Community Health Workers (30%)
- 2 LHD staff (20%)
- 5 external stakeholders (50%)

Source: Grantee quarterly reports, FY25.

Implementation Coaching, Mid-Year FY25

FY25 Mid-Year Highlights

During the first half of FY25, ICO4MCH implementation coaches continued to support Durham County, Guilford Collaborative, and Wake County. Primarily, coaches worked with all three grantees as they onboarded new staff and implemented plans for the new fiscal year. During Quarter 1 (Q1), coaches worked most closely with Durham and Wake County teams. During Quarter 2 (Q2), coaches worked more with Guilford Collaborative as they expanded ICO4MCH to Forsyth County. Coaches reviewed the team's workplan and strategized with team members about how to support a growing collaborative. Coaches also provided additional technical assistance (TA) to grantees including planning Community Action Team (CAT) meetings, working with grantees to problem solve specific challenges that affect relationships with partners, and managing internal messaging to health department staff and leaders.

Implementation Coaching for Durham County

In the first half of FY25, implementation coaches worked with Durham County most closely on:

1. Identifying ways to be more intentional about communication
2. Developing needed skills (e.g., Collective Impact, Health Impact, quality improvement)
3. Building and maintaining relationships with key stakeholders

Quarter 1

In Q1, the implementation coach was supportive during CAT meetings by helping to organize the meeting agenda, develop and refine their CAT Community guidelines, and suggest logistical improvements (e.g. offering feedback opportunities, scheduling breaks, framing discussions to engage members). The coach helped to identify professional development opportunities and conferences. The coach observed practice and provided feedback. Additionally, they provided follow up to meetings and assessments through written communication, reports, and presentation of results. At the end of the quarter, the coach helped to plan an activity using the workforce development toolkit for the next CAT meeting, where they will revisit the action steps from the previous breastfeeding Health Equity Impact Assessment (HEIA).

Quarter 2

In Q2, the coach helped the local program manager to decide which activity from the MCH workforce development toolkit would best address the HEIA modifications. They used an asset mapping activity co-facilitated by the coach, who led discussion questions to engage CAT members. The implementation coach has continued to offer support and guidance for the preparation of the next HEIA on the Family Connects strategy. Their coach worked with coordinators to identify needs and assets, clarify goals, and develop strategic approaches to meet strategic goals.

Source: Grantee quarterly reports, FY25.

Preconception & Interconception, Mid-Year FY25

Durham County received ICO4MCH funding for Preconception and Interconception Health programs for individuals of reproductive age with the goal of improving birth outcomes. To accomplish this, the Local Health Department (LHD) is implementing Northwestern University's Mothers and Babies program to promote healthy mood management and how to effectively respond to stress. They will also implement a community-based outreach program for women of reproductive age and utilize social media to expand public awareness of preconception and interconception health. Durham County also chose to partner with a local community college or four-year university to reach students through a Preconception Health Peer Educator (PPE) program.

Outreach & Education

Durham County hosted educational events on preconception and Interconception health to increase the awareness and adoption of healthy eating, active listening skills, enhanced mental wellness, or reproductive life planning.

11 *Outreach and/or educational events held in Quarters 1 and 2 (Q1 & Q2)*

181 *Individuals reached at educational events*

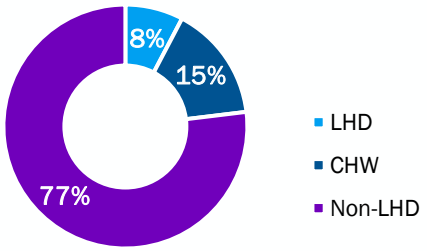
Reproductive Life Planning

- In Q1 and Q2, no trainings on Reproductive Justice were held.
- **40 unique women of reproductive age created a Reproductive Life Planning (RLP) assessment.** Most of these women were between the age of 20 and 24 and identified as Black or African American.
- No men of reproductive age created an RLP during the first half of Fiscal Year 2025 (FY25).

During Q1 and Q2, 13 total staff members were trained in M&B program delivery. Of these, 10 (77%) were non-LHD staff.

Mothers & Babies

During the first half of FY25, Durham County focused on training staff on how to deliver the Mothers & Babies (M&B) program. Their Community Health Worker (CHW) completed the "train the trainer" program in Q1. After the initial trainings are completed, the team will organize additional training sessions and launch group M&B sessions.



Preconception Health Peer Educator (PPE) Program

3 PPE trainings were held in the first half of FY25, all held in Q2

8 students were trained at these PPE trainings in Q2

11 peer educators were active during Q1 and Q2

During the first half of FY25, Durham County held one on-campus event at North Carolina Central University in Q2. This was a campus outreach event to promote safe sex, HIV/STI prevention, mental health, and reduce stigma around sexual health topics. During this event, PPEs conducted a Kahoot on myths and facts of preconception health, "Real Talk" presentation by active PPE students, condom demonstration presentation, and a panel discussion with health educators, sexual coaches, and an epidemiologist.

Major Accomplishments

During the first half of FY25, major accomplishments included completing trainings for Mothers & Babies and partnering with MAAME to start offering M&B sessions next quarter. The CHW enhanced community engagement by participating in a biweekly Giving Closet event, providing education on preconception topics, and increasing total student PPEs to **19 total peer educators,** who hosted their first on-campus event during Q2.

Source: Grantee quarterly reports, FY25.

Ten Steps for Successful Breastfeeding, Steps 3 & 10, Mid-Year FY25

ICO4MCH funding was awarded to Durham County with the goal of reducing infant mortality by encouraging and promoting breastfeeding. The Ten Steps for Successful Breastfeeding is an evidence-based protocol used by Baby-Friendly USA. Steps 3 and 10, to "*inform all pregnant women about the benefits of and management of breastfeeding*" and "*foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center*" are areas that grantees can support as they focus on broader strategies to increase initiation, duration, and support of breastfeeding. To accomplish this, Local Health Departments (LHDs) are training and collaborating with health care providers, community-based and faith-based organizations to increase the knowledge and skills to support breastfeeding women; and increasing social media messaging. Additionally, grantees chose to implement 1) the Making It Work: Empowering Employers and Mothers, 2) Breastfeeding-Friendly City Program, 3) Shared Decision-Making Using Patient Decision Aids, 4) Prenatal Breastfeeding Education: Ready, Set, BABY, or 5) Establish Public Lactation Rooms. **Durham County chose to implement the Prenatal Breastfeeding Education program.**

Outreach & Education

Durham County hosted educational events on the importance of breastfeeding for the mother-baby dyad.

44 *Educational events held*

962 *People of childbearing age reached at educational events*

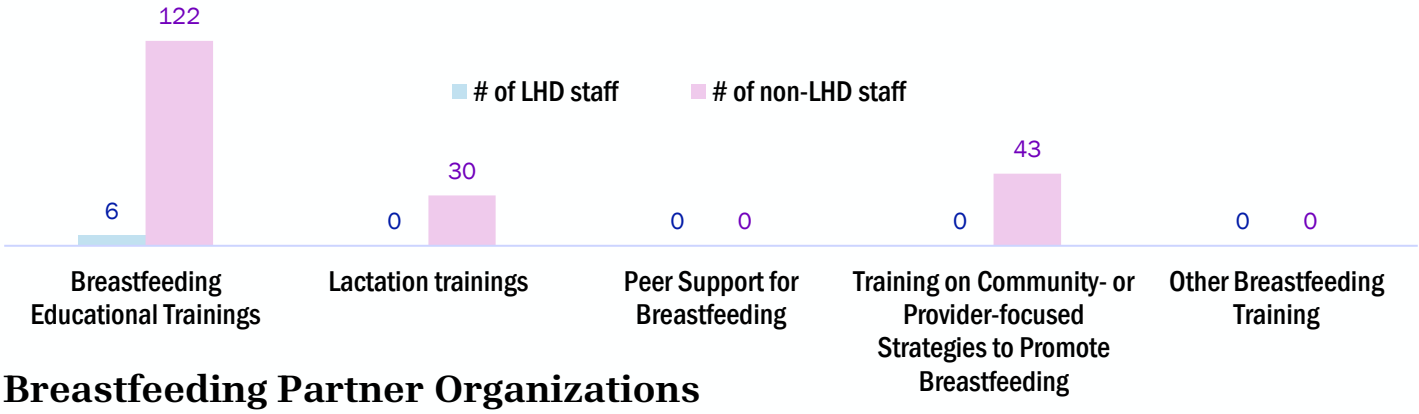
Accomplishments

- In Quarter 1 (Q1), **Durham County finalized an agreement with Welcome Baby - Durham to collaborate on hosting breastfeeding support groups and implementing Ready, Set, BABY classes.**
- In Quarter 2 (Q2), Durham County formed 23 new partnerships with various organizations, including faith-based groups, childcare centers, preschools, and a public library.

Trainings

In the first half of FY25, Durham County held 7 trainings with 201 staff members trained (6 LHD and 195 non-LHD staff).

In the first half of FY25, most of the trainings Durham County held were on breastfeeding education and community or provider-focused strategies to promote breastfeeding.



Breastfeeding Partner Organizations

In the first half of FY25, Durham County began collaborating with 30 new partner organizations (7 in Q1 and 23 in Q2) to support breastfeeding women. In Q1, Durham County participated in the Triangle Area Parenting Support (TAPS) Community Baby Shower alongside established community partners which attracted over 150 families. At this event, the LHD provided breastfeeding pillows and soothing gel pads, along with guidance on breastfeeding basics.

Source: Grantee quarterly reports, FY25.

Family Connects Newborn Home Visiting Program, Mid-Year FY25

FAMILY CONNECTS DURHAM

ICO4MCH funding was awarded to Durham County for the Family Connects International (FCI) Nurse Home Visiting Program to increase child well-being by bridging the gap between parent needs and community resources. Utilizing the Family Support Matrix, home visiting nurses ask questions pertaining to the well-being of the mother, father, and infant in the following domains: health (parental and infant), infant care, safe home (including safe sleep), and social and emotional support for the parents, as well as other needs. Nurses make referrals to resources for the family as indicated by the score on the Family Support Matrix. Activities include: one integrated home visit (IHV) by a registered nurse to all parents of newborns 2 – 12 weeks old born in the service area; two additional home visits from the nurse home visitor for families who need additional support; and referrals to resources and services for the parents or infant.

Mothers Served in Fiscal Year 25

- Of mothers whose ethnicity was assessed, 64% were Hispanic or Latina.
- Of mothers whose racial identity was assessed, 25% were Black or African American.
- 50% of mothers served have no insurance or Medicaid.

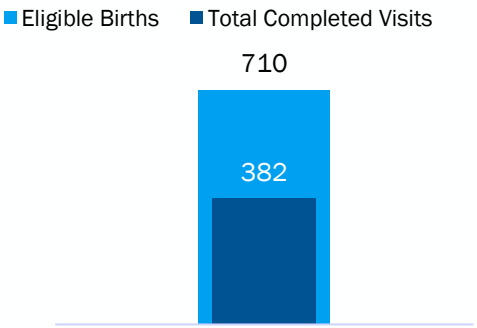
Accomplishments

- Family Connects Durham continued offering Mothers and Babies groups for interested parents, launching its first Spanish-speaking group in November.
- They hired a new Community Alignment Specialist, which has helped reestablish relationships within the community. Additionally, they participated in the Diaper Bank's Health Fair in the fall.

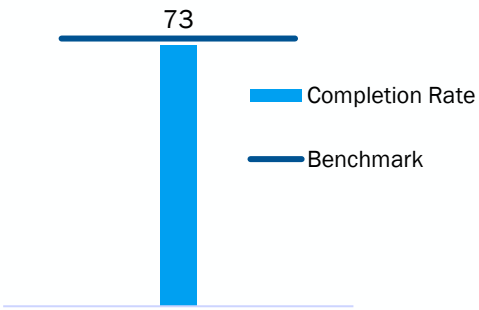
FY25 Family Connects Activity

Family Connects Program Activity	N/%
Eligible Birth Population	710
Scheduled Integrated Home Visits (IHV)	382
Integrated Home Visits Completed	279
Population Reach (IHV Completed out of Eligible)	39%
Completion Rate (IHV Completed out of Scheduled)	73%
Follow-up and Referrals	**N/%**
Families Receiving Follow-up Visit	5
Families Receiving Referrals for Long Term Support	13
Families with Referrals Completed	13
Successful Linkage Rate (Families with Referrals Completed out of Families Receiving Referrals)	100 %

In Fiscal Year (FY) 25, Durham reached 39% of all eligible births with home visits, up from 37% in FY24.



In FY25, Durham completed 73% of all scheduled home visits. The goal is 75%.



Challenges

The new database makes it difficult to capture the number of referral linkages. Only the referrals that nurses mark as complete prior to closing the case are captured. Additionally, two nurses were on medical leave, and one was limited to virtual visits. Combined with the holiday season, this resulted in a lower in-person completion rate.

Source: Grantee quarterly reports, FY25.